STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555777	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Care Center	151 Pioneer LN Bishop, CA 93514

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two out of three sampled residents (Resident 11 and 80) to be free from physical restraints when: 1. For Resident 11, the resident was unable to freely access an exit the bed from both sides as intended, and documentation supporting the need, safety or authorization of the intervention was not provided 2. For Resident 80, the resident's bed was positioned directly against the wall, thereby limiting Resident 80 ability to move freely and restricting safe access. These failures had the potential to contribute to Resident 11 and 80 decline in physical functioning, and increasing the risk of accidents. Findings: 1. During a review of Resident 11's admission Record (contains demographic and clinical information) the admission Record indicated Resident 11 was admitted to the facility on [DATE], with the diagnosis of paraplegia (partial or complete paralysis affecting the lower part of the body, resulting in impaired mobility and increased dependence on staff assistance for movement and transfers), cognitive communication deficit (difficulty understanding, processing, or expressing information which may affect the residents ability to communicate needs, report concerns or request assistance) and anoxic brain damage (brain injury caused by a lack of oxygen to the brain, which may affect memory, judgement, safety awareness, thinking abilities, and the ability to recognize or respond to unsafe situations). During an observation May 18, 2026 at 4:05 PM, Resident 11 was observed lying in bed with eyes closed. Further observation revelated Resident 11's bed was positioned against the wall on the left side with a floor mat located on the right side of the bed. During an observation on May 19, 2026 at 8:56 AM, Resident 11's bed was observed positioned against the wall on the left side of the bed. Further observation revealed the bed frame and mattress were directly adjacent to the wall with no visible space between the bed and the wall. There was a floor mat located to the right side of the bed. During an interview on May 19, 2026 at 11:08 AM with the Director of Nurses (DON), DON confirmed Resident 11's bed was positioned against the wall as a nursing intervention. During a review of Resident 11's MDS (Minimum Data Set – a standardized assessment tool that measures health status in nursing home residents) Section C (Cognitive (involving consciousness intellectual activity Patterns), dated April 2, 2026, indicated Resident 11 had a BIMS (brief Interview for Mental Status – tool used to screen how a resident is functioning cognitively) score of 5 (a BIMS score 0-7: suggests residents is severe impairment). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's MDS (Minimum Data Set – Section GG (functional abilities dated April 2, 2026, indicated, A. Roll left and right: ability to roll from lying on back to left side, and return to lying on back on the bed. Coded 03. Partial / moderate assistance, helper does less than half the effort. Helper lifts hold, or supports truck or limbs, but provides less than half the effort. B. Sit to lying: the ability to move from sitting on side of bed to lying flat on the bed. Coded 02. Substantial/maximal assistance, helper does more than half the effort. Helper lift or hold trunk or limbs and provided more than half the effort. During a review of Resident 11's Physician Orders dated January 1, 2024, the physician orders indicated, Resident 11 to have 1/2 (half) side rails up to both sides of bed for safety and repositioning. Further review indicated, Fall Mat at bedside when in bed every shift for safety Bilaterally on both sides of bed to reduce risk of injury from attempts to crawl out of bed. Dated, October 6, 2022. There was no documented evidence a physician order was identified authorizing placement of the resident's bed against the wall in a manner that restricted exit from one side of the bed. During a concurrent interview and record review on May 21, 2026 at 11:08 AM with DON, the facility's policy and procedure (P&P) titled, Use of Restrains, dated Revised April 2017, was reviewed. The P&P indicated, 4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and not permitted, included d. Placing a resident who uses a wheelchair so close to the wall prevents the resident from rising., 9. Restrains shall only be used upon the written order of a physician and after obtaining consent from the resident and/ or representative (sponsor) the order shall include the following: a. The specific reason for the restrain (as it relates to the resident's medical symptom); b. how the restraint will be used to benefit the resident's medical symptom; and c. the type of restraint, and period of time for the use of the restraint. The DON acknowledge Resident 11's bed was positioned directly against the wall and could affect the