STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 230000024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDDING POST ACUTE	1836 GOLD STREET , REDDING, California, 96001

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C0000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of one complaint and one facility reported incident. Complaint number: 2632222 Incident number: 2649854 The inspection was limited to the specific complaint and incident investigated and does not represent the findings of a full inspection of the facility. Deficiencies were cited for complaint number 2632222 at C0820, C0825, C0900, C1630, C2185, C4985, C4990, C5135, and C5215. Deficiencies were cited for incident number 2649854 at C0990 and C4490.	C0000	CA DEPT OF PUBLIC HEALTH CHCQ Field Operations North Division- Chico Received Date: 11/13/2025 Compliance Date: 11/21/25 Approved Date: 11/21/25 Approved By: Yvonne Mulcahy, NSS I	
C0820	Nursing Service--General CFR(s): T22 DIV5 CH3 ART3-72311(a)(1)(A) (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility did not ensure the accuracy of the admission Minimum Data Set (MDS, a resident assessment tool) for one out of three sampled residents (Resident 1) when the admission MDS indicated Resident 1's hearing was adequate (no hearing difficulty).	C0820		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	RN DON	11/8/2025

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C0820	Continued from page 1 This failure had the potential to place Resident 1 at risk for social isolation and mood or behavior disorders. Findings: A review of the Resident Assessment Instrument Manual (RAI, the instruction manual assisted the MDS nurse with completing an accurate MDS to provide the residents with high quality plan for care), dated 10/1/25, indicated, "Problems with hearing can contribute to sensory deprivation [being deprived of stimulation such as sound], social isolation, and mood and behavior disorders. Unaddressed communication problems related to hearing impairment [difficulty with hearing] can be mistaken for confusion or cognitive impairment [memory, ability to pay attention, and problem solving]. The RAI Manual indicated, hearing assessment information would be utilized to assist with developing the residents plan of care (care plan, a document that described resident goals and the care instruction for staff to assist residents in achieving their goals). The RAI Manual indicated, the MDS nurse would interview and observe the resident for hearing, perform a record review, and "Consult the resident's family, caregivers, direct care staff, activities personnel, and speech or hearing specialists" (a speech specialist was also known as a speech therapist). A review of the "Admission Record," dated 7/3/25, indicated, Resident 1 was admitted to the facility on 7/3/25 with the diagnoses of presence of left artificial hip joint (left hip replacement) and dependence on supplemental oxygen (extra oxygen that was breathed in along with normal air to help people breathe). Resident 1 was not his own responsible party (RP, decision maker). During an interview on 10/9/25 at 3:30 pm, Resident 1's family member (FM) stated, "there was a clip board in the room that should have some information, but it was always blank and there was nothing that said he was hard of hearing and couldn't hear out of his right ear. When staff talked to him, it didn't appear they knew he was hard of hearing." During a concurrent interview and record review on 10/22/25 at 8:19 am, with Director of Nursing (DON), Resident 1's referral packet (documentation sent to the facility that contained medical information and was reviewed by the facility prior to facility admission) was reviewed. DON confirmed, the undated document titled, "PT, OT, ST," indicated, Resident 1 was hard of	C0820		

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C0820	Continued from page 2 hearing. DON reviewed the "IDT Discharge Summary RPA," dated 8/15/25, and confirmed, under the section titled, "Social Services," the document indicated Resident 1 was hard of hearing. DON reviewed all care plans dated 7/3/25 through 8/18/25. During a concurrent interview and record review on 10/22/25 at 9:20 am, with Director of Rehab (DOR), Resident 1's "Speech Therapy SLP Evaluation and Plan of Treatment" (ST eval), dated 7/7/25 was reviewed. DOR confirmed, the ST eval indicated, Resident 1's hearing was functional with increased volume and could not state what that meant. Speech Therapist (ST) arrived to clarify the meaning and confirmed, ST had performed the ST eval. ST stated, "he was able to hear if you increased your volume." During a concurrent interview and record review on 10/22/25 at 11:05 am, with Activities Director (AD), Resident 1's "Activities Initial Assessment," dated 7/7/25 was reviewed. AD stated, "[Resident 1] had trouble communicating and I did the assessment with his [RP]. AD confirmed, the assessment indicated, Resident 1 had trouble hearing out of the right ear. During a concurrent interview and record review on 10/22/25 at 11:08 am, with MDS Coordinator, Resident 1's admission MDS, dated 7/10/25, was reviewed. MDS Coordinator confirmed, MDS "Section B-Hearing, Speech, and Vision," indicated, Resident 1 had scored a "0" which indicated Resident 1 had no hearing difficulties. MDS Coordinator was asked where the information was obtained for completing the hearing section of the MDS and stated, "we review all charting from nurses and therapies, we interview the resident, and assess the hearing ourselves." MDS coordinator reviewed the RAI Manual dated 10/1/25, the ST eval dated 7/7/25, and the "Activities Initial Assessment," dated 7/7/25. MDS Coordinator stated, "based on the RAI, ST eval, and the AD's assessment, the admission MDS was inaccurate" and confirmed, the admission MDS should have reflected Resident 1 was hard of hearing.	C0820		
C0825	Nursing Service--General CFR(s): T22 DIV5 CH3 ART3-72311(a)(1)(B) (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (B) Development of an individual, written patient care	C0825		

