

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555776	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Gridley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide nursing services in accordance with professional standards of quality for two of six sampled residents (Resident 1, Resident 3). Licensed nursing staff did not adequately assess and monitor Resident 1 after the onset of new pain and emerging signs of clinical decline. The lack of timely nursing assessment and intervention resulted in a delay in transferring Resident 1 to the hospital, where Resident 1 was subsequently treated for sepsis (life-threatening systemic infection) and diverticulitis (inflammation of the gut lining that causes severe pain). Licensed nursing staff did not change Resident 3's Peripherally Inserted Central Catheter (PICC - a long, thin tube that is inserted into a vein in the arm. The tube travels up the vein until it reaches a large vein near the heart. It is used when someone needs medicines, fluids, or nutrition for a long time) line dressing according to facility policy and accepted standards of care. This had the potential to compromise catheter integrity and increase the risk of catheter-related complications, including infection, which could result in the resident's health status. Findings: A review of the facility's undated document titled Resident Examination and Assessment indicated that the procedure's purpose is to examine and assess the resident for any abnormalities in health status. The document states that a pain assessment requires a physical examination including the description of pain, its location, duration, severity, aggravating and relieving factors, and the impact of pain on activities, mood, sleep, and appetite, as well as current pain medications and treatments. It further specifies that the following information must be recorded in the resident's medical record: the date and time the procedure was performed; the name and title of the individual performing the procedure; all assessment data obtained; how the resident tolerated the procedure; if the resident refused, the reason and interventions taken; and the signature and title of the person documenting the information. A review of the facility's document titled Registered Nurse (RN) job description, revised May 2022, indicated that RNs are responsible for monitoring residents for acute changes in condition-such as confusion, fever, breathing difficulties, increased pain, urinary issues, loss of appetite, constipation, diarrhea, vision or hearing changes, general malaise, or decreased range of motion-and for conducting assessments and notifying the provider when needed. A review of Resident 1's admission record, indicated that Resident 1 was admitted on [DATE] with diagnoses including high blood pressure, a history of falling, and adult failure to thrive (a condition involving significant weight loss, poor nutrition, decreased physical activity, and social withdrawal.) Resident 1 was her own health care decision maker. During a concurrent interview and record review on 7/23/26 at 11:46 p.m. with RN A, Resident 1's nursing progress notes and the May 2026 medication administration record were reviewed. RN A confirmed that Resident 1 developed abdominal pain on 6/23/26 at 2:45 p.m. and was administered Hydrocodone Acetaminophen (Norco) 5~325 mg. RN A acknowledged that no documentation was completed regarding Resident 1's pain assessment or pain level before or (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after the administration of Norco. RN^A further confirmed that Resident^1 continued to experience pain, had one episode of vomiting, requested transfer to the hospital, and departed the facility at 5:05 p.m. the same day. RN^A also verified that the medication administration record for 6/23/26 did not contain any entry indicating that Norco had been administered to Resident^1. During a concurrent interview and record review on 7/23/26 at 12:17 p.m. with the Director of Nursing (DON), the DON confirmed that Resident^1 reported abdominal pain at 2:45 p.m., experienced green-colored vomiting, and was administered a Norco as ordered; the record further indicated that Resident^1 requested transfer to the hospital and departed the facility at 5:05 pm for evaluation. During a subsequent interview and record review on 7/31/26 at 10:25 am, the DON stated that documentation of Resident^1's pain should have been entered in the nursing progress notes, confirmed that ongoing assessments were required, and indicated RN^A should have utilized a pain scale and completed a full gastrointestinal assessment, including bowel^sound evaluation and palpation for abdominal tenderness or abnormalities. A review of the facility's undated policy titled Peripheral Intravenous (IV - inside a vein) Dressing Changes (the sterile process of removing a soiled, loose, or old protective covering over an IV site), indicated