Resident 11 ability to exit the bed from the side. 2. During areview of Resident 80's admission Record (contains demographic and clinical information), the admission Record indicated Resident 80 was admitted to the facility on [DATE], with diagnoses which included altered mental status (sudden, noticeable change in a person's thinking, awareness, or behavior), recurrent major depressive disorder (a mental health condition where a person experiences multiple, distinct episodes of severe depression throughout their life, separated by periods of normal mood), hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (one-sided physical impairments caused by a stroke) and dementia (decline in mental abilities—such as memory, thinking, and reasoning—that is severe enough to interfere with daily life). During an observation on May 19, 2026, at 9:02 AM, Resident 80 was observed lying in bed, awake and covered with a blanket. A fall mat was on the floor on the left side of the bed. The right side of the bed was flushed against the wall. During an interview with Certified Nursing Assistant 1 (CNA 1) in the resident's room on May 19, 2026, at 9:10 AM, CNA 1 confirmed Resident 80's bed has been positioned directly against the wall to reduce the likelihood of the resident falling out of bed and sustaining injuries. CNA 1 further acknowledged that positioning the bed against the wall restricts the resident's freedom of movement, effectively blocking access to one side of the bed and limiting the resident's ability to exit the bed independently from that side. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Infection Preventionist (IP) in the resident's room on May 19, 2026, at 9:15 AM, IP confirmed Resident 80's bed is positioned directly against the wall. The IP further explained that placing the bed against the wall is a fall precaution utilized by the facility specifically for residents identified as having a high risk of falls, such as Resident 80. The IP acknowledged that positioning Resident 80's bed against the wall restricts the resident's free movement, as it prevents the resident from exiting the bed on the right side and is considered a form of restraint due to the obstruction of the resident's ability to freely access and leave the bed from both sides. During an interview with Licensed Vocational Nurse 1 (LVN1) in resident's room on May 19, 2026, at 9:23 AM, LVN 1 confirmed that Resident 80's bed is against the wall and stated that the bed is placed against the wall because staff need more room between the beds for the Hoyer lift and other medical equipment. LVN1 acknowledged that placing the bed flushed against the wall restricts Resident 80's ability to move freely, as it prevents him from exiting the bed from both sides. During a concurrent interview and record review on May 19, 2026, at 11:00 AM, with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Use of Restraints, revised on April 2017, the P&P was reviewed. The P&P stated, Policy Statement - Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body . 4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. Using bed rails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; b. Tucking sheets so tightly that a bed-bound resident cannot move; c. Placing a resident in a chair that prevents the resident from rising, and d. Placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising . 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms . 9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. 10. Orders for restraints will not be enforced for longer than twelve (12) hours, unless the residents' condition requires continued treatment . 17. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problem that may be causing the symptom(s). The Director of Nursing (DON) confirmed Resident 80's bed was positioned against the wall with the intent to reduce the risk of the resident exiting the bed and potentially falling. The DON stated she was not aware that placing the resident's bed against the wall could be considered a form of restraint limiting the resident's mobility and free mobility. The DON acknowledged the P&P was not followed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide sufficient number of staff when 22 out of 31 sampled days had less than 3.5 direct care service hours per patient day (DHPPD- the total number of hours worked per patient day divided by the average daily number of residents in the facility).This failure had the potential to result in unmet needs, such as psychosocial and physical needs, and safety concerns for 97 residents who reside in the facility.Findings: During a concurrent interview and record review on May 20, 2026, at 9:56 AM, with the Director of Staff Development (DSD), the Director of Nursing (DON), and the Administrator (ADMIN) the facility's document titled, Census and Direct Care Service Hours Per Patient Day (DHPPD- the number that results from dividing the actual nursing hours perform by direct caregivers per patient day and the number of