STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555939	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plumas District Hospital Dp/Snf	1065 Bucks Lake Rd Quincy, CA 95971

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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 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 provide pharmaceutical services to meet the needs of each resident when:The facility failed to ensure the safe disposal and storage of controlled substances when one controlled substance was not double locked according to facility's controlled substance storage policy.The facility failed to ensure the safe and effective use of medication when the policy for medication storage was not implemented for one medication cart. This failure resulted in putting residents at risk of harm from receiving expired and potentially contaminated or ineffective medications.1.During a record review of facility policy titled Medication Administration Controlled Substances dated 1/2025 indicated, Controlled substances remaining in the nursing care center after the order has been discontinued are retained in the nursing care center in a securely double locked area with restricted access until destroyed, as outlined by state regulation.During a concurrent medication cart inspection and interview on 2/9/26 at 9:41 am with Director of Nursing (DON), one bottle of Tramadol 50 milligrams (mg) (a prescription opioid/narcotic pain reliever used to treat moderate to severe pain in adults) that was no longer administered to the prescribed resident was located in the drawer. DON confirmed this bottle of medication needed to be destroyed. DON confirmed the medication was not double locked per facility policy. DON stated it was not double locked because she needed a safe that could fit in her office drawer. DON confirmed that narcotic medications that needed to be destroyed should be double locked. DON confirmed she did not follow facility controlled substance storage policy and should have.2.During a record review of facility policy titled Medication Administration General Guidelines dated 1/2023 indicated, No expired medication will be administered to a resident. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. During a record review of facility policy titled Medication Storage, Storage of Medications dated 1/2023, indicated Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal.During a concurrent medication cart inspection and interview on 2/9/26 at 9:46 am with Licensed Nurse (LN) A, the following was observed:There were two Tramadol 50 mg blister packs (a protective, unit-dose packaging system where individual pills or capsules are sealed within small, plastic cavities (blisters) covered by aluminum foil) with incomplete expiration dates.There was one Hydrocodone-acetamin 10-325 mg (a prescription, combination opioid/narcotic medication used to treat moderate to severe pain) blister pack with an incomplete expiration date.There was one bottle of Hydrocodone-acetamin 10-325 mg with no lid and approximately 10 tablets in a smaller plastic bag that was open. The tablets fell out into the medication cart drawer. The plastic bag could not be closed. The medication bottle was missing a lid. LN A confirmed the storage of this medication did not follow facility's medication storage policy.There was one bottle of expired Tessalon [NAME] (a prescription, non-narcotic medication capsules used to treat coughs caused by colds, bronchitis, or other breathing issues by numbing the lungs and air passages).There was one bottle of expired Gabapentin 600 mg (a prescription medication primarily used to treat nerve (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pain).There were two bottles of expired Metformin 500 mg tablets (a prescribed oral medication used primarily to lower blood glucose levels).There were 35 out of 50 medication blister packs with incomplete expiration dates. During an interview on 2/9/26 at 11:39 am, DON stated facility expectation was for staff to notify her if expiration dates were incomplete or not legible on resident medications. DON confirmed the expired medications as well as the incomplete expiration dates. DON stated facility expectation was for staff to follow medication administration policy, which included to not administer expired medications as well as destroy expired medications per facility requirement.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to investigate suspicions of abuse for one resident of eight sampled residents (Resident 6) when:Facility reported that Resident 6's son verbally assaulted Resident 6 and coerced her to give him money and did not investigate.Facility reported that when Resident 6's son visited the facility during the months of January 2026 and February 2026, he yelled and made other residents feel uncomfortable and did not investigate.These failures caused Resident 6 mental anguish and had the potential to cause mental anguish to the rest of the facility residents.During a record review of facility policy titled Abuse and Neglect Prevention and Reporting (undated), indicated Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Facility policy also indicated It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Facility policy further indicated The Director of Nursing (DON), Registered Nurse (RN) Supervisor or designee will immediately notify the resident's representative regarding the alleged incident and assessment findings. Document notification in the health record. Facility policy also indicated Investigation steps