STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555891	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veterans Home of California - Redding	3400 Knighton Road Redding, CA 96002

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store and label pasteurized eggs in accordance with professional standards for food service safety, and facility policy, when an unlabeled tray containing 18 pasteurized eggs was found in the walk-in refrigerator outside of its marked container.This failure had the potential to expose medically fragile residents to food contamination, increasing the risk of foodborne illness for all 39 residents who eat meals prepared in the kitchen.During an observation on 4/20/26 at 2:20 p.m. in the Main Kitchen's walk-in refrigerator a tray containing 18 pasteurized eggs was observed left outside of its marked container. The tray did not have a label indicating the received-on date or the use by date.During an interview on 4/20/26 at 2:31 p.m. with Stock Clerk (SC) 1, SC1 was unable to identify a used by date labeled on the tray of eggs.During an interview on 4/20/26 at 2:34 p.m. with [NAME] (C) 1, C1 was unable to identify a used by date labeled on the tray of eggs.During an interview on 4/23/26 at 3:11 p.m. with the Food Services Manager (FSM), the FSM stated that the tray of eggs should have been stored in the original container. The FSM further stated that if stored outside of original container, then the tray of eggs should have been relabeled using the details from the original container.During a review of the facility's policy and procedures (P&P) titled, Food & Nutrition Services- Leftover and Extra Food, dated 4/13/26, the P&P indicated, Labeling, dating and monitoring refrigerated food, including but not limited to, leftovers, so it is used by its used-by date or frozen where applicable or discarded The P&P further indicated, Foods stored in refrigerators, freezers and dry storage will have food item name and expiration date on label.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to maintain proper grooming by ensuring fingernail care for one of twelve sampled residents (Resident 7), in accordance with the facility policy titled, Activities of Daily Living.This failure had the potential to increase the risk of infection for Resident 7.During a review of Resident 7's admission Record, dated 12/16/25, the admission Record, indicated Resident 7 was admitted to the facility with diagnoses of osteoarthritis (breakdown of cartilage) and tremor (involuntary shaking).During a concurrent observation and interview on 4/20/26 at 2:31 p.m. with Resident 7, in the facility hallway, Resident 7 was seated in his wheelchair with his fingernails exposed. Resident 7's fingernails were long. Resident 7 stated he wanted his nails trimmed and staff did not consistently perform nail trimming.During a concurrent observation and interview on 4/20/26 at 4:13 p.m., with Certified Nursing Assistant (CNA) 1, in the facility hallway, Resident 7 was seated in his wheelchair with his fingernails exposed. CNA 1 confirmed Resident 7's fingernails were long and that they should have been trimmed.During an interview on 4/22/26 at 3:16 p.m. with the Director of Nursing (DON), the DON stated licensed nurses should provide hygiene care, including nail trimming, to reduce the risk of skin injury.During a review of the facility policy and procedure titled, Activities of Daily Living dated 1/26/26. The policy indicated, nursing staff must assist the resident with activities of daily living, including maintaining proper grooming and providing finger and toenail care.

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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 0761 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure expired medication was not available for use when two vials of Lidocaine HCL (used to rapidly numb specific body areas for medical procedures by blocking nerve pain signals) were stored in the emergency kit beyond their expiration date.This failure had the potential to place residents at risk of receiving expired medication, which may lead to harmful side effects or reduced effectiveness.During a concurrent observation and interview on [DATE] at 9:10 a.m. with the Director of Nursing (DON) inside the medication room, the emergency kit contained two vials of Lidocaine HCL which had an expiration date of 3/2026. The DON confirmed the medication vials were expired. The DON stated that pharmacy and nursing staff should check the emergency kit for expired medication.During an interview on [DATE] at 10:24 a.m. with the DON, the DON stated, medication should not be expired for resident safety and for drug efficacy.During a review of the facility's policy and procedure (P&P) titled, Emergency Drug Kit, dated [DATE], the P&P indicated, 1. The pharmacist checking the Emergency Drug kit will also indicate the earliest expiration date and the name of that item on the outside of the container. 2. It is the responsibility of the contract production pharmacy to cycle out the e-kits prior to the expiration date listed on the exterior of the kit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to maintain an effective infection control program when one of twelve sampled residents (Resident 20) indwelling catheter (a tube placed in the body to drain and collect urine from the bladder) bag was touching the floor.This failure had the potential to cause crossˆcontamination and increase the risk of infection for Resident 20.During a concurrent observation and interview on 4/20/26 at 5:55 p.m., with Registered Nurse (RN) 1 in the facility hallway, Resident 20 was observed seated in a wheelchair self-propelling in the hallway. A urinary catheter drainage bag was secured to the lower portion of the wheelchair however, the catheter tubing was touching the floor. RN 1 confirmed the observation and stated the tubing should not be in contact with the floor due to infection control concerns.During a review of Resident 20's admission Orders (AR) dated 12/2/25, the AR indicated, Resident 20 required a indwelling catheter for a diagnosis of bladder outlet obstruction (blockage at the base of the bladder).During an interview on 4/22/26 at 11:08 a.m. with Infection Preventionist (IP), IP stated indwelling catheter tubing must not contact the floor to reduce infection risk.During a review of the facility policy and procedure titled, Guidelines for Use of a Urinary Catheter, dated 7/21/25, the policy indicated, catheter care is provided routinely to residents with Foley catheters in accordance with recognized standards.During a review of the facility In-Service Lesson Plan titled, Urinary Catheter Care, the basics dated 2/5/24, the In-service indicated, indwelling catheters should be secured to a wheelchair with tubing and bag kept off the floor, ensuring no contact or dragging during mobility.