residents in the facility), for April 18, 2026, to May 18, 2026, was reviewed. The DHPPD indicated the following: 1. The Actual DHPPD was 2.91 (facility was short of 0.59) on April 18, 2026.2. The Actual DHPPD was 3.24 (facility was short of 0.26) on April 19, 2026.3. The Actual DHPPD was 3.36 (facility was short of 0.14) on April 23, 2026.4. The Actual DHPPD was 3.23 (facility was short of 0.27) on April 24, 2026.5. The Actual DHPPD was 2.82 (facility was short of 0.68) on April 25, 2026.6. The Actual DHPPD was 2.71 (facility was short of 0.79) on April 26, 2026.7. The Actual DHPPD was 2.87 (facility was short of 0.63) on April 27, 2026.8. The Actual DHPPD was 3.10 (facility was short of 0.4) on April 28, 2026.9. The Actual DHPPD was 3.10 (facility was short of 0.4) on April 29, 2026.10. The Actual DHPPD was 3.22 (facility was short of 0.28) on April 30, 2026.11. The Actual DHPPD was 2.60 (facility was short of 0.9) on May 1, 2026.12. The Actual DHPPD was 2.87 (facility was short of 0.63) on May 2, 2026.13. The Actual DHPPD was 3.29 (facility was short of 0.21) on May 3, 2026.14. The Actual DHPPD was 2.78 (facility was short of 0.72) on May 9, 2026.15. The Actual DHPPD was 3.38 (facility was short of 0.12) on May 10, 2026,16. The Actual DHPPD was 3.09 (facility was short of 0.41) on May 11, 2026.17. The Actual DHPPD was 3.37 (facility was short of 0.13) on May 12, 2026.18. The Actual DHPPD was 3.14 (facility was short of 0.36) on May 13, 2026.19. The Actual DHPPD was 3.36 (facility was short of 0.14) on May 14, 2026.20. The Actual DHPPD was 2.64 (facility was short of 0.86) on May 16, 2026.21. The Actual DHPPD was 2.42 (facility was short of 1.08) on May 17, 2026.22. The Actual DHPPD was 2.59 (facility was short of 0.91) on May 18, 2026. The DSD stated the Actual DHPPD was accurate. The DON and the ADMIN acknowledged the facility did not meet the DHPPD required for those dates.During a record review on May 20, 2026, at 11:25 AM, the facility's staffing waiver for certified nursing assistants (CNAs), with a valid date of July 1, 2025, to June 30, 2026, indicated, .2. The facility shall provide no less than 3.5 direct care service hours per patient day.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services when: Insulin (injectable drug to manage blood sugar) was not administered at the prescribed time for three of three sampled residents (Resident 7, Resident 35, and Resident 46) on May 20, 2026, when License Vocational Nurse (LVN 2) administered physician-ordered insulin glargine (brand name Lantus) approximately 2 hours and 21 minutes to 2 hours and 29 minutes prior to the ordered administration time of 6:00 AM.LVN 5 administered Resident 82 chewable aspirin 81 mg (low dose blood thinner) instead of the physician ordered enteric coated aspiring 81 mg (a low dose blood thinner with a special coating designed to help protect the stomach from irritation). This failure resulted in the potential for adverse outcomes including hypoglycemia (low blood sugar), altered blood glucose control, diaphoresis (excessive sweating), dizziness, changes in level of consciousness, falls, and other complications associated with the early administration of insulin, a high-alert medication (a medication that bears an increased risk of causing significant resident harm when used in error). Findings:1a. During a review of Resident 7's admission Record, (contains demographic and clinical information), the document indicated Resident 7 was admitted to the facility on [DATE], with the diagnosis of type 2 diabetes mellitus with diabetic neuropathy (a chronic condition in which the body does not properly control blood sugar level with nerve damage), Chronic Kidney Disease Stage 3 (moderate decrease in kidney function that may affect medication processing and elimination), and vascular dementia with behavioral disturbance (a decline in memory and thinking abilities caused by reduced blood flow to the brain, accompanied by confusion, agitation, or poor safety awareness).During an interview on May 20, 2026, at 5:29 AM, with Licensed Vocational Nurse (LVN 2), LVN 2 stated they had already completed the blood sugar check and administered insulin glargine 5 units (a unit of measurement for dose) to Resident 7 prior to surveyor observation.During a concurrent interview and record review on May 20, 2026, at 5:29 AM, with LVN 2, the physician orders for Resident 7 dated January 9, 2026, were reviewed. The physician orders indicated to administer Lantus subcutaneous solution 100 Unit/ML (insulin glargine) with instructions to inject 5 units subcutaneously two times a day at 6:00 AM and 8:00 PM, for blood sugar management related to Type 2 diabetes mellitus with hyperglycemia. LVN 2 confirmed that insulin glargine was administered to Resident 7 at 3:31 AM that morning. LVN 2 further stated the insulin was administered approximately 2 hours and 29 minutes earlier than the physician ordered time and acknowledged insulin is considered a high alert medication. 