that the purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. The policy states that the dressing needs to be changed if it becomes damp, loosened or visibly soiled and at least every 5 to 7 days. Change dressing and perform site care if signs and symptoms of site infection are present. A review of the facility's document titled Registered Nurse (RN) job description, revised May 2022, indicated that RNs would Provide nursing services to residents in accordance with scope of practice, facility policies and professional standards of care. A review of Resident 3's admission record, indicated that Resident 3 was admitted on [DATE] with diagnoses including urinary tract infection (UTI), liver disease and acute kidney injury (AKI). A review of Resident 3's physician orders, dated 6/29/26, for PICC line dressing care - Change the transparent dressing on admission, then weekly and as needed, every day shift every 7 days.; for PICC line monitoring - Assess the left upper arm PICC site every shift for signs of infection or infiltration. A review of Resident^3's clinical nursing record obtained from the local infusion center, dated 7/20/26, indicated that the infusion center RN assessed Resident^3's PICC dressing and observed multiple layers of tape over the original dressing dated 6/27/26. The note further stated that the RN contacted the facility to discuss PICC line care and recommended that Resident^3 go to the emergency room for assessment and a dressing change. During an interview with Resident 3 on 7/31/26 at 11:10 am, Resident 3 stated that the staff were not changing the PICC line dressing as often as they should have been. Resident 3 reported becoming aware of this during a visit to the local infusion center, where a nurse informed her that the PICC dressing should be changed weekly and monitored regularly. During an interview with the DON on 7/31/26 at 11:21 am, the DON acknowledged receiving a call from the local infusion center regarding Resident^3's PICC line dressing. The DON stated, They told me it was old; I can't recall the date they mentioned on the dressing. The DON confirmed that the dressing changes for Resident^3 were not performed as required. During an interview with the Charge Nurse (CN) at the local infusion center on 8/4/26 at 1:10 pm, the CN reported that when Resident 3 arrived for treatment on 7/20/26, the date on the PICC line dressing was dated 6/27/26 and could not be used due to its condition. Resident 3 was subsequently sent to the local emergency department to have the PICC line evaluated and redressed. CN confirmed that her staff contacted the DON at the facility where Resident 3 resides and informed the DON of their assessment.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS - the resident assessment tool) for one of four sampled residents (Resident 3). The facility did not correctly identify the presence of a peripherally inserted central catheter (PICC - a central venous access device used for the administration of long-term intravenous medications.) This failure resulted in an inaccurate resident assessment and had the potential to lead to inappropriate care planning and adverse health outcomes for Resident 3. Findings: A review of MDS Assessment Coordinator Policy Statement, last revised 11/2019, indicated that each individual who completes a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment by identifying each section completed. A review of Resident 3's MDS readmission assessment, dated 7/7/26, indicated that under section O, Special Treatments, Procedures, and Programs, intravenous therapy (IV), , which includes administration through a PICC line, was not marked, despite Resident 3 receiving IV medication via a PICC line during the assessment period. During a concurrent interview and record review with the MDS Coordinator on 7/31/26 at 12:13 pm, Resident 3's MDS was reviewed. The MDS Coordinator confirmed that the IV section had not been marked to reflect the presence of the PICC line. The MDS Coordinator acknowledged that it should have been marked.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure smoking occurred only in designated areas, and that proper safety equipment (ashtrays and fire extinguishers) were available for use for one of two sampled residents (Resident 2). This deficient practice had the potential to place all residents at risk for smoking-related accidents and hazards. Findings: A review of an undated facility policy titled Smoking Policy - Residents indicated that smoking is permitted only in designated resident smoking areas. The policy further states that the facility may impose smoking restrictions at any time if it determines a resident cannot smoke safely. Additionally, the policy specifies that the facility reserves the right to confiscate smoking items found in violation of the smoking policies. A review of Resident 2's admission record indicated that Resident 2 