

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Eastern Plumas Hospital- Portola Campus Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 500 First Street Portola, CA 96122	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a clean, homelike environment when three of three shower rooms were found to be less than adequately maintained when paint was chipping from walls and ceiling, door jambs were missing paint with hints of rust, shampoo, and/or other products had spilled and dried in an open cupboard with clean towels placed on top, bolts, screws, and nuts that adhere the tub and toilet to the floor were rusty, the foot of the tub and around the toilet was unclean, and hard bristle brushes to scrub the floor were left hanging on hand rails in the shower. This failure had the potential to result in disease transmission, with increasing health and overall wellbeing concerns to those residents utilizing the common space. During a review of the facility's policy and procedure titled, Cleaning and Sanitizing Shared Equipment, dated Last Revised 06/2024, the policy indicated, To prevent disease transmission of shared patient care equipment (and areas) used throughout [the facility name] .All patient common equipment should be cleaned and disinfected between each and every patient use. During an observation on 7/22/25 at 07:30 am, the resident shower rooms were observed for adherence to overall cleanliness. Findings are as follows: 1. Shower room [ROOM NUMBER], with a tub, was found to have a substance, possibly shampoo, that appeared to have leaked out onto the bottom shelf of an open cupboard. The substance was dry and flaky and clean towels were stacked on top of the substance. There was paint missing and the appearance of rust spots around the door jamb. Screws, bolts, and nuts that adhered the tub and toilet to the floor appeared rusty, and the foot of the bathtub and around the toilet were unclean. 2. Shower room [ROOM NUMBER] was found to have multiple used razors sticking out of an almost full sharp's container, paint missing and the appearance of rust around the door jamb, and a used hard bristle brush was hanging from the shower safety handrail. 3. Shower room [ROOM NUMBER] was found to have paint chipping on the walls and ceiling, paint missing and the appearance of some rust around the door jamb, and a used hard bristle brush hanging from the shower safety handrail. During a concurrent observation and interview on 7/23/25 at 12:30 pm, with Certified Nurse Assistant (CNA) L , in shower room [ROOM NUMBER], CNA L stated the hard bristle brush was for floor cleaning and should not be hanging on the shower safety rails where residents could come in contact with it, nor was the room maintained at acceptable standards with noted paint chipping on walls, ceiling, and door jamb, and rust appearing on spots on the door jamb. During a concurrent observation and interview on 7/23/25 at 12:40 pm, with Licensed Nurse (LN) K , in shower rooms [ROOM NUMBERS], LN K confirmed the shower rooms were not adequately maintained, or clean to acceptable standards. During a concurrent observation and interview on 7/23/25 at 2:00 pm, with Assistant Director of Nursing (ADON) I, outside shower room [ROOM NUMBER], shower room [ROOM NUMBER] was observed as well as pictures of shower rooms [ROOM NUMBERS]. ADON I confirmed the shower rooms were not adequately maintained, or clean to acceptable standards. During a concurrent interview and picture review of shower rooms [ROOM NUMBER] on 7/23/25 at 5:00 pm, with Director of Nursing (DON), the DON confirmed the shower rooms were not adequately maintained, or clean to acceptable standards.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555433
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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>(continued on next page)</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to protect four of four sampled residents (Resident 3, 16, 20, and 45) from abuse by chemical restraints when Haldol (an antipsychotic medication used to alter mood and behavior) intramuscularly (IM, a shot) was used in excessive doses, without adequate indications for use, and without trying non-pharmacological interventions (redirection without using medication) first. This subjected the residents to potentially harmful and irreversible unwanted adverse side effects from antipsychotic use and violated their rights for alternative treatment methods prior to the use of medication. This had the potential to seriously impair their ability to attain or maintain their highest practicable level of physical, emotional and psychosocial well-being. Findings:According to Lexicomp an online National Library of Medicine information site for professionals, Haldol is not approved for the use of dementia-related psychosis. Haldol used in patients with dementia over [AGE] years old, can cause sudden death by heart failure. No more than 