

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 04/17/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41715</p> <p>Based on interview, observation and record review, the facility failed to meet this requirement when a medication cart was observed to be left unlocked on two occasions. This had the potential to result in unauthorized access to medications that had the potential to cause illness and death.</p> <p>Findings:</p> <p>Review of the facility's policy titled Medication Preparation and Administration, last reviewed 2010, indicated, If the nurse leaves the medication cart, it must be locked.</p> <p>On 4/15/25 at 12:32 PM, a medication cart was observed to be unlocked and openable outside room [ROOM NUMBER]. Unsupervised medications were observed to include heart medication, blood pressure medication, antipsychotics (medications for mental health), and diuretics ('blood pressure pills), among many other drugs. No staff was observed nearby to secure the cart while it was open.</p> <p>On 4/15/25 at 12:33 PM, LVN (Licensed Vocational Nurse) was observed coming toward the unlocked cart from a distant hall in the facility. In a concurrent interview, LVN stated she had left it open and forgot to lock it.</p> <p>On 4/16/25 9:50 AM, the med cart was observed second time, unlocked and with no staff present, outside room [ROOM NUMBER]. In a concurrent interview and observation on 4/16/25 at 9:51 AM, LVN came back to the cart from another hall, acknowledged that it was unlocked again, and stated she got sidetracked.</p> <p>In an interview on 4/16/25 at 9:55 AM, DON (Director of Nursing) stated, The med cart should be locked at all times when not attended.</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
-----------------------------------------------------------------------	-------	-----------

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 04/17/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41715</p> <p>Based on observation, interview and record review, the facility failed to meet this requirement when an expired food product was stored in the refrigerator and available for serving to residents. This had the potential to result in foodborne illness and poor food palatability (flavor, freshness).</p> <p>Findings</p> <p>Review of the facility's policy titled, Food Storage Policy and Procedure dated 2005 indicated, All food should be labeled and dated, and Refrigerated food should be stored upon delivery and careful rotation procedures should be followed.</p> <p>On [DATE] at 12:00 PM, a 15-ounce spray can of Redi Whip whipped topping was observed in the facility's foodservice refrigerator, with a use by date of [DATE] written per the facility's policy. It was observed that the product was nearly two months beyond this use-by date.</p> <p>In a concurrent interview on [DATE] at 12:00 PM, Dietary Manager (DM) confirmed that the whipped topping, Should have been thrown away. DM was observed disposing of the item.</p>		

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 04/17/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49934</p> <p>Based on observation, interview, and record review, the facility failed to follow infection control standards for 4 out of 5 residents (Resident 1, Resident 28, Resident 19, and Resident 29) during medication pass when staff did not disinfect medical equipment and when medication containers were brought into residents' rooms and handled by the residents.</p> <p>This had the potential to spread a communicable disease and cause cross-contamination.</p> <p>Findings:</p> <p>The facility's policy titled, Cleaning of Non-Critical Patient Care Equipment, dated 05/2017, indicated the purpose of this policy is to provide guidance on cleaning and disinfection of non-critical, patient care equipment. It is the policy for patient care equipment to be cleaned and disinfected to prevent the potential spread of infection and cross-contamination.</p> <p>The facility's policy titled, Medication Preparation and Administration, revised 2010, indicated this policy is to ensure the most complete and accurate implementation of a physician's medication orders and to optimize drug therapy by administering drugs in an accurate, safe, timely and sanitary manner.</p> <p>A review of Resident 1's record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that include dementia (impairment of memory, thinking and social abilities), hypertension (pressure in your blood vessels is too high), and renal insufficiency (poor function of the kidneys).</p> <p>Review of the most recent Minimum Data Set (MDS, a resident assessment tool), for Resident 1 dated 2/28/25, indicated that Resident 1 had a moderate cognitive deficit, with a brief interview for mental status (BIMS) score of 8 out of 15.</p> <p>During an observation on 4/16/25 at 7:11 am, Licensed Vocational Nurse (LVN) 1 took the blood pressure of Resident 1. Once finished, LVN 1 then placed the blood pressure cuff on the cart without disinfecting the cuff or the cart.</p> <p>A review of Resident 28's record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses that include diabetes mellitus (high concentration of sugar in the blood), hyperlipidemia (high concentration of fat in the blood), anxiety, and depression.</p> <p>Review of the most recent MDS, for Resident 28 dated 2/04/25, indicated that Resident 28 had no cognitive deficit, with a BIMS score of 13 out of 15.</p> <p>During an observation on 4/16/25 at 8:03 am, LVN 1 took a medication in the manufacturer's box into the room of Resident 28. The medication box was placed on the bedside table without a barrier. The resident then handled the box. After the medication was administered, LVN 1 put the medication box back into the cart drawer with other boxed medications.</p> <p>(continued on next page)</p>		

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 04/17/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LVN 1 on 4/16/25 at 11:15 am, LVN 1 confirmed that the blood pressure cuff should have been wiped with a disinfectant wipe, the box for the medication should not have been placed on a bedside table, and the resident should not have touched the medication box. LVN 1 stated, I could have transferred whatever one of the resident may have to another resident. This would be an infection control issue.</p> <p>A review of Resident 19's record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses that include mild cognitive disorder (the stage between typical thinking skills and dementia), hypertension (pressure in your blood vessels is too high), seizure disorder (when the flow of electrical signals in the brain are disrupted), and psychotic disorder (mental health illnesses that affect the mind where there has been some loss of contact with reality).</p> <p>Review of the most recent MDS for Resident 19 dated 3/14/25, indicated that Resident 19 had no cognitive deficit, with a BIMS score of 15 out of 15.</p> <p>A review of Resident 29's record indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that include hypertension (pressure in your blood vessels is too high), and anemia (blood disorder where the blood has a reduced ability to carry oxygen).</p> <p>Review of the most recent MDS for Resident 29 dated 2/07/25, indicated that Resident 29 had no cognitive deficit, with a BIMS score of 15 out of 15.</p> <p>During an observation on 4/16/25 at 8:23 am, LVN 2 took the blood pressure of Resident 19. At 8:55 am LVN 2 used the blood pressure cuff on Resident 29 without disinfecting the blood pressure cuff in-between the two residents.</p> <p>During an observation on 4/16/25 at 8:23 am, LVN 2 took a medication in the manufacturer's box to Resident 19 who was sitting at a table. The medication box was placed on the table without a barrier. The resident then handled the box. After the medication was administered, LVN 2 put the medication box back into the cart drawer with other boxed medications.</p> <p>During an interview with LVN 2 on 4/16/25 at 11:23 am, LVN 2 confirmed that the blood pressure cuff needed to be wiped down between residents with disinfectant wipes, the box for the medication should not have been placed on a table, and the resident should not have touched the medication box. LVN 2 stated, This is because of infection control.</p> <p>During an interview with the Nurse Manager (NM) and Director of Staff Development (DSD) on 4/16/25 at 10:21 am, both confirmed that the blood pressure cuffs should have been wiped down with disinfectant wipes after each resident. They also confirmed that medical equipment, including carts need to be wiped down. The NM confirmed that the medications boxes should not be placed on tables or allow residents to handle the boxes because of infection control issues. Both confirmed and agreed, Re-education of the nurses is due.</p> <p>During an interview with the Infection Prevention Nurse (IP) on 4/16/25 at 11:27 am, IP confirmed that the blood pressure cuffs should have been wiped with disinfectant wipes because that was an infection control issue. IP also confirmed that residents should not be touching medication boxes, and medication boxes should not touch furniture. IP stated this is another infection control issue. IP stated, It looks like some in-services need to be done.</p>		