

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER Modoc Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 228 W MC Dowell Ave Alturas, CA 96101	

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)
<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their visitation policy and procedure (P&P) for one out of three sampled residents (Resident 1) when Resident 1 was denied (not allowed) visitors of his choosing, the facility did not notify Resident 1 that his friend (Visitor) had been denied visits, there was no documentation present in the medical record, and rules and regulations regarding visitors were not posted for the public and residents to review.</p> <p>This failure violated Resident 1's right to receive visitors of his choosing and had the potential to cause psychosocial harm.</p> <p>Findings:</p> <p>A review of the facility's P&P titled, Visitation, Acute Hospital/SNF, revised 12/1/19, indicated, residents had the right to visitors of their choosing if they had the ability to make their own decisions. The P&P indicated, A visitor may also be prohibited [not allowed] if in the clinical judgement of the healthcare team, a visitor would negatively impact the health or safety of the patient, facility's staff, or other visitor at the facility. The P&P indicated, In all cases, where visitation is denied, the reasons will be clearly communicated to the patient and also documented in the medical record. The P&P indicated, visiting hours, rules, and regulations would be posted (displayed in a place that could be seen).</p> <p>A review of the Patient Information form, dated 12/14/22, indicated, Resident 1 was admitted to the facility on [DATE].</p> <p>A review of the History and Physical, dated, 3/18/25, indicated, Resident 1 had diagnoses of history of CVA (stroke, loss of blood flow to part of the brain) and atrial fibrillation with RVR (irregular heart rhythm).</p> <p>A review of the Admissions Minimum Data Set (MDS, a resident assessment tool), dated 3/11/25, indicated, a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was performed and Resident 1's BIMS score was 14 out of 15 (indicating good memory).</p> <p>A review of the Quarterly MDS, dated [DATE], indicated Resident 1 had a BIMS score of 15 out of 15.</p> <p>(continued on next page)</p>

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
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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/25 at 9:05 am, Visitor stated, [Risk Management, RM] told me, I was to never set foot on the property again and if I do, they will call the Sheriff. Visitor stated, I visit [Resident 1] every Monday, bring him items that he requests, and now I can't go see him.</p> <p>During a concurrent interview and record review on 6/11/25 at 11:18 am, Resident 1 was observed sitting up in bed and smiling. When Visitor's name was mentioned, Resident 1's facial features softened, and his smile widened. Resident 1 stated, [Visitor] visits me every Monday and hasn't been here this week. Resident 1 confirmed, facility staff had not informed him that Visitor was not allowed to enter the facility or visit with him. Resident 1's smile turned into an angry frown, his face scrunched up, and his face began to turn red. Resident 1's voice became loud and stated, I want [Visitor] to visit and I'm not happy that [Visitor] was told she couldn't visit.</p> <p>During an interview on 6/11/25 at 11:45 am, RM stated, I talked to [Visitor] on 6/4/25, she came in and insisted that staff video tape [Resident 1]. I told her she could not record without express permission. I trespassed her for 30 days (a 30-day trespass was an order issued by the Sheriff's department to a person who has threatened to or has caused physical harm. The trespass makes it illegal for that person to enter the facility for 30 days) due to being aggressive. RM stated, I made the decision based on concerns of resident and staff safety.</p> <p>During a concurrent interview and record review on 6/11/25 at 12:10 pm, an untitled document, written by Licensed Nurse (LN) A, dated 6/4/25 was reviewed with RM. RM confirmed, the document indicated, it was written by LN A due to Visitor requesting LN A being present while Visitor videotaped Resident 1 and LN A felt uncomfortable with the request. RM confirmed, the document did not indicate Resident 1's Visitor had been physically or verbally aggressive to residents or staff. RM confirmed, RM did not speak to Resident 1 regarding the incident or notify Resident 1 that Visitor was not permitted in the building or allowed to visit. RM confirmed, RM had not documented the incident or decision to perform a 30-day trespass on Visitor and confirmed, the facility's P&P regarding visitation had not been followed. RM confirmed, verbally informing Visitor there was a 30-day trespass against Visitor and Visitor was not allowed in the facility.</p> <p>A review of the Patient Information form, dated 5/6/25, indicated, Resident 2 was admitted to the facility on [DATE].</p> <p>A review of the History and Physical, dated, 5/6/25, indicated, Resident 2 had diagnoses of hypertension (high blood pressure) and depression (a sad mood).</p> <p>A review of the admission MDS, dated [DATE], indicated Resident 2 had a BIMs score of 11 out of 15 (memory was mildly impaired).</p> <p>During an interview on 6/11/25 at 12:20 pm, Resident 2 (Resident 1's roommate) confirmed, Visitor did not make Resident 2 feel unsafe and stated, she doesn't bother me.</p> <p>During an interview on 6/11/25 at 12:25 pm, Certified Nurse Assistant (CNA) B confirmed being familiar with Resident 1 and Visitor. CNA B stated, I've never had any issues with [Visitor] regarding safety for [Resident 1] or staff.</p> <p>(continued on next page)</p>		

