STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Crest Post-Acute	50 Concordia Lane Oroville, CA 95966

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** 43739 Based on interview and record review, the facility failed to notify the Medical Director (MD) for one of three sampled residents (Resident 1), when there was a need to alter Resident 1's healthcare decision maker as Resident 1 was still listed as the decision maker. Resident 1 had a St. Louis University Mental Status (SLUMS) examination (a cognitive screening test designed to detect the early signs of mild cognitive impairment and dementia) done on 7/22/24, and had a score of 3 out of 30, indicating that Resident 1 was cognitively impaired. This failure resulted in the facility continuing indicating that Resident 1 Has the capacity to make and understand decisions , and only notified Resident 1 when there was an alleged abuse allegation. Findings: During a review of the facility's policy titled, Change in a Resident's Condition or Status , revised 5/2027, indicated: 1. Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 2. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an) . significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly 3. A significant change of condition is a major decline or improvement in the resident's status that .Will not normally resolve itself without intervention by the staff or by implementing standard disease-related clinical interventions (is not self-limiting); 4. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's admission record, indicated that Resident 1 was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), left hip fracture, muscle weakness (generalized), and abnormalities of gait and mobility. Resident 1 was listed as her Responsible Party (RP - an individual chosen by the resident to act on behalf of the resident to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications). During a review of Resident 1's Minimum Data Set (MDS - an assessment and care screening tool), the MDS indicated that Resident 1's cognition level had changed from moderately impaired to severely impaired since early 2024: 1. On 1/16/24, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 11 out of 15, indicating her cognition was moderately impaired. 2. On 4/12/24, the MDS indicated that Resident 1 had a BIMS score of 3 out of 15, indicating her cognition was severely impaired. 3. On 6/14/24, the MDS indicated that Resident 1 had a BIMS score of 3 out of 15, indicating her cognition was severely impaired. 4. On 2/2/25, the most recent MDS indicated that Resident 1 had a BIMS score of 3 out of 15, indicating her cognition was severely impaired. During a review of Resident 1's record titled, SLUMS Examination , dated 7/22/24, indicated Resident 1 had a score of 3 out of 30, suggesting Resident 1 had dementia. During a review of Resident 1's Speech Therapy (ST) Evaluation record, dated 7/22/24, completed by the Speech-Language Pathologist ([SLP] - the healthcare professionals who work to prevent, identify, diagnose, and treat disorders related to speech, language, social communication, cognitive communication, and swallowing in people of all ages), the ST evaluation record indicated that Resident 1 was referred to the ST services for assessing any changes in her status. In the Impressions section, the record indicated: - Patient [Resident 1] completed SLUMS assessment with a score of 3/30, deficits noted across all cognitive-linguistic domains (a way of studying language as a mental phenomenon). - Patient [Resident 1] presented with decreased orientation on this date with patient [Resident 1] oriented to state and mixed orientation to self. - Patient [Resident 1] was able to provide first name and date of birth but was unable to provide last name and age. - Patient [Resident 1] presented with difficulty with memory recall both in structured assessment tasks as well as in conversational tasks requiring memory recall. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- She [Resident 1] presented with deficits in basic problem solving such as using call light. Also noted was decreased awareness of deficits as patient [Resident 1] stated she was safe to get out of bed. During a concurrent interview and record review on 2/5/25 at 11:20 am with the ADMIN in the ADMIN's office, Resident 1's grievance resolution form, dated 10/26/24, was reviewed. The ADMIN stated he did not recall he filed the alleged abuse report to the proper authorities, and he believed the SSD was the one investigating the allegation. The ADMIN stated he was the facility abuse coordinator, and he and the SSD would be the one investigating any alleged abuse event. When asked as a mandated reporter and the facility abuse coordinator, why he did not report to the authorities, the ADMIN said, We did our own review, and it was unsubstantiated. Even We did our own investigation, do we still need to report it? She [Resident 1] had Alzheimer's, dementia, and often made false accusation, we did not have a staff look like that, and she was her own RP, so I didn't think we had to report it. During a concurrent interview and record review on 2/5/25 at 11:28 am with the ADMIN in the ADMIN's office, Resident 1's current physician order and the most current MDS, dated [DATE], were reviewed. The order indicated that Resident 1, Has the capacity to make and understand decisions , and it was ordered on 5/28/23 and had never been revised or updated based on Resident 1's status. When asked why Resident 1 who had Alzheimer's disease, with a BIMS score of 3, and was still listed as the RP, the ADMIN agreed that Resident 1 shouldn't be listed as the RP, and stated, We will ask the doctor to update it. During an interview on 2/5/25 at 11:50 