STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555776	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gridley Post Acute	246 Spruce Street Gridley, CA 95948

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that one of three sampled residents (Resident 1), was treated in a respectful and dignified manner. Resident 1 reported that Certified Nursing Assistant (CNA) A accused the resident of using the call light too often, crossed their arms, and yelled at the resident to shut up.This failure resulted in Resident 1 feeling fearful and worried about possible retaliation from staff.Findings:A review of the facility's policy and procedures titled, Dignity, revised 10/2025, indicated that staff are required to speak respectfully to residents at all times and to treat residents with cognitive impairments with dignity and sensitivity.A review of Resident 1's admission record, indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses including stroke, depression, and paranoid personality disorder (a mental health condition in which the person has distrust and suspicion of others).A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) section C - Cognitive Patterns, and section GG - Functional Abilities, indicated on 4/7/26, Resident 1 had a cognitive sore of 7, indicating severe problems with thinking and memory, and on 4/8/26, the functional assessment documented that the resident was dependent on staff for showering, lower body dressing, personal hygiene, and oral care.During a concurrent observation and interview on 6/4/26 at 1:45 pm with Resident 1, in Resident 1's room, Resident 1 stated that CNA A accused them of using the call light too often, crossed their arms, yelled at them, and told them to shut up. Resident 1 stated they could not defend themself and were afraid to report the incident. When CNA A entered the room during handˆoff rounds, Resident 1's body visibly tensed. CNA A asked the resident if there was anything they needed; Resident 1 turned their face toward the window and closed their eyes in response.During a interview on 6/4/26 at 2:45 p.m. with CNA A, CNA A stated that Resident 1 presses the call light a lot for attention and described Resident 1 as stressed, anxious, and lonely. CNA A acknowledged that sometimes when I talk to residents, I sound authoritative, which may be perceived as aggressive, but that is not my intent. CNA A further stated he became frustrated when responding to Resident 1's call light because, on many occasions, Resident 1 did not have a specific need. He added that he is working on improving the way he communicates with residents and is doing the best I can do right now.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary mental health services for two of three sampled residents (Resident 1, 2) when:1.Resident 1 did not receive consistent counseling and psychiatric services to meet his mental health need.This resulted in Resident 1 reporting being in a constant state of fear and feeling unsafe in the facility, which had the potential to place Resident 1 at increased risk for selfˆharm and social isolation.2.Resident 2 did not receive psychiatric services to meet his mental health need.This resulted in Resident 2 experiencing increased social isolation and expressing thoughts that they would be better off dead, placing Resident 2 at increased risk for selfˆharm.Findings:A review of the facility's policy and procedure titled, Behavioral Assessment, Intervention, and Monitoring, revised 2/2025, indicated that behavioral interventions are described as individualized, non-drug approaches to care. These interventions are meant to support both the physical and emotional needs of residents, focusing on understanding, preventing, and relieving distress or loss of abilities. The policy also emphasizes the importance of maintaining or improving a resident's mental, physical, or social well-being.1.A review of Resident 1's admission record, indicated that Resident 1 was initially admitted to the facility on [DATE] with diagnoses including depression, paranoid personality disorder (a mental health condition marked by a pattern of distrust and suspicion of others without adequate reason to be suspicious) and mood disorder. Resident 1 was his own health care decision maker.A review of Resident 1's Minimum Data Set (MDS - a resident assessment toll), dated [DATE], indicated Resident 1 had a Brief Interview for Mental Status (BIMS, assessment of thinking and memory) score of 7, indicating severe impairment in memory and cognitive abilities.A review of Resident 1's care plan, initiated on [DATE] and revised on [DATE], indicated that the resident uses antidepressant medication for statements of sadness. The Care Plan goal stated, The resident will be free from discomfort. Interventions to meet this goal included monitoring, documenting, and reporting changes in mood, behavior, cognition, hallucinations, delusions, social isolation, suicidal thoughts, and withdrawal as needed. The Care Plan for behaviors of paranoia, initiated on [DATE] and revised on [DATE], indicated the goal, The resident will have no evidence of behavioral problems.A review of Resident 1's Preadmission Screening and Resident Review (PASRR, behavioral health and disabilities assessment) Level II (State mental health and disability assessment), dated [DATE], indicated Resident 1 was clinically recommended to