

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 06/29/2026
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 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 interviews, and record review the facility failed to ensure adequate supervision and safe environment was provided for one (1) of five (5) sampled residents (Resident 1) when the assigned Certified Nursing Assistant (CNA 2) did not verify Resident 1's whereabouts during the shift. This failure led to Resident 1 being found unresponsive in the facility parking lot and subsequently pronounced dead. During a review of Resident 1's face sheet (contains demographic and medical information), the face sheet indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (brain disorder that primarily affects movement) with dyskinesia (uncontrollable, involuntary muscle movements), and difficulty of walking. During a review of Resident 1's Minimum Data Set (MDS-facility assessment tool), dated [DATE], under Section C, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS) score was 12. (A BIMS score of 12 indicates moderate cognitive or thinking impairment, meaning the resident can generally understand and participate in conversations, remember most information and may show occasional mild confusion). During a review of [Name] Police Dept [Department] Controlled Document (Police Report), date reported [DATE], the Police Report indicated, on [DATE], at about 4:55 PM, a police officer responded to the radio traffic of [name] dispatch, dispatching [name] Paramedics to an unresponsive male, not breathing, believed to be deceased and was a resident from the facility. Upon arrival, there was a crowd of people standing in the southeast corner of the small concrete/asphalt parking lot, located just east of the facility. This parking lot is property of the facility and is used for employee parking as indicated by signage by the entrance. The elderly male identified by the facility staff as Resident 1 was lying in a shaded area shaded by a tree. During an interview on [DATE], at 2:35 PM, with Certified Nursing Assistant (CNA 1), CNA 1 stated, on [DATE], shortly before 5:00 PM, she heard a report via walkie-talkie (a portable, handheld two-way radio) about a resident lying on the sidewalk in the facility's parking lot. When CNA 1 arrived, she found Resident 1 was lying curled up in a fetal position on the asphalt, unresponsive, near the curb in the facility parking area. CNA 1 stated Resident 1 had no pulse (heartbeat), no breathing, stiff, and cold to touch. CNA 1 further stated she called 911, then the nurses from the facility also arrived. During an interview on [DATE], at 2:54 PM, with License Vocational Nurse (LVN 1), LVN 1 stated on [DATE], at about 5:00 PM, she received an alert on her walkie-talkie about a person lying in the parking lot and when she arrived, CNA 1 was already there, Resident 1 was lying in the parking lot. LVN 1 stated she assessed Resident 1 and found him cold, with no pulse, pale, and while his hands were pale, his face was red. LVN 1 further stated she did not perform CPR, because Resident 1 Physician Orders for Life-Sustaining Treatment (POLST) indicated do not attempt resuscitation/DNR (a medical order to withhold CPR). During a telephone interview on [DATE], at 4:03 PM, with CNA 2, CNA 2 stated he was assigned to Resident 1 on [DATE]. CNA 2 indicated he checked on Resident 1 around 2:53 PM, and noticed Resident 1 was not in the room. CNA 2 stated he did not verify Resident 1's actual location and did not check the sign-out form to determine if Resident 1 had left the facility. CNA 2 stated according to the facility policy, staff are required to account for all residents at the beginning of their shift to ensure residents (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
--	-------	-----------

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 06/29/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are present in their rooms, but he did not follow this requirement. CNA 2 did not report Resident 1 was missing to anyone because he thought Resident 1 was still in the facility. A follow-up review of Police Report, date reported [DATE], the Police Report indicated, the paramedic arrived on [DATE], at about 5:00 PM (about 2 hours after staff last checked on Resident 1), and Resident 1 was pronounced death at 5:02 PM. The cardiopulmonary resuscitation (CPR-a lifesaving procedure performed when someone's breathing or heartbeat has stopped) was not initiated as it was apparent the male had been here for a while (indicating decease). During an interview on [DATE], at 4:20 PM, with the Director of Staff Development (DSD 1), and the Director of Nursing (DON), in the DSD office, the DSD stated that it is the responsibility of CNAs to ensure that residents are accounted for at the beginning and during their shifts, but CNA 2 did not meet these expectations. This indicates CNA 2 was not in compliance with the policy. The DON responded by saying, I agree with what DSD stated. The DON further stated that Resident 1 did not sign the sign-out sheet that day because he remained within the facility premises. Residents are not obligated to sign out on the form if they do not exit the facility. During a concurrent telephone interview and record review on [DATE], at 11:38 AM, with the DON, the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, dated [DATE], and the CNA job description, dated February 2024, were reviewed. The P&P indicated, . 2. Resident supervision is a core component of the system's approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment . The CNA job description indicated, . Check each resident routinely to ensure that his/her personal care needs are being met in accordance with his/her wishes . Immediately notify the Nurse Supervisor/Charge Nurse of any resident leaving/missing from the facility . The DON confirmed that both the policy and job description belong to them. The DON also noted that in this situation, CNA 2 did not follow the job description. During a review of facility's Unusual Occurrence Summary Report - Resident Death, dated [DATE], it indicated . At approximately 1650 [4:50 PM] hours, the facility received a phone call from a passerby reporting that an individual was lying in the parking area. Nursing staff checked their own Residents and found [name of Resident 1] was not located within the facility and immediately responded and located the resident [Resident 1] in the second parking area. He [Resident 1] was found lying on his left side in a semi-fetal position with his arms clenched and crossed over his chest. Initial assessment revealed the resident [Resident 1] to be unresponsive, without respirations or palpable [felt by touch] pulse. Visible skin was intact with no obvious discoloration, external injuries, or signs of trauma. There was no immediate evidence to suggest a fall or other traumatic event. Compressions were not deemed appropriate at the time of nursing assessment due to Residents desired POLST Code Status of Do Not Resuscitate although Emergency Medical Services (911) were activated. [Paramedics] assessed the resident and pronounced him deceased at the scene. The official time of death was 1702 [5:02 PM] hours.		