am, with the Certified Nursing Assistant (CNA) D, in the dining area, the CNA D stated she took care of Resident 1 this month, she said, Resident 1 had dementia, she was not accurate, and often confused. During an interview on 2/5/25 at 2 pm with Licensed Nurse (LN) A, in the hallway, LN A stated, Resident 1 has Sundowning syndrome (a set of symptoms that can occur in people with dementia in the late afternoon and evening. Symptoms include confusion, anxiety, agitation, and difficulty sleeping), especially in the afternoon, she would be very agitated, try to walk out of the room on her own, and refuse any help. Resident 1 could not walk on her own . During a concurrent interview and record review on 2/7/25 at 10:37 am, with the ADMIN in the ADMIN 's office, Resident 1's SLUMS examination report, dated 7/22/24, was reviewed. The ADMIN stated that he wasn't sure whether the MD was notified about the report, the ADMIN said, Once we received the result, we would notify the physician, the nurse probably would be the one who notifies the MD. The ADMIN stated the Director of Nursing (DON) should have more information about whether the MD was notified. During an interview on 2/7/25 at 11:10 am with CNA B in Resident 1's room, the CNA B stated that she took care of Resident 1 very often, so she knew her. The CNA B said, Resident 1 has dementia, her mood swings a lot. She is very confused and forgetful. She would ask to go to the bathroom, then in seconds, when I tried to help her, she would refuse to go, and say she did not have to go . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/7/25 at 10:55 am with the DON in the ADMIN's office, Resident 1's medical record was review. When asked whether the MD was notified about Resident 1' SLUMS examination report, the DON stated, I believed the MD was notified. At 12:10 pm in the ADMIN'S office, the DON admitted that he could not locate such note that indicating the MD was notified in Resident 1's medical record, and he stated, First of all, someone had to be made aware of. The medical record received the report and scanned it into the resident's PointClickCare (PCC - a cloud-based healthcare software platform that helps manage care, services, and finances.) They did not come to me, so I was not made aware of it . The MDS nurse did the cognition assessment, found her BIMS was 3, she should mention it during the Interdisciplinary care team (IDT - a group of health care professionals from different disciplines who work together to provide care) meeting when we were discussing Resident 1's capacity of signing treatment consent. Then Resident 1's SLUMS report, BIMS, and her capacity would be brought to the attention during the meeting, and the MD would be eventually notified. The DON agreed that the above process did not occur for Resident 1.

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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** 43739 Based on interview and record review, the facility failed to report an abuse allegation for one of three sampled residents (Resident 1) when Resident 1 informed Certified Nursing Assistant (CNA) A that a male staff was Really rough when getting her [Resident 1] in & out of bed, grabbed her really hard, and wanted to hurt her on 10/24/24. This failure had the potential to result in psychosocial and emotional harm for Resident 1 and had the potential to place all the residents at risk for undetected/unreported elder neglect or abuse. Findings: During a review of the facility's policy titled, Abuse Prevention Program , revised 12/1/22, indicated this policy is to, Promote and environment free from any form of resident abuse, neglect, misappropriation of resident property, exploitation and /or mistreatment. The policy also indicated that: 1. The facility shall thoroughly investigate allegation of abuse by identifying and interviewing all involved, including the alleged victim, alleged perpetrator, witness (es) and others who might have seen, heard or have knowledge of the allegations, and with documented evidence that support the investigation. 2. The facility's Abuse Prevention Coordinator shall initiate the investigation process immediately within the required time frame in accordance with the regulation after the alleged incident occurred - focusing on determining if allegations have occurred, the cause and its extent and by providing complete and through documentation of the investigation and exercising caution in handling possible evidence(s). 3. The facility shall respond to abuse allegation(s) immediately by protecting the alleged victim and integrity of the investigation. 4. The facility shall report any and all allegation of abuse to the District California Department of Public Health (CDPH), Local Ombudsman, and/or Local Law enforcement, either by phone, email or facsimile, within 2-hour timeframe. During a review of Resident 1's admission record, indicated that Resident 1 was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included Alzheimer's disease ((a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), left hip fracture, and need for assistance with personal care. Resident 1 was her Responsible Party (RP - an individual chosen by the resident to act on behalf of the resident to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications). During a review of Resident 1's most recent Minimum Data Set (MDS - an assessment and care screening tool), dated 2/2/25, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 3 out of 15, indicating her cognition was severely impaired. (continued on next page)