2 mg of Haldol should be administered to patients over 65 with dementia. Haldol has a Black Box Warning (BBW), this is the most stringent Food and Drug Administration (FDA) warning for drugs that have dangerous side effects. During a review of the facility's policy and procedure (P&P) titled, informed Consent for use of Psychotherapeutic Drugs dated 2025, the P&P indicated, before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent and non-pharmacological approaches that could address the resident's needs. During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Drug Management, dated 2025, the P&P indicated, unnecessary drugs shall be avoided. The facility shall monitor all psychotherapeutic medications for effectiveness and side effects according to Omnibus /budget Reconciliation (OBRA) guidelines. Psychotropic drugs shall only be utilized with a physician order and shall never be used for the convenience of staff. The physician shall write a progress note describing the behaviors and the reason for ordering the psychotropic drug. A review of the medical record for Resident 3 indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), without behaviors, and anxiety. During a concurrent interview and record review on 7/23/25 at 10:00 a.m., with Director of Nursing (DON), Resident 3's, Medication Administration Record (e-MAR), dated July 2025, was reviewed. The DON confirmed Resident 3 was given Haldol 2.5 milligrams (mg, a unit of measure), IM on 7/15, 7/16, 7/17, and 7/21/25. During a concurrent interview and record review on 7/23/25 at 10:10 a.m., with DON, Resident 3's Progress Notes (PG), April and May 2025 was reviewed. The DON confirmed PG there were no physician PG notes describing the behaviors and reason for ordering Haldol. During a concurrent interview and record review on 7/23/25 at 10:20 a.m., with DON, Resident 3's Behavior Monitoring and Interventions Report, (BMIR) dated July 2025 was reviewed. The DON confirmed Resident 3's BMIR indicated there were no behaviors or non-pharmacological interventions charted for Resident 3 on 7/15/25, at 5:04 a.m. A review of the medical record for Resident 16 indicated, Resident 16 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, unspecified severity, with behavioral disturbance. During a concurrent interview and record review on 7/24/25 at 10:00 a.m., with DON, Resident 16's e-MAR, dated May 2025 was reviewed. The DON confirmed Resident 16 was given Haldol 5mg IM on 5/24, 5/25, 5/27, 5/30, 5/31/25. During a concurrent interview and record review on 7/24/25 at 10:10 a.m., with DON, Resident 16's PG, dated April and May 2025 were reviewed. The DON confirmed there were no physician PG notes describing the behaviors and reason for ordering Haldol. During a concurrent interview and record review on 7/24/25 at 10:20 a.m., with DON, Resident 16's BMIR dated May 2025 was reviewed. The DON confirmed Resident 16's BMIR indicated, there were no non-pharmacological interventions charted for 5/24/25 and 5/30/25. During a review of Resident 16's PG, dated 5/24/25 at 1:48 a.m., and 5/24/25 at 2:06 a.m., the PG indicated Resident 16 was given Haldol 5 mg IM for agitation and being combative toward nursing staff. At 4:45 p.m., the PG indicated Resident 16 did not get his morning medications because he was sleepy. During a record review of Resident 16's PG dated 5/27/25 at 11:38 p.m., the PG indicated Resident 16 was refusing care and sitting in his wheelchair leaning dangerously forward and tried to get out of his chair and walk. Haldol was given IM by nursing staff. During a record review of Resident 16's PG dated 5/30/25 at 6:34 p.m., 7:15 p.m., and 7:35 p.m. the PG indicated, Resident 16 became physically combative with staff when they attempted to</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents were protected from accidents and hazards when: One of two residents sampled for falls with injuries (Resident 9), was transferred by staff from her bed to her wheelchair, without using the proper equipment. Two of three shower rooms were observed to have unlocked, open cabinets that contained disposable razors and a sharps container (a plastic safety container for needles and sharp objects), that was over spilling with used razors. These failures resulted in Resident 9 sustaining a broken ankle and had the potential for residents who used the shower rooms to be injured by cuts from razors which could negatively impact residents physical and emotional well-being. 1. Resident 9 was admitted to the facility for heart disease with heart failure, lymphoma (a form of blood cancer), a history of falling, cervicalgia (back pain), osteoporosis (brittle bones), and an above the knee amputated (surgically removed) left leg.