

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/10/2026
NAME OF PROVIDER OR SUPPLIER Bishop Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 Pioneer LN 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)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a change in a resident's condition was promptly reported to the licensed nurse for one (1) of one (1) resident (Resident 1) reviewed, when a Certificate Nurse Assistant (CNA 1) observed discoloration under Resident 1's right eye on the upper cheekbone area, but did not report the finding to the licensed nurse, on May 13, 2026. This failure had the potential to delay Resident 1's timely assessment, treatment, and notification of the physician and or responsible party regarding a potentially significant change in the resident's condition. During a review of Resident 1's face sheet (contains demographic and medical information), the face sheet indicated Resident 1 was originally admitted to the facility on [DATE], with diagnoses that included lack of coordination (the brain and the body are struggling to communicate, resulting in movements that feel clumsy, jerky, or unsteady) and paraplegia (the loss of movement and feeling in the lower half of the body, including both legs). During a review of Resident 1's SOC 341 - Report of Suspected Dependent Adult/Elder Abuse (A mandated report form used to document and report suspected abuse), dated May 15, 2026, Section C (Reporter's observations, beliefs, and statement) indicated, on May 15, 2026, at approximately 6:30 AM, a Certificated Nurse Assistant (CNA) reported that Resident 1 had a Bruise on his eye . During an interview on June 1, 2026, at 1:53 PM, with CNA 1, CNA 1 reported that she was assigned to care for Resident 1 on May 13, 2026. CNA 1 explained that although she worked 12 hours-shift, she was assigned to Resident 1 for only the first 8 hours. CAN 1 further stated that near the end of her shift, she noticed a blue discoloration under Resident 1's right eye on the upper cheek area. CNA 1 stated she did not report the change in Resident 1 condition to the licensed nurse because she believed she was no longer responsible, for Resident 1. CNA 1 further stated she was aware that facility policy requires CNAs to promptly report any changes in a resident's condition to the licensed nurse. During a review of Resident 1 nurses' notes, dated May 12, 2026, through May 15, 2026, there was no documented evidence of a bruise under Resident 1's right eye on May 13, 2026. In addition, no nursing notes were recorded on May 14, 2026. During an interview on June 1, 2026, at 2:41 PM, with the Director of Staff Development (DSD 1), the DSD 1 stated that all staff are required to report any changes in a resident's condition while on duty, even if the resident is not assigned to them. The DSD 1 emphasized that any staff member who observes a change in a resident's condition is responsible for reporting it to the licensed nurse. During a concurrent interview and record review on June 1, 2026, at 3:17 PM, with the Director of Nursing (DON) and DSD, the facility's policy and procedure (P&P) titled, Acute Condition Changes - Clinical Protocol, dated March 2018, was reviewed. The P&P indicated, . 3. Direct care staff, including nursing assistants, will be trained to recognize subtle yet significant changes in the resident (for instance, a reduction in food intake, heightened agitation, alterations in skin color or condition) and how to effectively communicate these changes to the Nurse. The DON indicated that CNA 1 was not following the policy in this case.		

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
--	-------	-----------