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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	During a review of Resident 1's medical record titled, St. Louis University Mental Status (SLUMS) Examination (an assessment tool for dementia and mild cognitive impairment), dated 7/22/24, indicated Resident 1 had a score of 3 out of 30, suggesting Resident 1 had dementia. During a review of the facility's document titled, Grievance Resolution Form , dated 10/26/24, indicated that Resident 1 reported to CNA A on 10/24/24, stating, A tall, male, attractive, light-colored hair, on 10/24/24, really rough when getting in & out of bed. Grabbed her [Resident 1] really hard. He wanted to hurt her. He does not like her or women. He helped her twice on the same day. The person listed as the investigator was the Social Service Director (SSD). The SSD and the administrator (ADMIN) both signed the form and dated 10/28/24. The statement for the Resolution on the form indicated, No one of that description worked that shift. Name [Resident 1] has diagnose of Alzheimer's. During a concurrent interview and record review on 2/5/25 at 11:20 am with the ADMIN in the ADMIN's office, Resident 1's grievance resolution form, dated 10/26/24, was reviewed. The ADMIN stated he did not recall he filed the alleged abuse report to the proper authorities, and he believed the SSD was the one investigating the allegation. The ADMIN stated he was the facility abuse coordinator, and he and the SSD would be the one investigating any alleged abuse event. When asked as a mandated reporter and the facility abuse coordinator, why he did not report to the authorities, the ADMIN said, We did our own review, and it was unsubstantiated. Even We did our own investigation, do we still need to report it? She [Resident 1] had Alzheimer's, dementia, and often made false accusation, we did not have a staff look like that, and she was her own RP, so I didn't think we had to report it. During a concurrent interview and record review on 2/5/25 at 12 pm, with the ADMIN in the ADMIN's office, Resident 1's most recent MDS, dated [DATE], progress note, social service note, and care plan were reviewed. The ADMIN agreed that Resident 1's BIMS was 3, and Resident 1 shouldn't be listed as the RP, the ADMIN said, Family B was the main contacted person, we would ask the doctor to update it. The ADMIN admitted that he could not locate any documentation from the social service department regarding the investigation for the alleged abuse allegation. The ADMIN stated, There should have been an interdisciplinary care team (IDT - a team of health care professionals from different disciplines that work together to provide care) meeting, a documentation of investigation, and it should be care planned. When asked whether Family B was contacted for this alleged abuse allegation, the ADMIN stated, I am not sure. During an interview on 2/5/25 at 1:40 pm with the SSD in the SSD's office, when asked for the record of Resident 1's alleged abuse allegation investigation, the SSD stated, I did not do the investigation. The SSD said, It's been too long, I don't remember. When asked if she was to investigate an abuse incident, would she document the investigation process in the resident's record, the SSD stated, Probably, but I am not sure. When asked whether she would report the abuse incident to CDPH, and local authorities, the SSD stated that she wouldn't, and she would only report it to the ADMIN.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview and record review, the facility failed to ensure social services met the needs for two of three residents (Resident 1, 2) when: 1. The Social Service Director did not investigate and reported to the authorities after Resident 1 informed the Certified Nursing Assistant (CNA) B of an allegation of abuse on 10/24/24. This failure had the potential to result in psychosocial and emotional harm for Resident 1 and had the potential to place all the residents at risk for undetected/unreported elder neglect or abuse. 2. The Social Service Director failed to ensure the Behavior Management Committee address the appropriateness of the use of the psychotropic medication when Resident 2 was prescribed with PRN Lorazepam (brand name: Ativan - used to relive anxiety) for extended time period without the rationale. This failure could contribute to unsafe use of psychotropic medications that could have placed residents at risk for adverse consequences. Findings: A review of a facility policy titled, Social Services Assessment, revised 11/22/16, indicated the purpose was to identify information to help staff develop a personalized plan of care that utilizes the individual's existing needs, strengths, functional deficits, and optimizes function and quality of life and meets individual's goal and preferences. When a resident is admitted a discharge plan is discussed, documented in the social services assessment, and updated in the record to reflect changes to the initial discharge plan. 1. A review of a facility job description for Social Service Director (SSD), no revised date provided, indicated The primary purpose of the job position is to plan, organize, develop, and direct the overall operation of the facility's Social Services Department in accordance with current federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator (ADMIN), to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. The duties and responsibilities of the SSD were to: Administrative Functions - Perform administrative requirements, such as completing necessary forms, reports, etc., and submitting such to the ADMIN as required. Committee Functions - Serve on, participate in, and attend various committees of the facility (i.e., Infection Control, Policy Advisory, Pharmaceutical, Budget, Quality Assessment, and Assurance, etc.) as required, and as appointed by the ADMIN; Evaluate and implement recommendations from established committees as they may pertain to social services. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Rights - Review complaints and grievances made by the resident and make a written/oral report to the ADMIN indicating what action(s) were taken to resolve the complaint or grievance. Follow facility's established procedures; Maintain a written record of the resident's complaints and/or grievances that indicates the action taken to resolve the complaint and the current status of the complaint. Specific Requirements - Must be knowledgeable of the rules, regulations, and guidelines that govern nursing care facilities. During a review of Resident 1's admission record, indicated that Resident 1 was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included Alzheimer's disease ((a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), left hip fracture, and need for assistance with personal care. Resident 1 was listed as her health care decision maker (Refer to F 580). During a review of Resident 1's most recent Minimum Data Set (MDS - an assessment and care screening tool), dated 2/2/25, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 3 out of 15, indicating her cognition was severely impaired. During a review of Resident 1's medical record titled, St. Louis University Mental Status (SLUMS) Examination (an assessment tool for dementia and mild cognitive impairment), dated 7/22/24, indicated Resident 1 had a score of 3 out of 30, suggesting Resident 1 had dementia. During a review of the facility's document titled, Grievance Resolution Form , dated 10/26/24, indicated that Resident 1 reported to CNA A on 10/24/24, stating, A tall, male, attractive, light-colored hair, on 10/24/24, really rough when getting in & out of bed. Grabbed her [Resident 1] really hard. He wanted to hurt her. He does not like her or women. He helped her twice on the same day. The person listed as the investigator was the Social Service Director (SSD). The SSD and the administrator (ADMIN) both signed the form and dated 10/28/24. The statement for the Resolution on the form indicated, No one of that description worked that shift. Name [Resident 1] has diagnose of Alzheimer's. During a concurrent interview and record review on 2/5/25 at 11:20 am with the ADMIN in the ADMIN's office, Resident 1's grievance resolution form, dated 10/26/24, was reviewed. The ADMIN stated he did not recall he filed the alleged abuse report to the proper authorities, and he believed the SSD was the one investigating the allegation. The ADMIN stated he was the facility abuse coordinator, and he and the SSD would be the one investigating any alleged abuse event. During a concurrent interview and record review on 2/5/25 at 11:40 am with the Director of Staff Development (DSD) in the ADMIN's office, the facility's abuse training record was reviewed. The DSD confirmed that the SSD had abuse training titled, titled, Mandated Reporter, Elder and Dependent Adult Abuse , on 2/12/24, 7/31/24, and 1/30/25. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/5/25 at 12 pm, with the ADMIN in the ADMIN's office, Resident 1's most recent MDS, dated [DATE], social service progress note, and care plan were reviewed. The ADMIN agreed that Resident 1's BIMS was 3, and Resident 1 shouldn't be listed as the RP, the ADMIN said, Family B was the main contacted person, we would ask the doctor to update it. The ADMIN admitted that he could not locate any documentation from the social service department regarding the investigation for the alleged abuse allegation. The ADMIN stated, There should have been an interdisciplinary care team (IDT - a team of health care professionals from different disciplines that work together to provide care) meeting, a documentation of investigation, and it should be care planned. When asked whether Family B was contacted for this alleged abuse allegation, the ADMIN stated, I am not sure. During an interview on 2/5/25 at 1:40 pm with the SSD in the SSD's office, when asked for the record of Resident 1's alleged abuse allegation investigation, the SSD stated, I did not do the investigation. The SSD said, It's been too long, I don't remember. When asked if she was to investigate an abuse incident, would she document the investigation process in the resident's record, the SSD stated, Probably, but I am not sure. When asked whether she would report the abuse incident to CDPH, and local authorities, the SSD stated that she wouldn't, and she would only report it to the ADMIN. 2. During a review of the facility policy titled, Behavior Management Committee , revised 9/2025, indicated, It is the policy of this facility that the residents exhibiting behavior problem will be assessed thoroughly and less restrictive interventions will be offered prior to the administration of the psychoactive medications. The Social Services: Will meet with residents and attempt to identify possible psychosocial issues that may be causing the behaviors. In collaboration with the Director of Nursing Services/designated Licensed Nurse will oversee the Behavior Management Committee. Decide further intervention in collaboration with the Attending Physician and Psychiatrist to support the need of psychotropic medication not to exclude gradual dose reduction. Will ensure that the Behavior Management Committee will address the appropriateness of the use of the psychotropic medication and the need for gradual dose reduction. Will document in the Social Service note information discussed during the Behavior Management Committee Meeting which includes the intervention, psychological or psychiatric referral and gradual dose reduction. Will ensure that the Behavior Management Committee address the appropriate use of the psychotropic medication. During a review of Resident 2's admission record, indicated that Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive state of decline in mental abilities), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and need for assistance with personal care. Resident 2 was not her healthcare decision maker. (continued on next page)