</p> <p>Review of Resident 9's care plans (undated) indicated that staff should use Resident 9's, "Procedures for Transfer," which were printed and taped near Resident 9's bedside with instructions for the Certified Nursing Assistants (CNAs) on how to safely transfer Resident 9 using a slide board (a plastic or wooden flat board that assists those who cannot stand by sliding across the board to transfer in and out of bed). Resident 9's care plan indicated, "7. [Resident 9] can lean to the left while using slide board, and that slide board was necessary to transfer Resident 9 safely.</p> <p>Review of Resident 9's Minimum Data Set (MDS, a panel of assessments to determine the level of care needed for a resident), section GG "Functional Abilities," performed on 4/27/25 indicated that Resident 9 was "dependent" (needed complete assistance) for a bed-to-chair transfer.</p> <p>Review of the facility's record titled, "Shift Report" (undated), an informational sheet CNA's used for the level of care a resident needs, indicated that Resident 9 was a "two person assist, using a slide board."</p> <p>Review of the facility's Occupational Therapy department's record titled, "OT Daily Documentation," dated 11/25/24, indicated that Resident 9 required a slide board for CNA staff to transfer her and that education and demonstration using the slide board had been provided to staff.</p> <p>A review of Occupational Therapy notes from 12/1/24 to 7/1/25 indicated Resident 1 was a, "moderate" to "maximum assist" with transfers using a slide board in all instances.</p> <p>Review of Resident 9's Nurses Notes dated 7/1/25, indicated that on 7/1/25 at 11:30 AM CNA A was attempting to transfer Resident 9 from her bed to a wheelchair without the use of a slide board, the resident [Resident 9] slid to the bed, injuring her ankle.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 9's progress notes dated 7/11/25 at 11:30 AM, indicated that CNA A was helping transfer Resident 9 from her bed to her wheelchair. CNA A directed Resident 9 to stand up on her right leg to make the transfer, instead of using the slide board. Resident 9 was not able to bear her weight on one leg, her only leg, and fell and broke her right ankle. The progress note indicated that Resident 9's right ankle became swollen and bruised and she had to go to the hospital emergency room for treatment.</p> <p>Review of the hospital emergency room notes, dated 7/12/25, indicated that Resident 9 had sustained a, "fracture [broken] of the right ankle." Resident 9's right ankle was put in an orthopedic boot (a splint that keeps the ankle from moving), and returned back to the facility.</p> <p>In an interview on 7/21/25 at 1:39 PM, Resident 9's family member (FAM) N confirmed that Resident 9 was always transferred using a slide board and that the instructions were posted right next to Resident 9's bed.</p> <p>In an interview on 7/22/25 at 10:05 AM, CNA A confirmed that she had transferred Resident 9 on 7/11/25, without using a slide board, and confirmed she had been instructed to always use the slide board when transferring Resident 9. CNA A confirmed that she had not asked another staff to help her transfer Resident 9 and confirmed that she knew two staff were required but attempted to transfer Resident 9 by herself. CNA A stated that on 7/11/25, Resident 9 expressed she did not want to use the slide board and CNA A chose to stand Resident 9 up on one leg to transfer her. CNA A stated that she should have asked the nurse what to do when Resident 9 didn't want to use the slide board, because there were no instructions on what to do if Resident 9 refused to be transferred with the slide board.</p> <p>In an interview on 7/22/25 at 10:27 AM, Occupational Therapist (OT) B stated, When we worked with [Resident 9], we recommended a slide board be used because of her knee pain and having only one leg, it relieved the pressure on her knee. She is at least a two-person assist for patient and staff safety. If a resident refuses to use the board to transfer, they should 1) Get help, or 2) speak to their resident and let her know that we would need to use a Hoyer (mechanical) lift, which is also a two person assist.</p> <p>In an interview on 7/24/25 at 11:00 AM, OT C stated that she worked with Resident 9 for nine months on transferring safely. OT C stated, "She needed the slide board because of her knee pain, we shouldn't be doing "stand and pivot" transfers because they torque [twist] the knee and ankle, and she only had that leg to stand on." OT C stated that the slide board was recommended for Resident 9's safety and for staff safety. "We did in-services [training] with nursing assistant staff working with the resident [Resident 9], to transfer her safely. Somedays she refused, the remedy was just to spend more time with resident to persuade her to allow the slide board to be used."</p> <p>In an interview with Director of Nursing (DON) on 7/22/25 at 3:00 PM, DON indicated that the standard of care used by the facility for transferring residents is the, "Lippincott procedures" (undated), an online nursing resource.