1b. During a review of Resident 35's admission Record, the document indicated Resident 35 was admitted to the facility on [DATE], with the diagnosis of type 2 diabetes mellitus with diabetic neuropathy, heart failure (a condition in which the heart is unable to pump blood effectively, increasing the resident's vulnerability to complications associated with blood glucose fluctuations and medication errors), and difficulty walking (impaired ability to walk safely).During an interview on May 20, 2026, at 5:31 AM, with LVN 2, LVN 2 stated they had already completed blood sugar check and administered insulin glargine 26 units to Resident 35 prior to surveyor observation.During a concurrent interview and record review on May 20, 2026, at 5:31 AM, with LVN 2, the physician orders dated February 11, 2026, were reviewed. The physician orders indicated to administer Lantus subcutaneous Solution 100 unit/mL (insulin Glargine) inject 26 units subcutaneously in the morning at 6:00 AM related to type 2 mellitus. LVN 2 confirmed that insulin glargine was administered to Resident 35 at 3:31 AM that morning. LVN 2 confirmed the insulin was administered approximately 2 hours and 29 minutes before the physician ordered administration time of 6:00 AM time and acknowledged insulin is considered a high alert medication. 2. During a review of Resident 46's admission Record, the document indicated Resident 46 was admitted to the facility on [DATE], with diagnosis of type 2 diabetes mellitus with diabetic neuropathy, essential (primary) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hypertension (elevated blood pressure), and difficulty walking. During an interview on May 20, 2026, at 5:33 AM, with LVN 2, LVN 2 stated they had already completed blood sugar check and administered insulin glargine 32 units to Resident 46 prior to surveyor observation. During a concurrent interview and record review on May 20, 2026, at 5:33 AM, with LVN 2, the physician orders dated December 29, 2025, were reviewed. The physician orders indicated, to administer Insulin Glargine solution 100 Unit/ML inject 32 units subcutaneously in the morning at 6:00 AM related type 2 diabetes mellitus with diabetic neuropathy. LVN 2 confirmed that insulin glargine was administered to Resident 46 at 3:39 AM that morning. LVN 2 further stated the insulin was administered approximately 2 hours and 21 minutes earlier than the physician ordered time and acknowledged insulin is considered a high alert medication. During a concurrent interview and record review on May 20, 2026, with the LVN 2, the facility's P&P titled, Administering Medications, revised April 2019 was reviewed. The P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 7. Medications are administered within (1) hour of their prescribe time, unless otherwise specified (for example, before and after meal orders). 10. The individual administering the medication check the labeled THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.23 As required or indicated, for a medication the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered. LVN 2 confirmed that the policy was not followed because the insulin was administered too early and it have may cause hypoglycemia reaction. During a concurrent interview and record review on May 21, 2026, with the Director of Nursing (DON), the facility's P&P titled Administering Medications, revised April 2019 was reviewed. The P&P indicated, Medications are administered in a safety and timely manner, as prescribed. The DON stated it is important for nursing staff to follow physician orders and administer medications within the facility's approved medication administration time frame. During a review of Resident 32's admission Record (contains demographic and clinical information), the admission Record indicated Resident 32 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with foot ulcer (a chronic condition here the body does not properly use insulin, causing high blood sugar levels and wounds on the feet that heal slowly), Peripheral autonomic neuropathy (nerve damage caused by diabetes that can affect body functions such as blood pressure, heart rate, and blood sugar regulation), and acute respiratory failure with hypoxia (a serious condition where the lungs cannot provide enough oxygen to the body, increasing the resident's risk for complications). During a review of resident 32's Care Plan Report dated April 26, 2023, the care plan indicated, Focus Diabetes care plan, resident with altered blood glucose AEB (as evidence by) fluctuating blood sugars. At risk for ill effects as: Hypoglycemia (tremors, confusion., Hyperglycemia (blurred vision, acetone odor breath) related to DM (diabetes mellitus), Goal Resident will not have any complications of diabetes through next review.Interventions.Obtain blood glucose levels as ordered, document and notify MD (doctor) as needed. During a review of Resident 32's physician's

