STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Park Rehabilitation Hospital	2850 Sierra Sunrise Terrace Chico, CA 95928

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42192 Based on interview, record review, and facility policy review, the facility failed to ensure a certified nursing assistant (CNA) immediately reported an allegation of rough care to facility management so they could carry out the facility's abuse protocol for 1 (Resident #32) of 1 resident reviewed for an allegation of staff-to-resident abuse. Findings included: A facility policy titled, Abuse, Prevention of, revised 05/10/2018, indicated, PURPOSE: To ensure that residents' rights, safety and well-being are protected by providing a method for the prevention of any type of resident abuse. POLICY: It is the policy of this facility that each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, exploitation, mistreatment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultant or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The section of the policy titled, G. Reporting specified, 5. First responder or first staff member informed of the incident are responsible for informing their immediate supervisor and Administrator. Resident #32's Admission Record indicated the facility admitted the resident on 07/18/2024. According to the Admission Record, the resident had a medical history that included diagnoses of type two diabetes mellitus, muscle weakness, difficulty walking, unsteadiness on feet, and history of falling. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/21/2025, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. During an interview on 03/13/2025 at 5:15 AM, CNA #12 stated last Thursday (03/06/2025) Resident #32 mentioned that they had a horrible day. According to CNA #12, the resident reported that while their usual CNA, CNA #5, was on break, CNA #17 assisted them with a transfer using a lift. CNA #12 stated the resident told her CNA #17 was a little rough. She stated she should have told the nurse about the resident's statement about CNA #17, but she did not. During an interview on 03/13/2025 at 9:57 AM, Resident #32 stated they had received care provided by CNA #17. The resident described CNA #17 as nice but stated CNA #17 was kind of rough with care and did not take his time while assisting the resident. (continued on next page)

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
	555625	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Park Rehabilitation Hospital	2850 Sierra Sunrise Terrace Chico, CA 95928

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/2025 at 2:01 PM, the Director of Nursing (DON) stated no staff members had reported complaints from residents about rough care from CNAs. She stated if the staff had reported rough care concerns to the nurses, a note would have been made. The DON stated she reviewed Resident #32's record, and she did not find any notes concerning rough care. During an interview on 03/13/2025 at 3:26 PM, the Administrator stated CNA #12 knew better than to not report the resident's statement regarding rough care. He stated CNA #12 should have reported the resident's statement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Park Rehabilitation Hospital	2850 Sierra Sunrise Terrace Chico, CA 95928

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52224 Based on interview, record review, facility policy review, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the classes of medications received during the assessment look-back periods for 2 (Resident #74 and Resident #70) of 2 residents reviewed as part of the Resident Assessment task and failed to ensure MDS assessments accurately reflected weight-loss statuses for 2 (Resident #8 and Resident #25) of 2 sampled residents reviewed for nutrition. Findings included: A facility policy titled, Certifying Accuracy of the Resident Assessment, revised 11/2019, indicated, 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. 3. The information captured on the assessment reflects the status of the resident during the observation ('look-back') period for that assessment. The CMS Long-Term Care Facility RAI 3.0 User's Manual, version 1.19.1, dated October 2024, revealed section K0300: Weight Loss specified, -Code 0, no or unknown: if the resident has not experienced weight loss of 5% [percent] or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is unavailable. - Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in the past 30 days or 10% or more in 180 days as a result of a physician-ordered diet plan or expected weight loss due to loss of fluid with physician's orders for diuretics, K0300 can be coded as 1. The User's Manual further revealed section N0415: High-Risk Drug Classes: Use and Indication specified, -N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g. [exempli gratia, for example], aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). 1. An Admission Record indicated the facility admitted Resident #74 on 01/26/2025. According to the Admission Record, the resident had a medical history that included diagnoses of transient cerebral ischemic attack (brief stroke-like attack) and cerebral infarction (stroke) without residual deficits. Resident #74's Order Summary Report contained an active order dated 01/27/2025 for Plavix (clopidogrel, an antiplatelet medication) 75 milligrams (mg) by mouth one time a day. The Order Summary Report did not reflect any orders for anticoagulant medications. Resident #74's 01/2025 Medication Administration Record (MAR) revealed documentation that indicated the resident received their Plavix daily as ordered during the timeframe from 01/27/2025 through 01/31/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Park Rehabilitation Hospital	2850 Sierra Sunrise Terrace Chico, CA 95928