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's most recent Minimum Data Set (MDS - an assessment and care screening tool), dated 12/18/24, the MDS indicated that Resident 2 had a brief interview for mental status (BIMS) score of 7 out of 15, indicating her cognition was moderately impaired. During a concurrent interview and record review on 2/7/25 at 1:55 pm, with the administrator (ADMIN) in the admin's office, SOM - the guidance for PRN order for psychotropic and antipsychotic medication, and Resident 2's Medication Administration Record (MAR), dated from 4/1/24 to 4/30/24, were reviewed. The MAR record indicated Resident 2 was prescribed with Lorazepam tablet 0.5 mg, and was to Give 1 tablet by month every 8 hours as needed for Anxiety for 30 days as exhibited by yelling out even when all needs are met, start date-4/2/24 . The ADMIN stated he was aware that the PRN psychotropic drugs were limited to 14 days, unless the provider indicated the need for the extended time period in the resident's record. The ADMIN confirmed that he couldn't locate such note in Resident 2's medical record. During a concurrent interview and record review on 2/7/25 at 2:28 pm with the Director of Nursing, in the admin's office, Resident 2's medical record titled, Psychotherapeutic review interdisciplinary care team (IDT- a team of health care professionals from different disciplines that work together to provide care) v.2 , dated 4/10/24, was reviewed. The DON stated residents who were prescribed with psychotropic and antipsychotic medication, their status, indication of using the medication, and reaction to the medication, etc., would be discussed in the monthly Psychotherapeutic review IDT meeting, and Resident 2's rationale for needing PRN Ativan for 30 days should be discussed and documented in the Psychotherapeutic review IDT meeting. The DON confirmed that he could not locate such note in Resident 2's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Crest Post-Acute	50 Concordia Lane Oroville, CA 95966

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview and record review, the facility failed to ensure safe use of psychotropic medications (medication that alters mood, behavior, and cognition) for one of three sampled residents (Resident 2) when Resident 2 was prescribed with Lorazepam (brand name: Ativan - used to relive anxiety) for extended time period without the rationale. This failure could contribute to unsafe use of psychotropic medications that could have placed residents at risk for adverse consequences. Findings: During a review of the State Operations Manual (SOM -contains guidance on certification and survey activities, a federal document from the Centers for Medicare & Medicaid Services), revised 8/8/24, indicated, 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. 2. As needed (PRN) for psychotropic drugs are limited to 14 days. 3. Order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order. The Attending physician or prescribing practitioner should document the rationale for the extended time period in the medial record and indicate a specific duration. During a review of Resident 2's admission record, indicated that Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive state of decline in mental abilities), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and need for assistance with personal care. Resident 2 was not her healthcare decision maker. During a review of Resident 2's most recent Minimum Data Set (MDS - an assessment and care screening tool), dated 12/18/24, the MDS indicated that Resident 2 had a brief interview for mental status (BIMS) score of 7 out of 15, indicating her cognition was moderately impaired. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. Building B. Wing	03/07/2025

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/7/25 at 1:55 pm, with the administrator (ADMIN) in the ADMIN's office, the SOM - in the guidance for PRN order for psychotropic and antipsychotic medication, and Resident 2's Medication Administration Record (MAR), dated from 4/1/24 to 4/30/24, were reviewed. The MAR record indicated Resident 2 was prescribed with Lorazepam tablet 0.5 mg, and was to Give 1 tablet by month every 8 hours as needed for Anxiety for 30 days as exhibited by yelling out even when all needs are met, start date-4/2/24 . The ADMIN stated he was aware that the PRN psychotropic drugs were limited to 14 days, unless the provider indicated the need for the extended time period in the resident's record. The ADMIN confirmed that he couldn't locate such note in Resident 2's medical record. During a concurrent interview and record review on 2/7/25 at 2:28 pm with the Director of Nursing (DON) in the ADMIN's office, Resident 2's medical record titled, Psychotherapeutic review interdisciplinary care team (IDT- a team of health care professionals from different disciplines that work together to provide care) v.2 , dated 4/10/24, was reviewed. The DON stated residents who were prescribed with psychotropic and antipsychotic medication, their status, indication of using the medication, and reaction to the medication, etc. would be discussed in the monthly Psychotherapeutic review IDT meeting, and Resident 2's rationale for needing PRN Ativan for 30 days should be discussed and documented in the Psychotherapeutic review IDT meeting. The DON confirmed that he could not locate such note in Resident 2's medical record.