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Lippincott procedures, "Transfer from Bed to Wheelchair," (undated) provided by the facility indicated, "For a patient who can't stand, a transfer board allows safe transfer from a bed to a wheelchair;" and; "Assess the patient's needs and abilities when making decisions about the necessary equipment for transfer, because different patients require varying levels of assistance with transfer." The [NAME] further indicated, "A lateral patient transfer can pose risks to the patient and health care worker. Safe patient transfer may require the assistance of one or more coworkers as well as the use of assistive patient handling equipment, such as a sliding board;"</p> <p>2. During a review of the facility's policy and procedure titled, "Resident Safety", dated last revised 5/2022, the policy indicated, "It is the policy of [the facility] to ensure the optimum safety for all residents at all times;"</p> <p>During an observation on 7/22/25 at 7:30 AM, the resident shower rooms were observed for adherence to overall cleanliness and safety. Shower room [ROOM NUMBER] was observed to have an open container of new razors in an unlocked and open cabinet. Shower room [ROOM NUMBER] was observed to have multiple uncovered, used razors sticking out from the opening of an almost full sharp's container easily accessible to residents, and an open container of new razors in an unlocked cabinet.</p> <p>During a concurrent observation and interview on 7/23/25 at 12:40 PM, with Licensed Nurse (LN) K in shower room [ROOM NUMBER] and 2, LN K agrees that open packages of new razors should not be left in an unlocked, nor open cabinet, and used, uncovered razors should not be left sticking out of a mostly full sharp's container accessible to residents.</p> <p>During a concurrent observation and interview on 7/23/25 at 2:00 PM, with Assistant Director of Nursing (ADON) I, outside shower room [ROOM NUMBER], pictures of the shower rooms [ROOM NUMBERS] were observed. ADON I confirms that open packages of new razors should not be left in an unlocked, nor open cabinet, and used, uncovered razors should not be left sticking out of a mostly full sharp's container accessible to residents.</p> <p>During a concurrent interview and picture review on 7/23/25 at 5:00 PM, with DON in the office the surveyors were utilizing, pictures of shower rooms [ROOM NUMBERS] were observed. DON confirmed that open packages of new razors should not be left in an unlocked, nor open cabinet, and used, uncovered razors should not be left sticking out of a mostly full sharp's container accessible to residents. This is a matter of resident safety.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p>

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<p>F 0726</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 observation, interview, and record review, this requirement was not met when staff were inadequately trained in resident care for two of two sampled residents (Resident 9 and 36) when: 1. Certified Nursing Assistant (CNA) failed to follow policy and the resident's care plan when transferring Resident 9 from bed, which resulted in Resident 9 sustaining a broken right ankle. 2. A Registered Nurse (RN), delegated her responsibility to a CNA to administer oxygen to Resident 36. 1. Resident 9 was admitted to the facility for heart disease with heart failure, lymphoma (a form of blood cancer), a history of falling, cervicgia (back pain), osteoporosis, and an amputated (surgically removed) left leg. Review of Resident 9's care plans (undated) indicated that staff should use Resident 9's, Procedures for Transfer, a printed sign in a plastic sleeve that was taped near Resident 9's bedside to instruct CNAs in safely transferring Resident 9. Resident 9's care plan indicated, 7. [Resident 9] can lean to the left while using slide board, and that slide board was necessary to transfer the resident safely. Review of Resident 9's Minimum Data Set (MDS, an assessment tool), section GG Functional Abilities, performed on 4/27/25, indicated that Resident 9 was dependent (needed complete assistance) for a bed-to-chair transfer. Review of the facility's record titled, Shift Report (undated), a sheet used for CNAs to provide care to residents, indicated that Resident 9 was a two person assist, using a slide board [an assistive device that reduces a resident's need to support their weight while being transferred from one surface to another by staff]. Review of the facility's Occupational Therapy department's record titled, OT Daily Documentation, dated 11/25/24, indicated that Resident 9 required a slide board for CNA staff to transfer her, Educated and modeled [demonstrated] for staff transfers with slide board. A review of Occupational Therapy notes from 12/1/24 to 7/1/25 indicated Resident 9 was a moderate to maximum assist using slide board in all instances. Review of Resident 1's Nurses Notes, dated 7/1/25, indicated that on 7/1/25 at 11:30 