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #74's admission MDS, with an Assessment Reference Date (ARD) of 01/31/2025, revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS was coded to reflect Resident #74 received an anticoagulant medication, but not an antiplatelet medication, during the seven-day assessment look-back period. Registered Nurse (RN) #20 was interviewed on 03/12/2025 at 4:23 PM. RN #20 stated she had been working in the role of MDS Coordinator for almost one month. RN #20 stated that she was responsible for completing section N of the MDS regarding medications received by the resident. She stated that when she completed Section N of the MDS, she reviewed the MAR to see what medications were administered to the resident during the seven days prior to the ARD of the assessment, and if the resident received any medications listed in section N of the MDS she would code those medications on the MDS. RN #20 stated she completed section N of Resident #74's admission MDS, and she reviewed the resident's January 2025 MAR when she completed that section. After reviewing Resident #74's admission MDS and their January 2025 MAR, RN #20 stated that Resident #74 did not receive an anticoagulant medication at the time of the assessment and further stated, I made a mistake. Nurse Consultant (NC) #21 was interviewed via telephone on 03/12/2025 at 4:33 PM. NC #21 stated that the MDS Coordinator was trained on how to complete section N of the MDS and was trained to review the relevant medications the resident received during the seven days prior to the ARD. NC #21 stated the source of information to code section N usually included the MAR for the look-back period to determine if the medications listed in section N of the MDS were taken by the resident. NC #21 stated that when she reviewed Resident #74's January 2025 MAR, she did not see that the resident received an anticoagulant medication, but that the resident received Plavix, which should be coded as antiplatelet medication. NC #21 stated that section N of Resident #74's admission MDS was coded incorrectly, because the resident did not receive an anticoagulant medication during the seven-day look-back period for that assessment, but rather received an antiplatelet medication, which was not coded. The Director of Nursing (DON) was interviewed on 03/13/2025 at 10:07 AM. The DON stated that the current MDS Coordinator was new to that role and that there were three nurse consultants available to assist with training the current MDS Coordinator. The DON stated that the nurse consultants should assist with ensuring that the MDS assessments were completed timely and accurately. The DON stated that the nurse consultants were responsible for ensuring MDS assessments were accurate, because they were paid to review MDS assessments for accuracy. The DON stated that when completing section N of the MDS, the MDS Coordinator should run a MAR to determine which medications the resident received so that the MDS was coded correctly. The DON reviewed Resident #74's MAR and stated that the resident received Plavix, which was an antiplatelet medication, and did not receive an anticoagulant. The DON stated Resident #74's MDS was not coded correctly. The Administrator was interviewed on 03/13/2025 at 10:54 AM. The Administrator stated that he expected each MDS to accurately reflect the resident's condition. He stated that the MDS Coordinator was new in that role and nurse consultants were available for assistance. He stated that MDS assessments should be coded correctly and reviewed by the nurse consultants for accuracy. 2. An Admission Record indicated the facility admitted Resident #70 on 12/31/2024. According to the Admission Record, the resident had a medical history that included diagnoses of atrial fibrillation and essential hypertension. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Park Rehabilitation Hospital	2850 Sierra Sunrise Terrace Chico, CA 95928

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #70's 12/2024 Medication Administration Record (MAR) revealed no evidence of orders for or the administration of an anticoagulant or antiplatelet medication. Resident #70's 01/2025 MAR revealed the transcription of an order started on 01/03/2025 for aspirin delayed release (an antiplatelet medication) 325 milligrams (mg) by mouth one time a day. The MAR revealed documentation that indicated the aspirin was administered as ordered for the timeframe from 01/03/2025 through 01/05/2025. The MAR revealed no evidence of the transcription of orders for or the administration of an anticoagulant medication. Resident #70's admission MDS, with an Assessment Reference Date (ARD) of 01/05/2025, revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS was coded to reflect Resident #70 received an anticoagulant medication, but not an antiplatelet medication, during the seven-day assessment look-back period. Registered Nurse (RN) #20 was interviewed on 03/12/2025 at 4:33 PM. RN #20 stated she had been working in the role of MDS Coordinator for almost one month. RN #20 stated that she was responsible for completing section N of the MDS regarding medications received by the resident. She stated that when she completed Section N of the MDS, she reviewed the MAR to see what medications were administered to the resident during the seven-day assessment look-back period, and if the resident received any medications listed in section N of the MDS she would code those medications on the MDS. RN #20 stated she did not complete Resident #70's admission MDS assessment; it was completed by the facility's formed MDS Coordinator. Nurse Consultant (NC) #21 was interviewed via telephone on 03/12/2025 at 4:43 PM. NC #21 stated the nurse that completed Resident #70's admission MDS no longer worked at the facility. After reviewing Resident #70's admission MDS, NC #21 stated that section N of Resident #70's admission MDS was coded incorrectly, because the resident did not receive an anticoagulant during the seven-day look-back period for that assessment, but rather received an antiplatelet medication, which was not coded. The Director of Nursing (DON) was interviewed on 03/13/2025 at 10:07 AM. The DON stated that when completing section N of the MDS, the MDS Coordinator should run a MAR to determine which medications the resident received so that the MDS was coded correctly. The DON reviewed Resident #70's MAR and stated that the resident received an antiplatelet medication, and did not receive an anticoagulant. The DON stated Resident #70's MDS was not coded correctly. The Administrator was interviewed on 03/13/2025 at 10:54 AM. The Administrator stated that he expected each MDS to accurately reflect the resident's condition. He stated that MDS assessments should be coded correctly and reviewed by the nurse consultants for accuracy. 45645 3. A Transfer/Discharge Report indicated the facility admitted Resident #8 on 12/22/2019. According to the Transfer/Discharge Report, the resident had a medical history that included diagnoses of gastro-esophageal reflux disease without esophagitis, type two diabetes mellitus, chronic obstructive pulmonary disease, and iron deficiency anemia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Park Rehabilitation Hospital	2850 Sierra Sunrise Terrace Chico, CA 95928

