| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555877 | A. Building<br>B. Wing | 05/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ridgecrest Regional Transitional Care and Rehabili | 1081 North China Lake Boulevard<br>Ridgecrest, CA 93555 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Keep residents' personal and medical records private and confidential.<br><br>Based on interview and record review, the facility failed to implement their own policy and procedure (P&P) titled, Release of Information, for 88 of 89 residents (Resident 1, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 65, Resident 66, Resident 67, Resident 68, Resident 69, Resident 70, Resident 71, Resident 72, Resident 73, Resident 74, Resident 75, Resident 76, Resident 77, Resident 78, Resident 79, Resident 80, Resident 81, Resident 82, Resident 83, Resident 84, Resident 85, Resident 86, Resident 87, Resident 88, and Resident 89). This failure resulted in an unknown amount of private medical information for all 88 residents to be obtained by an unauthorized person and had the potential for negative consequences.Findings:During a review of the facility's Summary Report to CDPH (California Department of Public Health) re (regarding): HIPAA ( Health Insurance Portability and Accountability Act - a law passed that establishes national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge) Privacy Incident (SRPI), dated 5/27/26, the SRPI indicated, on 5/8/26 the facility provided and unknown amount of private health information for Resident 1, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 65, Resident 66, Resident 67, Resident 68, Resident 69, Resident 70, Resident 71, Resident 72, Resident 73, Resident 74, Resident 75, Resident 76, Resident 77, Resident 78, Resident 79, Resident 80, Resident 81, Resident 82, Resident 83, Resident 84, Resident 85, Resident 86, Resident 87, Resident 88, and Resident 89 to family member (FM) 1.During an interview on 6/10/26 at 12:05 p.m. with Director of Nursing (DON), DON stated on 5/8/26 the Medical Records Supervisor (MRS) had accidentally provided FM 1 with a thumb drive (a small, portable data storage device that plugs directly into a computer) with an unknown amount of private information for Resident 1, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, (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 |
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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 65, Resident 66, Resident 67, Resident 68, Resident 69, Resident 70, Resident 71, Resident 72, Resident 73, Resident 74, Resident 75, Resident 76, Resident 77, Resident 78, Resident 79, Resident 80, Resident 81, Resident 82, Resident 83, Resident 84, Resident 85, Resident 86, Resident 87, Resident 88, and Resident 89. DON stated the information on the thumb drive potentially went back to 2023. DON stated the facility attempted to obtain the thumb drive back from FM 1, but he refused.During an interview on 6/10/26 at 12:52 p.m. with MRS, MRS stated on 5/8/26 she was supposed to provide FM 1 with a thumb drive regarding his father (Resident 2) but it was not completed. MRS stated she called FM 1 to explain the requested information was not ready but FM 1 had became hostile, intimidating, and was yelling at her. MRS stated she had explained what happened to her Operations Manager (OM) and he instructed her to finish FM 1's request so that he can provide it to FM 1. MRS stated she finished obtaining the requested information and handed the thumb drive to OM to give to FM 1 on 5/8/26. MRS stated on 5/13/26, FM 1 had made another request for more information regarding Resident 1. MRS stated FM 1 was at her office door banging on it for the information requested. MRS stated as she began retrieving the requested information she noticed she had provided FM 1 with the wrong thumb drive on 5/8/26. MRS stated at that time she was not sure what other resident information was on the thumb drive handed to FM 1 on 5/8/26, just that there was information that FM 1 should not have access to. MRS stated she reported this incident immediately to her leadership.During an interview on 6/10/26 at 1:44 p.m. with Privacy Compliance Officer (PCO), PCO stated she was informed on 5/13/26 about FM 1 obtaining a thumb drive of resident information that he was not supposed to have. PCO stated multiple attempts to retrieve the thumb drive from FM 1 were made including having the police involved but have not been successful. PCO stated 88 residents (Resident 1, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 65, Resident 66, Resident 67, Resident 68, Resident 69, Resident 70, Resident 71, Resident 72, Resident 73, Resident 74, Resident 75, Resident 76, Resident 77, Resident 78, Resident 79, Resident 80, Resident 81, Resident 82, Resident 83, Resident 84, Resident 85, Resident 86, Resident 87, Resident 88, and Resident 89) were affected by this data breach but is not certain what exact documents are in the thumb drive.During a review of the facility's policy and procedure (P&P) titled, Release of Information - Minimum Necessary Use (RIMNU),dated 3/2014, the P&P indicated, Whenever practical/feasible, only the minimum information necessary to achieve the purpose of the use or disclosure will be released from, or used by, the facility in response to a request for information.During a review of the facility's P&P titled, Release of Information (ROI), dated 2001, the P&P indicated, Our facility maintains the confidentiality of each resident's personal and protected health information . Each resident will receive confidential treatment of his or her personal and medical records and may approve or refuse their release to any individual outside the facility, except in case of a transfer to another healthcare institution or as required by current HIPAA law. Medical records are the property of the facility. All information contained in the resident's medical record is confidential and may only be released by the written consent of the resident or his/her legal representative (sponsor),<br>(continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | consistent with state laws and regulations. Resident records, whether medical, financial, or social in nature, are safeguarded to protect the confidentiality of the information. Only those persons concerned with the fiscal affairs of the resident will have access to the resident's financial records as permitted by current HIPAA laws. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, interview, and record review, the facility failed to provide suprapubic catheter (a soft, flexible tube inserted through the lower part of the belly into the bladder [portion of the body that holds urine] to drain urine into an outside collection bag) care to one of three sampled residents (Resident 1). This failure had the potential to result in infection.Findings:During an observation on 5/19/26 at 11:45 a.m. in Resident 1's room, Resident 1 was observed to have a suprapubic catheter. The tubing was noted to have thick discolored white and yellowish growth/sediment (a buildup of mineral crystals and mucus, typically caused by bacteria. If left untreated, this sediment can form crusts that completely block the catheter, causing painful bladder distention [meaning to be swollen or enlarged], urinary leakage, and dangerous infections) from the insertion point into the lower down to the collection bag. The collection bag was noted to have discolored white to yellow brown type growth and sediment stuck to the sides.During a concurrent observation and interview on 5/19/26 at 12:10 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 1's room, Resident 1's suprapubic Catheter was observed. LVN 1 stated there was white to yellowish growth/sediment in Resident 1's tubing and white to yellowish brown type growth adhered to the sides of Resident 1's collection bag.During a concurrent observation and interview on 5/19/26 at 12:10 p.m. with Treatment Nurse (TX) 1 in Resident 1's room, Resident 1's suprapubic catheter was observed. TX 1 stated Resident 1's suprapubic catheter appeared to not have been flushed (a method of using sterile water to clear/clean out any sediment and mucous (a natural slippery gel that the body produces) and allow the urine to flow freely) in a long time. TX 1 stated Resident 1's suprapubic catheter needed to be flushed. TX 1 stated, It (Resident 1's suprapubic catheter) looks like it has not been flushed in over a week.During an interview on 5/19/26 at 12:29 p.m. with Treatment Nurse (TXN) 2, TXN 2 stated she was the treatment nurse assigned to Resident 1. TX 2 stated she provided treatment to Resident 1's suprapubic catheter earlier in the day at approximately 7:50 a.m. TX 2 stated part of her process with providing treatment is to observe the suprapubic catheter for any issues. TX 2 stated she did not notice any issues with Resident 1's suprapubic catheter. TX 2 stated an indication for Resident 1 to have his suprapubic catheter flushed, is if there was sediment or mucous in the tubing. TX 2 observed a photo of Resident 1's suprapubic catheter taken on 5/19/26. Tx 2 confirmed Resident 1's suprapubic catheter tubing and bag contained sediment and mucous. TX 2 stated during Resident 1's suprapubic catheter treatment, she did not look at Resident 1's suprapubic catheter tubing or bag and did not flush Resident 1's suprapubic catheter. TX 2 stated Resident 1's suprapubic catheter needed to be flushed.During an interview on 5/19/26 at 1:50 p.m. with Director of Nursing (DON), DON observed a photo of the condition of Resident 1's suprapubic catheter and stated, My expectation is that they (staff) look at all of the . suprapubic (catheter) not just the insertion site. DON confirmed Resident 1's suprapubic catheter should have been flushed. During a review of Resident 1's Order Summary Report (OSR), dated 5/2026, the OSR indicated, Resident 1 was to have his suprapubic catheter flushed with sterile water as needed for obstruction or malfunction.During a review of Resident 1's MEDICATION ADMINISTRATION RECORD (MAR), dated 5/2026, the MAR indicated, MONITOR SUPRAPUBIC CATHETER FOR: S/S (signs and symptoms) INFECTION: HEMATURIA (blood in the urine), INCREASED SEDIMENTS IN URINE, TEMPERATURE, FOUL ODOR, CLOUDY APPEARANCE. S/S CATHETER RELATED PAIN AND/OR URINARY RETENTION every shift. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated 10/2010, the P&P indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. If the catheter material contributes to obstruction, notify the physician and change the catheter if instructed to do so. Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction. Observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately . if urine has an unusual appearance. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review, the facility failed to follow their policy and procedure on medication administration for one of three sampled residents (Resident 1). This failure had the potential for medication induced negative health consequences.Findings:During an observation on 5/19/26 at 11:45 a.m. in Resident 1's room, a medication cup was observed on Resident 1's overbed table. The medication cup had nine medications (unable to identify) observed inside.During a review of Resident 1's Minimum Data Set (MDS) Assessment (a standardized assessment to evaluate a resident's functional abilities and healthcare needs), dated 5/22/26, under the section titled, Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns]), the BIMS score was 15 (cognitively intact status).During an interview on 5/19/26 at 11:48 a.m. with Resident 1, Resident 1 stated the medications on his overbed table have been there since between 6:30 a.m. and 8 a.m.During an interview on 5/19/16 at 12:10 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she provided Resident 1 with the medications observed on his bedside table at approximately 8:30 a.m. LVN 1 stated the medications included vitamins, blood pressure (the measured force of blood as the heart pumps it through the body) medication, and a stool softener (medication used to assist with having a bowel movement). LVN 1 stated she is not to leave medications at the resident's bedside but had done so in the hope Resident 1 would take his medications eventually.During an interview on 5/19/26 at 1:12 p.m. with Director of Nursing (DON), DON stated it is not in the facility's policy to leave medications at the resident bedside. DON stated leaving medications at the resident bedside that they did not take is considered a medication error.During a review of the facility's policy and procedure (P&P) titled, PREPARATION AND GENERAL GUIDELINES, dated 12/2019, the P&P indicated, The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents. Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications. When medications are administered by mobile cart taken to the resident's location (room, dining area, etc.) medications are administered at the time they are prepared. Medications are not pre?poured either in advance of the med pass or for more than one resident at a time. Medications are administered within (60 minutes] of scheduled time . The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate. |