

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER Blythe Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 285 West Chanslor Way Blythe, CA 92225	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents reviewed for abuse (Resident 1) was free from verbal abuse when a Certified Nurse Assistant (CNA) yelled profanity toward Resident 1. This failure had the potential to cause psychosocial distress, fear, humiliation, loss of trust, emotional harm, behavioral symptoms, and decline in psychosocial well-being. Findings: A review of Resident 1's record was conducted. Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (decline in cognitive function). A review of Resident 1's Minimum Data Set (MDS - an assessment tool) dated January 30, 2026, indicated a Brief Interview for Mental Status (BIMS - cognitive assessment) score of 11, indicating moderate cognitive impairment. A review of Resident 1's Change of Condition dated April 3, 2026, indicated the facility completed an assessment related to an allegation of verbal abuse involving a CNA. On April 15, 2026, at 11:12 a.m., an interview was conducted with the Laundry Aide (LA). The LA stated on April 3, 2026, at around 5:45 a.m., she heard CNA yelling, What the f**** (expletive) did I say to do? Do what the f****k (expletive) I said, toward Resident 1 while passing by Resident 1's room. The LA stated the CNA should not have spoken to Resident 1, or any resident, in that manner. On April 15, 2026, at 4:10 p.m., an interview with the Administrator was conducted. The Administrator stated this incident was considered verbal abuse. The Administrator stated the CNA's use of profanity and yelling toward Resident 1 was unacceptable and did not promote the resident's right to be free from verbal abuse. The Administrator stated the resident has the right to be treated with dignity and respect and to be free from verbal abuse to prevent feelings of fear, voicelessness, depression, and other negative psychosocial outcomes. The Administrator further stated during the facility's investigation, Resident 1's roommate reported hearing the CNA use profanity toward Resident 1. The Administrator stated the CNA was terminated on April 10, 2026. A review of the facility policy and procedure titled, Abuse Prevention Program, dated December 2016, indicated, residents have the right to be free from abuse. This includes but is not limited to verbal. A review of the facility policy and procedure titled, Abuse Investigation and Reporting, dated July 2017, indicated, If the investigation reveals that the allegation(s) of abuse are founded, the employee(s) will be terminated.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER Blythe Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 285 West Chanslor Way Blythe, CA 92225	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure an allegation of verbal abuse was reported immediately, but not later than two hours after the allegation was witnessed, for one of three residents reviewed for abuse (Resident 1). This failure delayed initiation of the facility's investigation and implementation of timely measures to ensure resident safety, placing Resident 1 at risk for potential ongoing abuse. Findings: On April 3, 2026, at 10:46am, the California Department of Public Health received a call from the facility reporting an allegation of abuse involving a resident and a Certified Nurse Assistant (CNA). On April 15, 2026, at 9:15 a.m., an unannounced visit was conducted to investigate an allegation of verbal abuse. A review of Resident 1's record indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia (a decline in cognitive function). A review of Resident 1's Minimum Data Set (an assessment tool) dated January 30, 2026, indicated a Brief Interview for Mental Status (a cognitive assessment) score of 11 indicating moderate cognitive impairment. A review of Resident 1's Change of Condition dated April 3, 2026, indicated the facility completed an assessment related to an allegation of verbal abuse involving a CNA. Further review of Resident 1's record indicated the facility did not submit the required report to the state agency within two hours. On April 15, 2026, at 11:12 a.m., an interview was conducted with the LA. The LA stated on April 3, 2026, at approximately 5:45 a.m., she heard the CNA yelling, What the f**k (expletive) did I say to do? Do what the f**k (expletive) I said, toward Resident 1 while in Resident 1's room. The LA stated she did not report the incident to her supervisor until approximately 8:45 a.m. (three hours after the incident). The LA stated allegations of abuse should be reported immediately to supervisor and the administrator. The LA further stated timely reporting was important to ensure resident safety and allow the facility to conduct a timely investigation while details of the incident could still be recalled. On April 15, 2026, at 12:26 p.m., an interview was conducted with the Licensed Vocational Nurs (LVN) 1. LVN 1 stated allegations of abuse involving Resident 1 should have been reported immediately after it was witnessed, within two hours to state agency. On April 15, 2026, at 1:50 p.m., an interview was conducted with the Administrator. The Administrator stated the incident was considered verbal abuse. The Administrator stated the incident occurred between approximately 5:15 a.m. and 5:30 a.m. and was not reported to him until approximately 9:15 a.m. to 9:30 a.m., by the Maintenance Supervisor. The Administrator stated the allegation of verbal abuse was not reported within the required two-hour timeframe to the state agency and should have been. The Administrator further stated timely reporting of abuse allegations was important to ensure resident safety and allow the facility to promptly initiate an investigation. A review of the facility policy and procedure titled, Abuse Investigation and Reporting, dated July 2017, indicated, .An alleged violation of abuse.will be reported immediately, but not later than.Two (2) hours if the violation involves abuse.		