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention control program for three of three sample residents (Residents 32, 12, and 13) when: 1.For Resident 32, the resident's nebulizer machine was observed with a brown crusted substance at the port site where the tubing connected to the nebulizer and nebulizer tubing not in use was observed hanging from a shelf in the resident's room and not stored in a protective plastic bag. 2.For Resident 12, the resident's wheelchair was observed with dried brown crusted substance on the wheelchair cushion, wheel areas and bilateral side panels. 3.For Resident 13, the resident's oxygen tubing / cannula (a flexible plastic tube to deliver Oxygen from the oxygen concentrator to the resident) was observed hanging underneath the bed and touching the floor. These failures had the potential to place Residents 32, 12, and 13 at risk for infection and harm. Findings: 1. During a review of 32's admission Record (clinical record with demographic information), the admission Record indicated, Resident 32 was admitted to the facility on [DATE], with diagnoses which included, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), acute respiratory failure(the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide from it) and dementia (a progressive state of decline in mental abilities). During an observation and interview on May 18, 2026, at 2:15 PM, in Resident 32's room, Resident 32's nebulizer machine was observed with brown crusted substance at the port site where the tubing connected to the nebulizer machine. Further observation revealed nebulizer tubing was not in use and hanging from a shelf in Resident 32's room. The nebulizer tubing was not stored in a protective plastic bag. Resident 32's stated, resident just finished treatment with the nebulizer machine. During a current observation and interview on May 18, 2026, at 2:34 PM, with Licensed Vocational Nurse 1 (LVN 1), in Resident 32's room, LVN 1 acknowledged the nebulizer equipment was not clean and the tubing should have been stored in a clean protective bag when not in use to prevent contamination. 2. During a review of 12's admission Record (clinical record with demographic information), the admission Record indicated, Resident 12 was admitted to the facility on [DATE], with diagnoses which included, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), hypertension (HTN-high blood pressure), behavior disturbances (persistent pattern of actions, emotions, or reactions that disrupt a person's ability to function normally in daily life) and dementia (a progressive state of decline in mental abilities). During an observation on May 18, 2026, at 4:30 PM, in the lobby next to nursing station 3, observed Resident 12's wheelchair with a dry brown crusted substance present on the wheelchair cushion, wheel area and on the both sides panels of the wheelchair. The wheelchair is visibly soiled and was in use by the resident 12. During a current observation and interview on May 18, 2026, at 4:38 PM, with Licensed Vocational Nurse 6 (LVN 6), in the lobby next to nursing station three, LVN 6 acknowledged the wheelchair was visibly soiled and stated the wheelchair should be maintained in a clean and sanitary condition to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevent infection risk to the resident. During a concurrent interview and record review on May 20, 2026, at 1:52 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Cleaning and Disinfecting of Resident Care Items and Equipment, dated 2001, was reviewed. The P&P indicated, . Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to the CDC recommendations for disinfection and the OSHA bloodborne pathogen standards. The DON confirmed the P&P was not followed for Residents 32 and 12. During a concurrent interview and record review on May 20, 2026, at 2:00 PM, with the Director of Nursing (DON), the facility's (P&P) titled, Prevention of Infection Respiratory Equipment, dated November 2011, was reviewed. The P&P indicated, . Purpose: the purpose of this procedure is to guide prevention of infection associated with respiratory therapy task and equipment among residents and staff.Infection Control Considerations Related to Oxygen Administration. 5. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use.Infection Control Considerations related to Medication Nebulizers/Continuous Aerosol.2. Take care not to contaminate internal nebulizer tubes.3. Store the circuit in plastic bag, marked with date and resident's name and replace tubing and plastic bag once a week. The DON confirmed the P&P was not followed for Residents 32. 