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 06/29/2026
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe oxygen administration was provided in accordance with the physician's orders and facility policies and procedures (P&P) for one of three sampled residents (Resident 1) when Resident 1's oxygen humidifier bottle (a water-filled bottle attached to the oxygen tubing and add moisture and prevent drying and irritation inside the nose) was empty while oxygen was flowing. This failure had the potential for Resident 1 to have nasal (nose) dryness, nosebleeds, and sore throat while on oxygen therapy. During a review of Resident 1's admission Record (contains demographic and medical information), the admission Record indicated, Resident 1 was admitted to the facility on [DATE], with the admitted diagnoses which included chronic obstructive pulmonary disease (COPD - a long - term lung disease that make it difficult to breathe and may require oxygen therapy), acute respiratory failure (a condition in which the lungs are not getting enough oxygen into the blood, requiring oxygen treatment to maintain adequate oxygen levels), and acute on chronic systolic congestive heart failure (a heart condition in which the hear does not pump blood effectively, which can cause fluid buildup in the lungs). During an interview on June 29, 2026, at 3:01 PM, with Resident 1, Resident 1 stated that during the previous week he had trouble breathing and felt he was not receiving enough oxygen through his nasal cannula (a small tube with two prongs place in the nostrils that delivers oxygen to help the person breathe). During a concurrent interview and record review on June 29, 2029, at 3:04 PM, with the Registered Nurse (RN 1), Resident 1's Physician Orders, dated November 25, 2025, was reviewed. The Physician Orders indicated, Resident 1 had an order for continuous oxygen @ [at] 2 [two] Liters/min [liters per minute-delivery unit flow of oxygen] via nasal cannula to keep Spo 2 (peripheral oxygen saturation - a measurement of the percentage of oxygen-carrying hemoglobin in the blood) > (more than) 90%; (keeping enough oxygen in the blood so body can work properly) Medical Dx (diagnosis) Chronic pulmonary disease. RN 1 verified and confirmed the oxygen order was for Resident 1. During a further record review of Resident 1's Physician Orders, dated December 11, 2025, the Physician Orders indicated, Oxygen Change Nasal Canula, Humidifier and clean filter every week and also PRN (as needed). During a review of Resident 1's care plan (a written plan that explains a person's health needs, goals, and the care and services staff must provide to meet those needs), dated April 7, 2026, the care plan indicated, Resident 1 has a high risk for altered respiratory status/difficulty breathing r/t [related to] chronic respiratory infection due to chronic decreased mobility. goal, the resident will have no complications related to SOB [shortness of breath] through the review date. Interventions. monitor for s/s [sign and symptoms] of respiratory distress [difficulty of breathing] and report to MD (medical doctor) PRN . During a concurrent observation an interview on June 29, 2026, at 3:38 PM, with Licensed Vocational Nurse (LVN 1) and RN 1, inside Resident 1's room, Resident 1 was lying in bed with head of the bed elevated, eyes open and agreed to be interviewed. Resident 1 was receiving continuous oxygen via nasal cannula, at the end of the tubing an oxygen humidifier bottle dated June 23, 2026, was attached. The oxygen humidifier bottle was empty with no water inside and no visible bubbling while oxygen was flowing, a clear tape was observed wrapped around the connection between the humidifier bottle and oxygen tubing. RN 1 stated the humidifier bottles should be check at the beginning of each shift, replaced when empty, and damaged oxygen tubing should be replaced rather than to be repaired with tape. RN 1 stated she did not know why the tape was placed on the oxygen tubing. LVN 1 acknowledged the humidifier bottle was empty and stated it must be replaced. During a review of the facility's P&P title, Oxygen Administration, dated October 2010, the P&P indicated, . 12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through.14. Periodically re-check water level in humidifying jar.		