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C0825	Continued from page 3 plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility did not develop a care plan (resident goals and written instruction for required care) for one out of three sampled residents (Resident 1) with hearing loss. This failure had the potential to place Resident 1 at risk for social isolation and mood or behavior disorders. Findings: A review of the "Registered Nurse (RN)" job description, dated 7/1/24, indicated, the RN was responsible for developing care plans. A review of the "Admission Record," dated 7/3/25, indicated, Resident 1 was admitted to the facility on 7/3/25 with the diagnoses of presence of left artificial hip join (left hip replacement) and dependence on supplemental oxygen (extra oxygen that was breathed in along with normal air to help people breathe). Resident 1 was not his own responsible party (RP, decision maker). During an interview on 10/9/25 at 3:30 pm, Resident 1's family member (FM) stated, "there was a clip board in the room that should have some information, but it was always blank and there was nothing that said he was hard of hearing and couldn't hear out of his right ear. When staff talked to him, it didn't appear they knew he was hard of hearing." During a concurrent interview and record review on 10/22/25 at 8:19 am, with Director of Nursing (DON), Resident 1's care plans, dated 7/3/25 through 8/18/25 were reviewed. DON confirmed that there was no hearing loss care plan present and stated, "if a resident was hard of hearing, there should be a care plan present." Resident 1's referral packet (documentation sent to the facility that contained medical information and was reviewed by the facility prior to facility admission) was reviewed. DON confirmed, the undated document titled, "PT, OT, ST," indicated, Resident 1 was hard of hearing. During a concurrent interview and record review on 10/22/25 at 9:20 am, with Director of Rehab (DOR),	C0825		

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C0825	Continued from page 4 Resident 1's "Speech Therapy SLP Evaluation and Plan of Treatment" (ST eval), dated 7/7/25 was reviewed. DOR confirmed, the ST eval indicated, Resident 1's hearing was functional with increased volume and could not state what that meant. Speech Therapist (ST) arrived to clarify the meaning and confirmed, ST had performed the evaluation and stated, "he was able to hear if you increased your volume." During a concurrent interview and record review on 10/22/25 at 11:05 am, with Activities Director (AD), Resident 1's "Activities Initial Assessment," dated 7/7/25 was reviewed. AD stated, "[Resident 1] had trouble communicating and I did the assessment with his [RP]. AD confirmed, the assessment indicated, Resident 1 had trouble hearing out of the right ear.	C0825		
C0900	Nursing Service--Administration of Medication CFR(s): T22 DIV5 CH3 ART3-72313(a)(2) (a) Medications and treatments shall be administered as follows: (2) Medications and treatments shall be administered as prescribed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure supplemental oxygen (extra oxygen that was breathed in along with normal air to help people breathe) was administered as prescribed for one out of three sampled residents (Resident 1) when Resident 1's oxygen saturation levels (blood oxygen level in the blood) were outside of the physician's ordered range. This resulted in Resident 1 receiving too much oxygen which had the potential to increase breathing problems, cause organ damage, and confusion. Findings: A review of the facility's policy and procedure (P&P) titled, "Oxygen Administration," revised 10/1/10, indicated, the purpose of the P&P was to ensure guidelines for safe oxygen administration. The P&P indicated that facility staff would verify and review the Physician's orders. A review of the "Admission Record," dated 7/3/25, indicated, Resident 1 was admitted to the facility on 7/3/25 with the diagnoses of acute (sudden) and chronic (ongoing and constant) respiratory failure with hypoxia	C0900		

