STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555420	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Modoc Medical Center D/P Snf	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)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review the facility failed to ensure there was a Licensed Nurse (LN) in the facility to provide care for 14 out of 14 residents when LN A left the facility for a lunch break. This had the potential to impact resident health status and could have caused a decline in psychosocial well-being. Findings:A review of the Facility Assessment Tool, dated 11/10/25, indicated the facility would staff two LNs on the night shift.A review of the undated Staffing Ratio for Revamping [changing or redoing] up Staffing, indicated, when the facility census (how many residents were in the facility) was less than 30, there would be one LN working the night shift.During an interview on 1/13/26 at 12:19 pm, Certified Nurse Assistant (CNA) B stated, one night, LN A went outside for a smoke break, and she drove away and was gone for an hour. CNA B confirmed, there was no LN in the facility or on the facility grounds while LN A was gone and stated, it was me and another CNA. CNA B stated a resident that was awake [Resident 1] was upset that the nurse left the facility.During an interview on 1/13/26 at 1:12 pm, Resident 1 confirmed, LN A had left the facility one night and stated, the nurse said she was going on break and didn't come back for a long time, maybe an hour. We waited a long time for her to come back and we notified [the Nurse Manager, NM].During an interview on 1/13/26 at 2:25 pm, NM confirmed, CNA B had called NM in the evening on 12/5/25 due to LN A leaving the facility.During a concurrent interview and record review on 1/13/26 at 2:25 pm, with Director of Nursing (DON), security camera video footage, dated 12/5/25 was reviewed. DON indicated that the review of the security camera footage showed LN A sitting in their car for approximately 15 minutes prior to leaving the facility grounds. DON stated, LN A was out of the building for approximately one hour. DON confirmed that LN A had driven away from the facility approximately 11:10 pm or 11:15 pm and returned approximately 40 to 45 minutes later. DON confirmed, there was no LN in the facility for the time LN A was gone.During an interview on 1/13/26 at 4:33 pm, LN A stated, I left to go get food. LN A confirmed that LN A was the only LN working on the evening of 12/5/25 and stated, a few times [in the past], a nurse just showed up to give me a lunch break, and I'm use to just leaving. I didn't think about being the only nurse. I'm used to having another nurse there. I didn't think, I guess I didn't realize at the time, reporting off [providing resident specific details about their care to another LN] to the CNAs left the facility without a nurse.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555420	A. Building B. Wing	01/14/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview and record review the facility failed to ensure that medication was stored securely when Licensed Nurse (LN) A left the medication keys at the nurse's station during a lunch break. This failure caused medication to be accessible to facility staff and residents and had the potential to cause a decline in resident health status. A review of the facility's policy and procedure (P&P) titled, Medication Cart, revised 8/1/24, indicated, the Pharmacists and LN would have access to the medication cart. The P&P indicated, If a nurse leaves the floor for any reason, they must turn over the keys to the cart to another nurse. During an interview on 1/14/26 at 11:41 am, Nurse Manager (NM) stated, I heard she [LN A] left one night for her lunch break and threw her medication keys on the counter at the nurse's station. One of the Certified Nurse Assistant's (CNA) called me. During an interview on 1/14/26 at 12:19 pm, CNA B confirmed that LN A had left the facility for a lunch break and left the medication keys unsecured at the nurse's station and Resident 1 had witnessed it. CNA B stated, Resident 1 was awake and knew the nurse left. During an interview on 1/14/26 at 1:12 pm, Resident 1 confirmed being present when LN A placed the medication keys at the nurses' stations and left the facility for a lunch break. Resident 1 stated, She left her med keys, I think, at the nurses station. During an interview on 1/14/26 at 2:24 pm, Director of Nursing (DON) confirmed, when the LN left the facility for a lunch break, they would hand over their medication keys to another LN. DON confirmed, on 12/5/25, LN A left the facility for a lunch break, placed the medication keys at the nurse's station, and the keys were available for anyone to use. During an interview on 1/14/26 at 4:33 pm, LN A confirmed leaving the medication keys in an unlocked area and LN A stated, I left to get food. I told the CNAs I was going to lunch, and put my keys in a drawer at the nurse's station. LN A confirmed that two CNAs and Resident 1 were present at the time LN A placed the medication keys in the unlocked drawer at the nurse's station.