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, high blood pressure and chronic obstructive pulmonary disease (a long-term lung condition where airways and air sacs are damaged, making it hard to move air in and out of the lungs). Resident 2 was his own health care decision maker. A review of Resident 2's smoking assessment, dated 6/11/26 at 11:11 am, indicated that Resident 2 was able to hold a cigarette without assistance and could safely extinguish a cigarette. A review of Resident 2's care plan with the initiated date of 6/11/26, indicated that Resident 2 had been assessed as an independent smoker. During an observation on 7/22/26 at 9:03 am, Resident 2 was observed outside on the east side of the facility, where a concrete walkway is bordered by rocks and mulch next to the facility's building. Seated in his wheelchair, Resident 2 removed a pack of cigarettes and a lighter from his shirt pocket and lit a cigarette. While smoking, Resident 2 did not have a smoking apron on, and there were no visible cigarette receptacles (a designated cigarette butt disposal container) available in the area. After finishing the cigarette, Resident 2 flicked the still lit butt into the surrounding rocks, which contained dry grasses. During an observation on 7/23/26 at 9:27 am, multiple cigarette butts were observed scattered throughout the dirt, rocks, and mulch along both sides of the walkway on the east side of the facility's building, leading toward the area where Resident 2 had been sitting. During a concurrent interview and record review on 7/23/26 at 9:43 am, with the Administrator (Admin), Resident 2's clinical record was reviewed. When asked how independent residents are monitored when smoking, the Admin stated that independent residents are not monitored when smoking once they sign themselves out of the facility. When discussing the east side of the facility's building, the Admin acknowledged being aware that Resident 2 had been smoking in a non-designated area and stated that staff and maintenance attempt to monitor that area and redirect residents to appropriate smoking locations. The Admin confirmed there was no designated smoking area outside of the facility property for independent smokers and that the only designated outdoor smoking area was located on the west side of the facility. The Admin further acknowledged that there were no appropriate cigarette receptacles available on the east side of the facility, despite residents being known to smoke there. At the time of the interview, the Admin confirmed that no smoking restrictions had been imposed and Resident 2's smoking privileges had not been modified. During an interview on 7/31/26 at 1:19 pm with the Admin, the Admin confirmed he reviewed the smoking policy with Resident 2 multiple times. The Admin confirmed that no smoking restrictions or privilege changes had been implemented for Resident 2.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor the food preferences for one of five sampled residents (Residents 1). This failure had the potential to result in Resident 1 not eating, placing Resident 1 at risk for nutritional deficiencies and unintended weight loss. A review of the facility's undated policy titled, Resident Food Preferences, indicated, If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with. A review of Resident 1's admission Record, indicated that she was admitted on [DATE] with diagnoses of high blood pressure, history of falling, and adult failure to thrive (a multifactorial syndrome where a person experiences a combination of significant weight loss, poor nutrition, decrease physical activity and social withdrawal. Resident 1 was her own health care decision maker. During an interview on 7/22/26 at 12:37 pm, with Resident 1, Resident 1 stated she had an allergy to eggs and reported that she was served eggs multiple times despite informing facility staff of her allergy. Resident 1 stated she was unsure why she continued to receive eggs even after she had spoken with staff on several occasions. A review of Resident 1's food preference activity log indicated on 5/27/26 at 10:35 am, egg was added as an allergy and at 10:38 am breakfast, lunch and dinner notepad changed allergies to eggs and egg yolk. During a concurrent interview and record review on 7/23/26 at 10:43 am, with the Dietary Manager (DM), when reviewing Resident 1's food preference activity log, DM confirmed that Resident 1 had eggs listed as an allergy on 5/27/26, egg allergy was then removed on 6/4/26 and on 6/23/26 the log indicated Resident 1's preference for no eggs for breakfast. The DM confirmed that Resident 1 continued to receive eggs during the period following the removal of eggs as an allergy and prior to documentation on 6/23/36 indicating Resident 1's preference for no eggs at breakfast. When asked whether Residents 1's documented food preferences were being honored during this period, the Dietary Manager stated no.		