3. During a review of Resident 13's admission Record (Contains demographic and medical information) it indicated Resident 13 was admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease (COPD), (a long-term lung disease that makes it difficult to breath and limits air flow in the lungs. Acute respiratory failure with hypoxia (a serious condition where the lungs cannot provide enough oxygen to the body) and Centrilobular emphysema (a type of lung damage, usually related to smoking, that destroys air sacs in the lungs and causes shortness of breath). During a review of Resident 13's Physician Orders, dated December 11, 2025, it indicated, continuous oxygen @ (at) 2 (two) Liters / Min (liters per minute) via nasal cannula .,medical Dx (diagnosis): acute respiratory failure., Start date: December 11, 2025. During a concurrent observation and interview on May 18, 2026 at 3:15 PM, with the Registered Nurse, (RN 1), in Resident 13's room, further observation revealed the oxygen tubing was loosely coiled and lying directly on the floor next to the resident's bed while remaining connected to the oxygen concentrator powered on at 1.5 L per minute. A clear bag intended for storage of breathing supplies (oxygen tubing) was hanging from the oxygen concentrator. The nasal cannula prongs and portions of the oxygen tubing remained in direct contact with the floor. The RN 1, confirmed the oxygen tubing was touching the floor and stated once the oxygen tubing should be stored in the plastic stored bag for infection control. During a concurrent interview and record review on May 21, 2026 at 10:45 PM with the Director of Nursing the facility's policy and procedure (P&P) titled, Prevention of Infection Respiratory Equipment dated Revised November 2011 was reviewed. The P&P indicated, The purpose of this procedure is to guide prevention of infection associated with associated with respiratory therapy tasks and equipment among residents and staff.5. Keep the oxygen cannula and tubing used PRN (as necessary) in plastic bag when not in use. The DON confirmed the policy was not followed by staff.

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	555777	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Care Center	151 Pioneer LN Bishop, CA 93514

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview, and record review, the facility to ensure 1 of 5 sampled Certified Nursing Assistant 5 (CNA 5) received required in-service training of no less than 12 hours per year. This failure had the potential to diminish CNA 5 continuing competence and reduce the CNA 5 ability to provide safe, appropriate care, including dementia management and resident abuse prevention.Findings: During a review of the facility's required in-services log book with the Director of Staff Development (DSD), on May 21, 2026, the following in-services were signed by CNA 5: 1. Fall prevention dated May 22, 2025 from 6:30 AM to 7:30 AM2. Choking Prevention dated May 29, 2025 from 6:30 AM to 7:30 AM and 2:30 PM to 3:30 PM.3. Abuse: Recognizing, Intervening, & Reporting dated May 29, 2025 from 2:30 PM to 3:30 PM.4. Oral Care dated July 22, 2025 from 2:30 PM to 3:30 PM.5. Standard, Enhanced, Droplet, Airborne Precautions dated November 11, 2025 with no time listed.6. Importance of Oral Hygiene dated November 18, 2025 with no time listed.7. Emergency Response Procedures dated February 5, 2026 from 6:30 AM to 7:30 AM and 2:30 PM to 3:30 PM8. Safe Repositioning Techniques dated February 5, 2026 from 6:30 AM to 7:30 AM and 2:30 PM to 3:30 PM During an interview with the DSD, on May 21, 2026 at 11:02 AM, the DSD stated CNA 5 did not meet the minimum required in-services.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a device that allows a resident to communicate with nursing staff when a resident needs assistance) was within resident reach for one of six sampled residents (Resident 49) when Resident 49's call light was hanging off the side of the bed and out of the reach. This failure had the potential to place Resident 49 at risk for safety and well-being.Findings:A review of Resident 49's admission Record (contains demographic and medical information), indicated Resident 49 was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure with hypoxia (the lungs are suddenly unable to adequately transfer oxygen into your bloodstream), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), osteoarthritis(a degenerative joint disease where the protective cartilage covering the ends of your bones gradually wears away). During a concurrent observation and interview on May 18, 2026, at 4:04 PM, with Resident 49 in Resident 49's room, observed Resident 49 lying in bed and looking around in the bed. Resident 49 stated I can't find my call light and this happens all the time. Further observation, noted the call light hanging off the side of the bed and out of reach. Resident 49 was unable to independently notify staff for assistance and to report need for care.During a concurrent observation and interview on May 18, 20, 2026, at 4:15 PM, with Certificated Nursing Assistant 4 (CNA 4), in Resident 49's room, CNA 4 validated Resident 49's call light was hanging off the side of bed and out of reach of resident. CNA 4 stated the call lights should be within resident's reach and it's important for the residents to be able to request care. During a concurrent interview and record review on May 20, 2026, at 1:43 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Answering the Call Light, dated October 2010 was reviewed. The P&P indicated, The purpose of this procedure is to respond to the resident's requests and needs.5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. The Director of Nurses (DON) stated the expectation is for call lights to remain within residents' reach at all times and acknowledged the facility's P&P was not followed.