AM, CNA A was attempting to transfer Resident 9 from her bed to her wheelchair without the use of a slide board, and had asked Resident 9 to stand on her only leg. Resident 9 slid to the bed, injuring her right ankle. In an interview with Director of Nursing (DON) on 7/22/25 at 3:00 PM, DON indicated that the standard of care for transferring residents in the facility is Lippincott procedures (undated), an online nursing resource as follows: A review of Lippincott procedures, Transfer from Bed to Wheelchair, (undated) provided by the facility indicated: For a patient who can't stand, a transfer board allows safe transfer from a bed to a wheelchair; and; Assess the patient's needs and abilities when making decisions about the necessary equipment for transfer, because different patients require varying levels of assistance with transfer. [NAME] further indicated, A lateral patient transfer can pose risks to the patient and health care worker. Safe patient transfer may require the assistance of one or more coworkers as well as the use of assistive patient handling equipment, such as a sliding board. Review of progress notes dated 7/11/25, indicated that Resident 9's right ankle became swollen and bruised and she was transferred to the hospital emergency room for an examination and treatment. Review of the hospital emergency room notes for Resident 9's visit, dated 7/12/25, indicated that Resident 9 sustained a fracture [broken] of the right ankle. In an interview on 7/21/2025 at 1:39 PM, Resident 9's Family Member (FAM) N stated that Resident 9 sometimes refused to use the slide board, but it's easy to redirect her and ask her to use the board. FAM N stated that if Resident 9 refused the board, staff should not be transferring her under any circumstances since she has to bear all her weight on one weak leg and has osteoporosis (weak, calcium-poor bones prone to breakage). In an interview on 7/22/2025 at 10:05 AM, CNA A confirmed that she had transferred Resident 1 without using a slide board or two-person assist as she had been instructed. CNA A stated that she should have alerted a nurse to help her when Resident 1 refused to use the slide board, and that she should have used a two-person assist and got another CNA to help. She confirmed that the using the sliding board for Resident 9 to transfer is listed on the rounding sheet, (shift report) that we are provided. CNA A stated that she was trained to get help and to use the slide board, and would do that next time. In an interview on 7/22/2025 at 10:27 AM, Occupational Therapist (OT) B stated, When we worked with [Resident 9], we recommended a slide board be used because of her knee pain and having only one leg, it relieved the pressure on her knee. She is at least a two-person assist for patient and staff safety. If a resident refuses to use the board to transfer, they should 1) Get help, or 2) speak to the resident and let her know that we would need to use a Hoyer (mechanical) lift, which is also a 2 person assist. 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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>Based on interview, observation and record review, the facility failed to meet this requirement when staff failed to follow a physician ordered therapeutic diet and fortify (add extra calories) one of six sampled residents who were on therapeutic diets. (Resident 12) This had the potential to cause undesired weight loss, delayed wound healing and malnutrition for Resident 1 and other residents who had physician ordered fortified diets. A review of the facility's record titled, Policy and Procedures Manual: High Calorie/High Protein Supplements, Nutrition Interventions dated 2021 indicated, Individuals needing supplemental nutrition will be served a suitable high calorie/high protein diet, and Nursing staff will supervise the delivery and consumption of all supplements and record appropriately in the medical record. A review of the facility's diet manual used by kitchen staff, Fortified Diet was defined as Foods that have protein, carbohydrates, and/or fats added to increase the total nutritional value of the food. A review of the facility's physician-ordered diet for Resident 12 (undated report) indicated Fortified diet. In a concurrent observation and interview on 7/22/25 at 12:16 PM, Dietary Manager (DM) G was observed plating food for residents on fortified diets. No fortification was observed being made to the Beef with Roasted Vegetables entree that DM G plated for Resident 12. When brought to DM G's attention, DM G stated that the fortification for today's entree was an extra pat of margarine. The margarine was observed to be placed alongside Resident 12's napkin on the tray with a pat of margarine for the roll that was presented. In an observation on 7/22/25 at 12:35 PM, Certified Nursing Assistant (CNA) D was observed presenting Resident 12's tray for lunch; CNA D did not offer the margarine that was