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8's Weights and Vitals Summary indicated that on 09/06/2024 the resident weighed 189.6 pounds, and on 10/02/2024 the resident weighed 174.6 pounds. The summary included an entry that noted the resident had a 15-pound weight loss, which was a 7.9 percent (%) loss in approximately one month. Resident #8's Progress Notes revealed a Dietitian Note, dated 10/09/2024, that indicated the resident underwent a dietary review due to a weight loss of 15 pounds or a 7.9% weight loss in one month. The note indicated the weight loss was unintended and was likely due to decreased intake by mouth, an increased need for oxygen, and the resident getting out of the bed for meals. The note reflected a recommendation to increase nutritional supplements to three times per day. Resident #8's quarterly MDS, with an Assessment Reference Date (ARD) of 10/10/2024, and a significant change in status MDS, with an ARD 10/28/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. Section K of both MDS assessment reflected the resident weighed 175 pounds and had not experienced a weight loss of 5% or more in the last month or 10% or more in the last six months. During an interview on 03/12/2025 at 10:28 AM, the Registered Dietitian (RD) stated Resident #8 was noted with a 7.9% weight loss in one month in 10/2024, and the MDS dated [DATE] did not reflect it. The RD further stated the resident's significant change in status MDS dated [DATE] was inaccurate because it also did not reflect the resident's weight loss. During an interview on 03/12/2025 at 11:31 AM, the Director of Nursing (DON) stated the facility's Director of Dietary (DD) was responsible for completing section K of the MDS assessments. The DON stated the DD should also consult with the RD and review the RD's documentation to ensure MDS assessments were coded accurately. During an interview on 03/13/2025 at 9:57 AM, the Administrator stated he expected MDS assessments to accurately reflect each resident's condition. 4. An Admission Record indicated the facility admitted Resident #25 on 07/03/2017. According to the Admission Record, the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing), unspecified dementia, and mild protein-calorie malnutrition. Resident #25's Weights and Vitals Summary indicated that on 02/05/2025 the resident weighed 147.6 pounds, and on 02/10/2025 the resident weighed 140 pounds. The summary included an entry that noted the resident had a 7.6-pound weight loss, which was a 5.1% loss in approximately one week. Resident #25's Progress Notes revealed a Dietitian Note, dated 02/12/2025, that indicated the resident underwent a dietary review due to a weight loss of 7.6 pounds or 5.1% in one week. The note indicated the weight loss was unintended due to an acute admission (hospital admission) from 02/06/2025 to 02/10/2025. Resident #25's five-day Minimum Data Set (MDS),with an Assessment Reference Date (ARD) of 02/14/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. Section K of the MDS assessment reflected the resident weighed 144 pounds and had not experienced a weight loss of 5% or more in the last month or 10% or more in the last six months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Park Rehabilitation Hospital	2850 Sierra Sunrise Terrace Chico, CA 95928

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2025 at 10:38 AM, the Director of Dietary (DD) stated Resident #25's MDS dated [DATE] should have been coded to reflect weight loss. The DD stated she completed that section of the MDS and was unsure how it happened, but it was a mistake. During an interview on 03/12/2025 at 10:44 AM, the Registered Dietitian (RD) stated that Resident #25 lost 7. 6 pounds or 5.1% of their body weight in one week. Per the RD, the resident's MDS dated [DATE] should have been coded to reflect significant weight loss, and not coding the MDS to reflect the weight loss was an error. During an interview on 03/12/2025 at 11:15 AM, Registered Nurse (RN) #20, who was serving as the MDS Coordinator, stated the DD may have initially completed the weight-loss section of Resident #25's 02/14/2025 MDS, but when RN #20 signed the assessment as complete, she may have overwritten the DD's initial information, and changed the MDS to reflect no weight loss. RN #20 stated MDS assessments should accurately reflect each resident's condition at the time of the assessment. During an interview on 03/12/2025 at 11:31 AM, the Director of Nursing (DON) stated the facility's Director of Dietary (DD) was responsible for completing section K of the MDS assessments. The DON stated the DD should also consult with the RD and review the RD's documentation to ensure MDS assessments were coded accurately. During an interview on 03/13/2025 at 9:57 AM, the Administrator stated he expected MDS assessments to accurately reflect each resident's condition.