to be taken by the DON, RN Supervisor or designee: Begin an investigation. Place all interview records, notes, correspondence or other pertinent documents relating to this matter together. Interview staff members, visitors, or residents who have knowledge of the alleged incidents, and document information obtained form them. Facility policy indicated Have staff members document a statement of what they have witnessed. Review health records to determine Residence history and condition and its relevance to current investigation. The DON, RN Supervisor or designee shall make reasonable efforts to arrive at a conclusion regarding the cause of the injury and to take corrective steps to eliminate ongoing dangers to the residents. Facility policy also indicated Complete a summation after investigation is completed. Must send summation to CDPH within 5 days of SOC-341 (Report of Suspected Dependent Adult/Elder Abuse, is a mandatory California state form used by mandated reporters to report suspected physical, emotional, financial, or sexual abuse, neglect, or abandonment of those aged 65 and up and dependent adults (ages 18-64) to local agencies) filing. Facility policy further indicated The DON and administrative staff will take whatever steps are necessary to prevent recurrence of the incident. This may include in-services given by Director of Staff Development (DSD) or clinical educator and other educational opportunities as appropriate.During a record review of Resident 6's admission record, she was admitted to the facility on [DATE] with diagnoses that included unilateral osteoarthritis right knee (chronic, degenerative joint disease), history of falling, other abnormalities of gait and mobility (deviations from normal walking patterns, often caused by injuries, pain, or aging).During a record review of Resident 6's progress notes dated 1/20/26 5:12pm, indicated Resident stated that her son came to visit and it was ?difficult.' She said he ?overspent the credit card' but found out she could raise her credit card limit to prevent it from happening again.During an interview on 2/9/26 at 2:23 pm with Licensed Nurse (LN) A, LN A stated son recently visited again and wanted money. LN A stated son came and yelled at Resident 6 every time he visited. LN A stated it was always about money. LN A stated Resident 6's son came and ate Resident 6's dinner meal at the facility multiple times. LN A stated, every time he leaves, she's upset and needs her music box on to calm her. During a concurrent interview with DON and record review of Resident 6's care plan dated 12/4/25 on 2/10/26 at 9:03 am, indicated there were no interventions for the facility's concerns with Resident 6's son's visits. DON stated son's behaviors have been loud and bothersome. DON confirmed Resident 6's son's behaviors likely made other residents uncomfortable. DON confirmed staff were very uncomfortable when he visited. DON stated facility did not initiate its investigation process per policy and should have.During a concurrent facility policy review of Abuse and Neglect Prevention and Reporting (undated) and interview on 2/10/26 at 9:13 am with Minimum Data Set Nurse (MDS), MDS stated she did not know what facility (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation process was. MDS stated she was not familiar with facility abuse policy. MDS stated facility did not follow its investigation process per policy and should have.During a concurrent observation and interview with Resident 6 on 2/10/26 at 9:48 am, Resident 6 was observed in her wheelchair in her room. Resident 6 stated her son came to visit her often and ate her food at dinner, but it's fine because I'm not that hungry. Resident 6 stated her son yelled when he visited and asked for money, but if he was mean to her, she would hit him with my baseball bat and call 911. Resident 6 stated her son asked for money a lot, but it's okay because he drives my car and it needs work done. Resident 6 confirmed son brought a male friend once or twice and they both ate her dinner. Resident 6 stated it upset her when her son yelled during his visits.During an interview on 2/10/26 at 1:00 pm with Certified Nursing Assistant (CNA) B, CNA B stated he was very aware Resident 6's son ate her food at dinner time. CNA B stated Resident 6's son called her stupid among other names that are not good. CNA B stated Resident 6's son was verbally abusive to her. CNA B stated her son came to visit frequently. CNA B stated he told DON and LN C about Resident 6's son's behavior towards her. CNA B stated he also told DON and LN C how the other residents appeared uncomfortable, and just ?off' after Resident 6's son visited.During an interview on 2/10/26 at 1:08 pm with LN C, LN C stated Resident 6's son was loud and obnoxious. LN C stated she smelled alcohol on him when he came to visit most times. LN C stated she notified DON about her concerns Resident 6's son's behaviors. LN C stated his behaviors made the other residents uncomfortable.