on his tray that was intended as required fortification. We present butter if they ask for it. CNA D stated that he was unaware that the additional pat of margarine was part of the fortified diet ordered for Resident 12. In an interview on 7/22/25 at 12:48 PM, CNA H was unaware that fortification for residents' diets that day was a butter pat. CNA H stated, They can eat whatever they want. In an interview on 7/23/25 at 10:05 AM, the Director of Nursing (DON) stated that nursing staff was not aware that butter pat was a part of the therapeutic diet, therefore no training was given to CNAs to ensure extra margarine pat was used and given to each resident requiring a fortified diet. In an interview on 7/24/25 at 3:30 PM, Registered Dietitian (RD) J stated that it is her expectation that additional calories for fortified diets should be part of each recipe for the food presented, not to be presented as margarine pats on the tray.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Eastern Plumas Hospital- Portola Campus Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 500 First Street Portola, CA 96122	
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 - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review the facility failed to maintain sanitary, clean kitchen equipment when the ice machine acquired a large amount of mineral buildup (white coating that harbors bacteria) on the tray and the spout, debris was noted in the internal cabinet area of the machine, and the cupboard the ice machine sat upon did not appear clean. This failure had the potential to result in ice that was contaminated with bacteria which could negatively impact the health and overall well-being to residents, staff and visitors. During a review of the facility's policy and procedure titled, Cleaning and Sanitizing Ice Machines, dated revised 9/2024, the policy indicated, It is the policy of [the facility name] that all ice machines will be properly maintained and cleaned. They should be clean to the sight and touch, including ice machine tray and spout. They also remove exterior scaling as needed. During an observation on 7/22/25 at 5:00 pm, the ice machine was observed to have a great deal of mineral buildup on its tray and on the inside of the ice spout. The internal cabinet to the functioning area of the machine was noted to have buildup and debris on the bottom of the cabinet, and the cupboard that the entirety of the ice machine sat upon was unclean with buildup, water and splash marks, and debris. During an observation and interview on 7/23/25 at 8:50 am, with Maintenance (Maint) in the space where the ice machine was located, Maint stated the mineral buildup on the ice machine is difficult to remove and agreed the machine and the cupboard it sits upon appears unclean. During an observation and interview on 7/23/25 at 11:00 am, with Director of Plant Management (DPM) in the space where the ice machine was located, the DPM stated the newly hired maintenance crew cleaned the machine recently, but confirmed there was a great amount of buildup in the tray and in the spout, the actual interior of the ice machine cabinet had loose debris, and the cupboard the ice machine sat upon appeared less than adequately cleaned.</p>		

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NAME OF PROVIDER OR SUPPLIER Eastern Plumas Hospital- Portola Campus Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 500 First Street Portola, CA 96122	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection control standards for 2 out of 5 sampled residents during a medication pass and dining (Resident's 1 and 23) when: 1. Staff did not sanitize a potentially contaminated instrument used to puncture and remove a safety seal on a medication.2. A medication container was brought into a resident's room and placed on a potentially contaminated surface without a barrier.3. Staff did not sanitize their hands after touching potentially contaminated surfaces while feeding residents in the dining room. This had the potential to spread a communicable disease and cause cross-contamination.</p> <p>1.The facility's policy titled, "Standard Precautions", last approved 09/2024, was reviewed and indicated, It is the policy of [the facility name] that standard precautions be followed for all patient care .to reduce risk of transmission from both recognized and unrecognized sources of infections . and to prevent the spread of infection from patient to patient.</p> <p>A review of Resident 1's record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (impairment of memory, thinking and social abilities), Multiple Sclerosis (damage to the protective cover around nerves causing muscle weakness, vision changes, numbness and memory issues), and muscle wasting and atrophy (loss of muscle mass and strength).</p> <p>Review of the most recent Minimum Data Set (MDS, a resident assessment tool), for Resident 1 dated 6/22/25, indicated that Resident 1 had a severe cognitive deficit, with a brief interview for mental status (BIMS) score of 00 out of 15.