

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Fountains, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1260 Williams Way Yuba City, CA 95991	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)		

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 (Resident 1) sampled for resident's right was treated with dignity and respect when Resident 2 reported that Certified Nurses Assistance (CNA) A was rude and impatiently spoke to Resident 1 in a Disrespectful manner, and denied them assistance to the bathroom when requested. These actions resulted in Resident 1 experiencing feelings of upset, disrespect, and intimidation. Findings: During a review of the undated facility policy titled, Prevention, Identification, and Reporting of Abuse indicated, It is the policy of the facility that abuse, neglect, abandonment, isolation, financial abuse shall not be tolerated in this facility at any time. Each resident has the right to be free from verbal, sexual, physical, mental, neglect, financial exploitation, and involuntary seclusion. Residents must not be subject to abuse by anyone, including, but not limited to facility staff. Verbal abuse is defined as any use of oral, written, or gestured communications, or sounds, that willfully includes disparaging and derogatory terms directed to residents within their hearing distance, which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. On 11/4/2025 at 2:49 pm the California Department of Public Health (CDPH) received a facility reported incident alleging Resident 2 observed CNA A verbally abusing Resident 1 on 11/3/2025 and 11/4/2025. A review of Resident 1's admission record, dated 10/13/2025, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of pneumonia, acute respiratory failure with hypoxemia (low oxygen levels), shortness of breath with activity, generalized muscle weakness, and difficulty in walking. A review of Resident 1's care plans dated 10/18/2025, indicated Resident 1 was to assist with use of the bedpan or to the toilet every shift, and will be assisted by staff to transfer in and out of bed and to walk due to fall risk. A review of Resident 1's most recent Minimum Data Set (MDS, resident assessment) dated 11/4/2025, indicated in the Cognitive Function Section that Resident 1's Brief Interview for Mental Status (BIMS, cognitive assessment) score was 14 indicating minimal cognitive impairment. Functional Abilities Section indicated Resident 1 requires supervision and touching assistance with toileting and walking. A review of Resident 2's admission record, indicated Resident 2 was admitted on [DATE] for post-operative orthopedic care (a phase of medical management after bone or joint surgery, focusing on preventing complications). A review of Resident 2's MDS, dated [DATE], indicated Resident 2's BIMS score was 15, indicating normal thinking and memory. Resident 2 makes their own decisions. During an interview with Resident 2 on 11/25/2025 at 4:14 pm, Resident 2 stated they observed CNA A Verbally abusing Resident 1 two days in a row. Resident 2 stated on 11/3/2025 their roommate, Resident 1, had a hard night and was crying and there were lots of tissues on the floor. Resident 2 stated CNA A scolded Resident 1 for Being messy and brought a trash can to the bedside telling Resident 1 to clean up their mess. Resident 2 also stated that the next morning (11/4/2025) CNA A was doing vital signs and woke Resident 1. Resident 2 stated CNA A said to Resident 1, No, I am here to do your vital signs. You always do this. I have a job to do. No, you will wait when Resident 1 requested assistance to go to the bathroom. Resident 2 stated that CNA A left the room and did not come back. Resident 2 stated that the way CNA A talked to Resident 1 was Upsetting and disrespectful. Resident 2 stated CNA A did not take Resident 1 to the bathroom until much later when Resident 2 called for help. Resident 2 stated that later that day CNA A came by their room and pounded on her chest saying, Thank you directed at Resident 2. Resident 2 stated they felt they were being threatened. Resident 2 stated they reported these incidents to Resident 1's family member. During an interview on 12/2/2025 at 10:10 am, Resident 1's Family member stated Resident 2 reported the incident to them on 11/4/2024 and they reported it to the facility. Family member stated they had not witnessed the incident however described Resident 2 as 100% legit (believable). During an interview on 12/2/2025 at 10:12 am, Resident 1 stated they remembered CNA A yelling at them stating, Why do you always do this to me when they requested to be changed. Resident 1 verbalized that she was upset. Resident 1 stated following the two incidents she observed CNA A coming back to her room and telling Resident 2 I will remember you. Resident 1 stated they felt that CNA A's statement was meant to intimidate Resident 2 for reporting the two incidents. During an interview with CNA A on 12/3/2025 at 11:02 am, CNA A stated on the morning of 11/4/2025 around 6:30 am, they went to Resident 1 and Resident 2's room to do vital signs. CNA A stated they started vital signs on Resident 1 and Resident 1 requested to go to the bathroom. CNA A stated they left Resident 1's room to get vital signs on the other residents they were assigned to and came back to Resident 1's room</p>		