

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Bishop Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  151 Pioneer Lane Bishop, CA 93514	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262</b></p> <p>Based on interview and record review, the facility failed to report for one of 3 sampled residents (Resident 1) per there policy and procedure to the state agency and the local ombudsman for an alleged abuse/ injury of unknown cause.</p> <p>This failure has the potential to put (Resident 1) health, safety and well-being at risk.</p> <p>Findings:</p> <p>During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: Alzheimer's (disease destroys memory and mental functions), osteoarthritis (bones wear down), benign prostatic hyperplasia (enlargement gland causing urination difficulty), lack of coordination.</p> <p>During a review concurrent interview and record review of Resident 1's Medical Record reviewed are as follows:</p> <ol style="list-style-type: none"> <li>1. March 01,2025, at 0612 Nurse Note: 1cm redness noted to resident Right side of face above eyebrow. No s/s of trauma, no bleeding, no drainage noted at this time. Will endorse to AM nurse.</li> <li>2. March 01, 2025, at 1324 Social Service Note: Resident Power Of Attorney (POA) came to this writer with concerns regarding marks on resident face. Per notes from night nurse resident had small scratch above eyes. POA is concerns with discolorations of nose, and that resident has more than scratch above his left eye. She is requesting investigation to find out what happened with the resident. Director of Nursing (DON) and administrator notified.</li> <li>3. March 06, 2025, SOC341, submitted to state agency. (facility could not provide 5 Day investigation).</li> </ol> <p>(continued on next page)</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on April 01, 2025, with the Certified Nursing Assistant (CNA1), the CNA1 stated, I worked with Resident 1 on February 28,2025, he was good, nothing on his face. My shift ended CAN 2 took over for me, Saturday morning 6:30AM I came back and then that when supervisor told me he had bruises on his face, cheek area. I was confused because that's not how we left him. We used pillows on bed rails for him not to hit self. The Director of Staff Development (DSD) assistant interviewed me, then on Monday (DSD) interviewed me. They proceeded with Resident 1 sister; she was here Saturday they had meeting with her. On Saturday, his left side of face redness some bruising and nose scratches. If I would have seen this, I would report to the nurse.</p> <p>During an interview on April 01, 2025, with the Certified Nursing Assistant (CNA2), the CNA2 stated, I work 11PM-7AM shift, when I first arrived on shift February 28, 2025, I didn't notice anything to Resident 1 face, he is usually up during the night, he calmed around down 1:00AM, that's when I do my rounds. When I checked on his, I didn't notice his face, at 3:00AM I noticed redness to left side to face, I explained to the License Vocational Nurse (LVN) it's the first time I seen it. She told me she was going to chart it. At 6:30AM I got him up and the redness was still there I notified the LVN that it looked the same from 3:00AM. It looked like red like when you are laying too long, not a bruise no open wound, no blood. I didn't get a clean view of his face with light on until 3AM.</p> <p>During an interview on April 01, 2025, with the License Vocational Nurse (LVN), the LVN stated, The CAN did mention a small abrasion to side of his face, prior to endorsement his nails were jagged, but his sister or mom (I don't know who it is) cuts his nails and does not let staff doing it. The redness, it did not look open, he was not bleeding. I cannot say it was 100% how he got it, it was that night or the day before. I wrote a note on this, I let the next nurse and DON know about this. I did not think it needed to be reported, or investigated, I personally felt it didn't look intentional. It didn't seem anything more than or intentional. I did leave a voicemail to family sister, that was my last day working with him after that I don't know what happened. The DON said she would look into it and notify the doctor and wound care. For unknown injuries we document and endorse to next nurse and notify the DON.</p> <p>During an interview on April 01, 2025, with the Director of Staff Development (DSD), the DSD stated, I spoke with Resident 1 sister, she called me regarding the scratches to his face. I got statements from the staff, they were not able to identify where they came from, he did have long nails at the time when scratches occurred. They place padding on bedrails to prevent him grazing against bed rails. We did not know where the scratches came from. I was notified approx. March 03 or 04 2025, I spoke with Administrator and DON, the DON did the investigation and gathered statements I got from the CNAs. We are only speculating we don't know they came from. I think it occurred on NOC shift. I'm assuming it was reported, the sister spoke with the DON and administrator. We do a SOC341 form, it would have been DON to report. I think this was reportable, no intent to cause harm. It should have been reported. The sister told me, the CNAs did report to the nurses. There should have been a progress note. The sister wanted this investigated. A few days after the ombudsman talked to me and she interviewed the CNAs. I can agree, this should have been reported sooner.</p> <p>During an interview on April 01, 2025, with the Administrator (Admin), the Admin stated, On March 01, 2025 I heard about it this, the sister noticed the markings, we interviewed and got statements from CNAs, we had them write the statements. The sister asked us what happened, she wanted an investigation. After reviewing the SOC341 (a report of suspected abuse form), this was sent March 06, 2025, to the state agency. I don't know about the 5-day investigation, I gave it to DON to do. (facility could not provide 5Day investigation report).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revised September 2022, the policy and procedure indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .</p> <p>2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative .3.Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; orb. Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p>		