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review on 6/11/25 at 12:27 pm, with Director of Nursing (DON), the entrance of the facility was observed and two information boards (the information boards contained various notices displayed for visitors, staff, and residents to review, such as resident rights and policies and procedures regarding facility rules and regulations) were inspected. DON confirmed, there was no information posted at the entrance of the facility or on the information boards, regarding visitor hours, rules, or regulations. Observed on the information board was an undated document titled, Resident Rights. DON confirmed, the document indicated, residents had the right to visits and reasonable restriction to visit with the resident's permission.		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure bedframes were maintained for resident safety when the Medical Equipment Management Plan and manufacture recommendations were not followed for one of four sampled residents (Resident 1), when the footboard fell off of Resident 1's bed.</p> <p>This had the potential to subject all residents to injury from equipment that the facility had not regularly inspected and maintained for the safe use by residents.</p> <p>Findings:</p> <p>A review of the facility's policies and procedures (P&P) titled, Equipment Management Program, revised 3/1/18, indicated, electronically operated patient beds would be included in the Equipment Management Program.</p> <p>A review of the facility's P&P titled, Preventative Maintenance, revised 3/1/23, indicated, the facility maintained a comprehensive Preventative Maintenance Program for all equipment that included scheduled maintenance and documentation of maintenance.</p> <p>A review of the Medical Equipment Management Plan, dated 1/1/11, indicated, the purpose of the plan was to ensure medical equipment supported safe patient care through maintenance and repair of the equipment. The Medical Equipment Management Plan, indicated, maintenance would be provided based on manufacturer recommendations and work orders would be used for planned maintenance and documentation of maintenance that was performed.</p> <p>A review of the Patient Information form, dated 12/14/22, indicated, Resident 1 was admitted to the facility on [DATE].</p> <p>A review of the History and Physical, dated, 3/18/25, indicated, Resident 1 had diagnoses of history of CVA (stroke, loss of blood flow to part of the brain) and atrial fibrillation with RVR (irregular heart rhythm).</p> <p>A review of the Quarterly Minimum Data Set (MDS, a resident assessment tool), dated 6/9/25, indicated, a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was performed and Resident 1's BIMS score was 15 out of 15 (indicating intact memory).</p> <p>During an interview on 6/11/25 at 11:13 am, Maintenance Lead (ML), stated, Bedframes were inspected on a quarterly basis (every three months).</p> <p>During an interview on 6/11/25, at 11:18 am, Resident 1 stated, the footboard to my bed broke off. Resident 1 was not able to verbalize when it had happened.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/11/25 at 12:02 PM, with ML, Manufacture Recommendations, dated 1/1/23 was reviewed. ML confirmed, the Manufacturer Recommendations indicated, facility staff should thoroughly and visually inspect the bedframe monthly. ML provided an undated document titled, Headboard/Footboard Safety Weekly Checklist (weekly checklist) ML stated, this [weekly checklist] was created after [Resident 1's] footboard broke. ML confirmed, the weekly checklist was blank and stated, the weekly checklist form has not gone into effect. ML confirmed, there was no documentation present that indicated resident bedframes had been inspected for safety.</p> <p>During a concurrent interview and record review on 6/11/25 at 1:15 pm, ML reviewed work orders from 9/1/24 through 6/11/25 and stated, I don't remember when the footboard broke. ML confirmed, there was no work order that indicated Resident 1's footboard had broken or had been repaired and stated, there should be.</p>		