receive specialized addˆon services, including psychotherapy or counseling by a licensed mental health professional, psychiatric consultation and followˆup care, diagnostic clarification, medication interventions, and monitoring of mental health conditionsDuring a concurrent observation and interview on [DATE] at 1:10 pm with Resident 1, in Resident 1's room, Resident 1 was tearful and stated that he was in fear of his life on a daily and nightly basis.During an interview on [DATE] at 3:02 pm with Certified Nursing Assistant (CNA) A, CNA A stated, [Resident 1] has always struggled with depression and talked about the suicide of a significant other. CNA A further stated that the facility previously had counselors before the new company assumed ownership. CNA A reported that Resident 1 often excluded themself from social activities and had declined due to depression, including not wanting to eat.During an interview on [DATE] at 3:16 pm with Licensed Nurse (LN) C, LN C stated Resident 1 had progressively declined and experienced constant episodes of paranoia, especially at night.During a concurrent interview and record review on [DATE] at 2:10 pm, with Social Services Designee (SSD), the SSD stated that Resident 1 was often unsatisfied and complained about not receiving enough psychiatric services. The SSD reported that Resident 1 had talked about participating in satanic rituals with a sibling. The SSD stated that a message was left for the crisis line and county behavioral health on [DATE] and acknowledged that followˆup should have occurred sooner. The SSD further stated that the facility is responsible for coordinating transportation (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and services with behavioral health.During an interview on [DATE] at 2:38 pm with the Administrator (Admin), Admin stated that Resident 1 had received counseling until the resident's insurance no longer covered the service. Admin also stated that the current psychiatrist had limited availability and frequently cancelled scheduled appointments. When asked to review the counseling records and the date of the last counseling session, the Admin stated that the facility did not have counseling records.During a concurrent interview and record review on [DATE] at 4:00pm with the Assistant Director of Nursing (ADON), Resident 1's medical record was reviewed. The ADON stated that the facility currently does not have psychiatric services. The ADON reported that the psychiatrist had provided fullˆtime services in [DATE]; however, since [DATE], the psychiatrist had not met the residents' needs. The ADON stated that the alternative teleˆpsychiatric provider did not offer services in the region. ADON reported that Resident 1 was depressed at times, had a history of hospitalization for suicidal thoughts, and had experienced a decline in the ability to perform activities of daily living, including dressing, washing, and bathing. The ADON also stated that Resident 1 isolated and refused to participate in group activities.A review of the facility's Quality Assurance and Performance Improvement (QAPI) meeting notes dated [DATE] indicated under Psych Services that the current provider typically calls in once a month. We would love to have weekly. He cannot do that at the current time. QAPI meeting notes dated [DATE] further indicated under Psych Services that the current provider has not been consistent and that appointments were scheduled and then cancelled on the same day.2. A review of Resident 2's admission Report record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of cognitive social and emotional impairment and depression.A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS score of 9 , indicating moderate cognitive impairment.A review of Resident 2's Psychosocial Assessment dated [DATE] indicated, was ordered Zoloft (antidepressant) for depression. Assessment indicated Resident 2 attends activities of his choosing and goes and does individual activities of his choosing.A review of Resident 2's nursing progress note, dated [DATE], indicated that Resident 2's brother passed away.A review of Resident 2's nursing progress note, dated [DATE], indicated Resident 2 was frustrated, yelling at another resident.During a concurrent observation and interview on [DATE] at 12:50 pm with Resident 2, in Resident 2's room, Resident 2 stated, How does a person work all his life and end up with a life like this? Resident 2 further stated that he had spoken to facility staff about his feelings, but nobody understands, they don't want to hear I'm unhappy and that he would rather be dead. Resident 2 stated he had felt this way for a while. When asked whether the facility offered mental health services or whether social services had visited, Resident 2 responded, no.During an interview on [DATE] at 2:10 pm with SSD, the SSD stated that Resident 2 was not social, preferred to keep to themself, and had behaved this way since admission.During a concurrent interview and record review on [DATE] at 4:00pm with ADON, the ADON stated that Resident 2 was on the list for psychiatric services. The ADON reported that Resident 2's brother had recently died and that the resident's sister no longer visited. The ADON stated that Resident 2 tended to keep to themself and slept frequently. The ADON also confirmed that Resident 2 had requested hospice services but did not qualify.