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to revise and implement comprehensive care plans to reflect changes in condition and identified needs for 3 of 8 residents when reviewed for care planning (Residents 2, 6, and 8). These failures had the potential to result in inconsistent care, unmanaged symptoms, and unmet resident needs.Findings: During a record review on 2/9/26 at 3:00 p.m. of Resident 8's admission record, the resident was admitted to the facility on [DATE] with diagnoses including muscle weakness, difficulty walking, dysfunction of the bladder, pressure ulcer of the sacral region, stage 4, chronic pain syndrome, and osteomyelitis. During an observation on 2/9/26 at 10:00 a.m., Resident 8 was observed with an indwelling urinary catheter in place. During a record review on 2/9/26 at 3:00 p.m. of Resident 8's comprehensive care plan dated 1/28/26, the care plan did not include interventions addressing catheter care, monitoring, or associated risks. The care plan did not reflect catheter use. During an interview on 2/10/26 at 12:00 p.m. with the DON, the DON confirmed Resident 8's comprehensive care plan did not include catheter-related interventions During a record review on 2/9/26 at 3:00 p.m. of Resident 2's admission record, the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, osteoarthritis, and chronic pain. During a record review on 2/9/26 at 3:00 p.m., documentation dated 2/3/26 revealed a progress note indicating Resident 2 complained her legs felt like they were ripping apart and reported bilateral hip spasms. During a record review on 2/9/26 at 3:00 p.m., documentation dated 2/3/26 at 9:47 a.m. revealed communication with the physician after Resident 2 complained of muscle spasms in her legs. The physician recommended encouraging the resident to get out of bed more frequently and to provide pain medication as needed. During a record review on 2/9/26 at 3:00 p.m. of Resident 2's comprehensive care plan, the care plan did not include interventions addressing bilateral hip spasms, increased mobility, or pain management related to the reported symptoms. During an interview on 2/10/26 at 12:00 p.m. with the Director of Nursing (DON), the DON confirmed Resident 2's comprehensive care plan had not been revised to address the reported spasms or incorporate the physician-recommended interventions. During a record review of Resident 6's admission record, she was admitted to the facility on [DATE] with diagnoses that included unilateral osteoarthritis right knee (chronic, degenerative joint disease, often called wear-and-tear arthritis), history of falling, other abnormalities of gait and mobility (deviations from normal walking patterns, often caused by injuries, pain, or aging). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview with DON of Resident 6's care plan dated 12/4/25, indicated there were no interventions for the facility's concerns with Resident 6's son's visits. DON confirmed son's behaviors have been loud and bothersome. DON stated facility had an intervention to have a male staff member outside of Resident 6's room when her son visited. DON confirmed this intervention was not documented in Resident 6's care plan. DON stated she spoke to Resident 6's daughter who applied to be Resident 6's Power of Attorney (POA - a legal document granting someone authority to act on your behalf or financial, legal, or medical matters). DON confirmed this intervention was not documented in Resident 6's care plan. DON confirmed facility did not follow their care plan policy and should have.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate management of an indwelling urinary catheter for 1 of 8 residents reviewed for urinary catheter care (Resident 8) when the facility failed to obtain or maintain a physician order for the catheter, failed to assess and document the continued medical necessity for catheter use, failed to include catheter care and monitoring interventions in the comprehensive care plan, and failed to document routine catheter care. This deficient practice placed Resident 8 at risk for urinary tract infection, urethral trauma, obstruction, and other catheter-related complications. During a record review on 2/9/26 at 3:00 p.m. of Resident 8's admission record, the resident was admitted to the facility on [DATE] with diagnoses including muscle weakness, difficulty walking, dysfunction of the bladder, pressure ulcer of the sacral region, stage 4 (a severe, full-thickness injury characterized by significant tissue loss, where underlying fascia, muscle, tendon, ligament, cartilage, or bone are exposed), chronic pain syndrome, and osteomyelitis (a serious, often bacterial, infection of the bone that causes inflammation, pain, swelling, and warmth in the affected area).During an observation on 2/10/26 at 9:00 a.m., Resident 8 was observed with an indwelling urinary catheter in place with a drainage bag attached at the bedside.During a record review on 2/9/26 at 11:00 a.m., Resident 8's medical record was reviewed. No physician order was found for the insertion or continued use of the indwelling urinary catheter. There was no documented assessment identifying the medical indication for catheter use and no documented evaluation of continued necessity.During a review of Resident 8's comprehensive care plan revealed no goals or interventions related to the presence of an indwelling urinary catheter, catheter care, monitoring for complications, or prevention of urinary tract infection.During a review of Resident 8's treatment administration records and nursing documentation revealed no documentation of routine catheter care, including peri-care, catheter securement, drainage bag positioning, tubing assessment for kinks or obstruction, or monitoring for signs and symptoms of urinary tract infection.During an interview on 2/10/26 at 12:00 p.m., the Director of Nursing (DON) confirmed that no physician order for the urinary catheter, no documented assessment of continued necessity, no catheter-related care plan interventions, and no documentation of routine catheter care could be located in the medical record for Resident 8.