</p> <p>During an observation on 7/23/25 at 8:27 am, Licensed Vocational Nurse (LN) K, during the medication pass on cart 1, retrieved a new, unopened liquid medication from the medication room (room where extra medications are stored). LN K took the lid off of the medication and could not remove the safety seal. LN K used a writing pen to puncture the seal and to scrape along the inside edge of the opening of the bottle to loosen the safety seal enough to enable her to pull it off.</p> <p>During an interview with LN K on 7/23/25 at 12:38 pm, at the nurse's station, LN K confirmed that using the writing pen to open the new medication, "was not appropriate and this could cause an infection control issue."</p> <p>2. A review of Resident 23's record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses that included osteoporosis (a medical condition where bones become brittle and fragile from loss of tissue), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and Chronic Obstructive Pulmonary Disease (COPD, a condition involving constriction of the airways and difficulty or discomfort with breathing).</p> <p>Review of the most recent MDS for Resident 23, dated 7/03/25, indicated that Resident 1 had no cognitive deficits, with a BIMS score of 15 out of 15.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Eastern Plumas Hospital- Portola Campus Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 500 First Street Portola, CA 96122	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 7/23/25 at 8:56 am, LN O, during the medication pass on cart 2, took a medication in the manufacturer's box into the room of Resident 23. The medication box was placed on the bedside table without a barrier. After the medication was administered to the resident, LN O put the medication back into the medication box, and put the medication box back into the medication cart drawer with other boxed medications.</p> <p>During an interview with LN O on 7/23/25 at 12:52 pm, at the nurse's station, LN O confirmed that the medication box is, "porous and cannot be thoroughly cleaned, and this is an infection control issue."</p> <p>During an interview with the Assistant Director of Nursing (ADON) I on 7/23/25 at 2:28 pm, in the ADON I's office, the ADON I confirmed, "Inserting a pen into a medication to open the safety seal is an infection control issue. Also, bringing in a box for a medication into a resident's room without a barrier is an infection control issue, too. These things should not happen."</p> <p>During an interview with the Director of Nursing (DON) on 7/23/25 at 3:55 pm, in an office, the DON confirmed that opening a medication's safety seal with a writing pen and bringing a boxed medication into a resident's room without a barrier, "is an infection control problem."</p> <p>3. During a review of the facility policy and procedure titled, "Hand Sanitizing", dated Last Revised 4/2024, the policy indicated, "It is the policy of [the facility's name] to practice hand hygiene in compliance with standards set forth by the Centers for Disease Control and Prevention (CDC) and the California Department of Public Health (CDPH) in order to prevent transmission of infectious diseases via health care providers' hands and to decrease the chance of health care provider colonization. When to perform hand hygiene&hellip;after touching patient&hellip;after touching a patient's surroundings, including&hellip;surfaces&hellip;before eating (feeding)&hellip;";</p> <p>During observations on 7/22/25 at 08:10 am and 12:15 pm, in the dining room. Certified Nursing Assistant (CNA) M was observed assisting two residents to eat at the assisted dining table. CNA M was observed touching wheelchair handles, chairs, other residents' trays after they had finished eating, and countertops. No hand sanitizing was observed amongst these actions prior to returning to feeding the two assisted dining residents.</p> <p>During an interview on 7/22/25 at 2:00 pm, in the hallway outside of room [ROOM NUMBER], with CNA M, CNA M confirmed they had not thought about the result of touching surfaces such as wheelchair handles, and other trays, and then not sanitizing before continuing feeding the residents.</p> <p>During an interview on 7/23/25 at 4:00 pm, with ADON I, in the ADON I's office, ADON I stated the expectation for staff is to follow hand sanitizing guidelines and standards of care and to hand sanitize after touching potentially contaminated surfaces and prior to assisting to feed residents in the dining room.</p> <p>During an interview on 7/23/25 at 5:00 pm, with the DON, the DON confirmed the expectation was for staff to follow appropriate hand sanitizing guidelines and standard of care and to hand sanitize after touching potentially contaminated surfaces and prior to assisting to feed residents in the dining room.</p>		