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse with an injury of unknown origin was reported to the State Survey Agency within the required time frame for one of one sample resident (Resident 11). This failure had the potential to put at risk the health and safety of Resident 11. Findings: During a review of Resident 11's admission Record (contains demographic and clinical information) the admission Record indicated Resident 11 was admitted to the facility on [DATE], with the diagnosis of paraplegia (partial or complete paralysis affecting the lower part of the body, resulting in impaired mobility and increased dependence on staff assistance for movement and transfers), cognitive communication deficit (difficulty understanding, processing, or expressing information which may affect the residents ability to communicate needs, report concerns or request assistance) and anoxic brain damage (brain injury caused by a lack of oxygen to the brain, which may affect memory, judgement, safety awareness, thinking abilities, and the ability to recognize or respond to unsafe situations). During a review of Resident 11's MDS (Minimum Data Set - a standardized assessment tool that measures health status in nursing home residents) Section C (Cognitive (involving consciousness intellectual activity Patterns), dated April 2, 2026, indicated Resident 11 had a BIMS (brief Interview for Mental Status - tool used to screen how a resident is functioning cognitively) score of 5 (a BIMS score 0-7: suggests residents is severe impairment). During a review of Resident 11's MDS (Minimum Data Set - Section GG (functional abilities dated April 2, 2026) indicated Resident 11 needs maximal assistance. During a review of Resident 11's Physician Orders dated January 1, 2024, the physician orders indicated, Resident 11 to have 1/2 (half) side rails up to both sides of bed for safety and repositioning. Further review indicated, Fall mat at bedside when in bed every shift for safety bilaterally on sides of bed to reduce risk of injury from attempts to crawl out of bed dated October 6, 2022. During an observation May 18, 2026 at 4:05 PM, Resident 11 was observed lying in bed with eyes closed. Observation revelated the resident's bed was positioned against the wall on the left side with a floor mat located on the right side of the bed. Further observation revelated approximately circular area of yellow - green discoloration surrounding the resident's right eye. The discoloration appeared faded in appearance. During a telephone interview on May 19, 2026 at 10:38 AM with Family Member (FM 1), FM 1 stated she visited Resident 11 on May 14, 2026 and observed a large black bruise underneath the resident's right eye while seated in the dining room. The FM1 stated she asked Resident 11 what happened; however, Resident 11 shrugged his shoulders and was unable to explain the cause of the injury. FM 1 stated a staff member assisting Resident 11 with his meals, was unable to explain how the injury occurred. FM 1 stated the facility did not contact her regarding the injury until May 15, 2026 when a licensed nurse informed her staff had observed the injury. FM 1 stated she informed the nurse she had already observed the bruise during her visit on May 14, 2026. FM 1 stated she was informed the facility would investigate the injury; however, as of the date of the interview, she had not received any follow up regarding the cause of the injury or the outcome of the investigation. FM 1 stated she did not know how the injury occurred. During an interview on May 20, 2026 at 1:08 PM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated Resident 11 had a long history of behaviors including removing clothing, throwing himself onto the floor and crawling and often requiring assistance from two to three staff members to return him to bed. CNA 3 further stated that on May 13, 2026, she assisted other staff members with showering Resident 11. CNA 3 observed discoloration around the resident's right eye and believed that nursing staff had already identified and reported the injury. CNA 3 further stated staff are expected to immediately report observations to the nurse who would then notify management. CNA 3 acknowledged that despite observing the discoloration around the resident's right eye, she did not report it. During an interview with the Director of Nurses (DON) on May 21, 2026 at 11:09 AM, the DON (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated staff are expected to immediately report new bruising, injuries of unknown origin, or allegations of abuse to the nurses for assessment and notification to management. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated, Revised April 2021, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft/misappropriation of resident property are reported to local, state a federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.3. Immediately is define as a. within two hours of an allegation involving abuse or resulting in serious bodily injury ; b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. During a review of facility's Reported Incident (FRI) , the allegation was reported to the state survey agency on May 15, 2026, 48 hours after the first observation of possible abuse to Resident 11.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled residents (Resident 11) had access to a functioning resident's call light in the bathroom. This failure had the potential for Resident 11 to experience delayed assistance and increased the risk for unmet care needs, falls, injury, and inability to request help during an emergency. Findings: During a review of Resident 11's admission Record (contains demographic and clinical information), the admission Record indicated Resident 11 was admitted to the facility on [DATE] with the diagnosis of paraplegia (partial or complete paralysis affecting the lower part of the body, resulting in impaired mobility and increased dependence on staff assistance for movement and transfers), cognitive communication deficit (difficulty understanding, processing, or expressing information which may affect the residents ability to communicate needs, report concerns or request assistance) and anoxic brain damage (brain injury caused by a lack of oxygen to the brain, which may affect memory, judgement, safety awareness, thinking abilities, and the ability to recognize or respond to unsafe situations). During observation on May 20, 2026 at 12:27 PM, in Resident 11's room, Resident 11 was sitting upright in a wheelchair. The resident was awake, alert and oriented to name, place and situation. The resident stated he wanted to use the restroom and reported he was waiting for staff assistance. During an observation on May 20, 2026 at 12:28 PM in Resident 11's bathroom, surveyor attempted to activate the bathroom emergency call light system by pulling the emergency call cord and pressing the call light button located inside the bathroom. There was no No alarm, signal, or notification was activated. The bathroom call light system was not functioning. During a concurrent observation and interview on May 20, 2026, at 12:39 PM, with the Director of Nurses (DON) and Administrator, they were requested to come to Resident 11's room to verify the functionality of the call light located inside the resident's restroom. Further observation revealed the restroom emergency call light was inoperable. The DON stated she was unaware the call light was not functioning and indicated maintenance would need to evaluate the system. The DON and Administrator confirmed the emergency call light located in Resident 11's restroom was not functioning. The DON and Administrator acknowledged that a functioning call light system was important for residents to request assistance and notify staff during emergencies. During an interview on May 20, 2026 at 12:43 PM with the Maintenance Director, (MDR), MDR stated Resident 11 frequently pulled on and damaged the call light equipment, requiring repairs on multiple occasions. The MDR confirmed the restroom call light located in Resident 11's bathroom was not functioning. During a review of Resident 11's MDS (Minimum Data Set - a standardized assessment tool that measures health status in nursing home residents) Section C (Cognitive (involving consciousness intellectual activity Patterns), dated April 2, 2026, indicated Resident 11 had a BIMS (brief Interview for Mental Status - tool used to screen how a resident is functioning cognitively) score of 5 (a BIMS score 0-7: suggests residents is severe impairment). During a review of Resident 11's MDS (Minimum Data Set) , Section GG (functional Abilities and Goals), dated April 2, 2026, indicated, Section GG0130 C. (toileting hygiene), was coded 01 Dependent - helper does all of the effort. Resident does none of the effort to complete the activity. Or , the assistance of 2 or more helpers is required for the resident to complete the activity. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light dated October 2010, the P&P indicated, 3. Ask the resident to return the demonstration so that you will be sure that the resident can operate the system (Note: Explain to the resident that a call system is also located in his / her bathroom. Demonstrate how it works.), 4. Be sure that the call light is always plugged in.,7. Report all defective call lights to the nurse supervisor promptly. 8. Answer the resident's call light as soon as possible. During an interview on May 21, 2026 at 11:10 AM with DON, the DON reviewed the P&P, and acknowledged the restroom emergency call light for Resident 11 was expected to be function and available for the resident to request staff assistance.