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C0900	Continued from page 5 (lungs did not function correctly and can't get enough oxygen into the lungs),chronic obstructive pulmonary disease (a group of lung diseases that made breathing difficult), chronic pulmonary edema (fluid that built up in the lungs over time), and dependence on supplemental oxygen (extra oxygen that was breathed in through a tube along with normal air to help people breathe). Resident 1 was discharged from the facility on 8/18/24 and was not his own responsible party (RP, decision maker). A review of Resident 1's Care Plan (a document that outline resident goals and care that would be provided) titled, "oxygen therapy," dated 7/7/25, indicated, Resident 1 was diagnosed with acute and chronic respiratory failure with hypoxia, and his oxygen saturation would be maintained between 88 percent (%) and 94%. During a concurrent interview and record review on 10/22/25 at 8:19 am, with Director of Nursing (DON), Resident 1's Medication Administration Records (MAR) dated 7/7/25 through 8/18/25 were reviewed. DON confirmed the MAR indicated, Resident 1 was to receive oxygen via the nasal cannula (tube inserted into nose) or mask (covered mouth and nose) to maintain oxygen saturation between 88% and 94%. DON confirmed, there were 66 out of 84 times, that nursing staff documented Resident 1's oxygen saturation was above 94%, and his physician was not notified. DON stated, "we should have been following the order."	C0900		
C0990	Nursing Service--Patient Care CFR(s): T22 DIV5 CH3 ART3-72315(b) (b) Each patient shall be treated as individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to protect the rights for one out of three sampled residents (Resident 3) when Certified Nurse Assistant (CNA) A stated witnessed verbal abuse towards Resident 3. This failure violated Resident 3's rights, caused fear, and had the potential to cause feelings of humiliation. Findings: A review of the facility's policies and procedures	C0990		

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C0990	Continued from page 6 (P&P) titled, "Resident Right's, dated 12/1/21, indicated, "Employees shall treat residents with kindness, respect, and dignity." The P&P indicated, residents would be provided with a dignified existence and be free from abuse. A review of the "LGBT [Lesbian, Gay, Bisexual, Transgender] Training Requirements" (LGBT training), dated 9/12/17, indicated, a Transgender person was described as having a gender identity that was different than their assigned birth gender. The LGBT training indicated, facility staff would use the LGBT individuals' preferred gender identity while speaking to or about them. A review of the facility's P&P titled, LGBT Resident Rights," revised 12/12/17, indicated, the facility prohibited (forbid) facility staff from discrimination against LGBT residents and facility staff would not discriminate against residents who were transgender. The P&P indicated, "Willfully and repeatedly failing to use a resident's preferred name or pronouns after being clearly informed of the preferred name or pronoun;" was considered discrimination. A review of the "Admission Record," dated 7/8/25, indicated that Resident 3 was admitted to the facility on 7/8/25 with the diagnoses of dysarthria following cerebral infarction (difficulty with speech after having a stroke), transsexualism (transgender), and aphasia (language disorder that affected the ability to speak). Resident 3 was their own responsible party (made own decisions). A review of Resident 3's care plan (a written plan of resident goals and care instructions for facility staff) titled, "psychosocial well-being," dated 7/9/25, indicated, Resident 3 identified as a female. A review of the minimum data set (MDS, a resident assessment tool), dated 10/14/25, indicated a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was performed. Resident 3's BIMS score was 6 out of 15, indicating poor memory. During a concurrent observation and interview on 10/10/25 at 9:52 am, Certified Nurse Assistant (CNA) A, CNA A stated, "I overheard [CNA B] tell [Resident 3] "to shut the [F word] up. Get it together, when you got here you were male, now you're female. I reported it to the charge nurse and Admin [administrator] [CNA B] was very rude to [Resident 3], so I interrupted and put a	C0990		

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C0990	Continued from page 7 stop to it." During a concurrent interview and record review on 10/10/25 at 10:08 am, Resident 3 was observed lying in bed with the sheet down around the waist. Resident 3 was observed smiling and had good eye contact during introductions. When Resident 3 was asked about living in the facility and being treated with dignity and respect, Resident 3's smile faded, eyes became watery, no longer maintained eye contact, while bowing her head, Resident 3's head moved back and forth, indicating no and stated "no" in a hushed voice. Resident 3 began to stutter and could not verbalize words. Resident 3 was asked if it was okay to talk about what had happened and Resident 3 stated, "no, I can't," pulled the sheet up underneath the chin with trembling hands. Resident 3's head was shaking, eyes were wide, and appeared to be fearful. Resident 3 was asked if Resident 3 was afraid to share the experience and she shook her head yes. The interview ended. During a concurrent observation and interview on 10/21/25 at 12:35 pm, Resident 2 was observed sitting in a wheelchair in the room. Resident 3 was smiling and laughed during re introductions and stated "yes" when asked if Resident 3 remembered who this writer was. Resident 3 was asked about statements made about alleged staff witnessed verbal abuse and Resident 3 shook head up and down, indicating yes when asked if that had happened. Resident 3 became visibly upset, with watery eyes and covered her face with both of her hands. Resident 3 confirmed feeling upset and when asked if everything between CNA B and herself were okay now, Resident 3 broke eye contact, looked at the floor and whispered "yes" while shaking head back and forth indicating no. During an interview on 10/21/25 at 1:19 pm, a phone interview with CNA B was conducted. CNA B had a loud tone with normal conversation. CNA B referred to Resident 3 using he/him pronouns seven times during the first few minutes of the interview. When asked why CNA B consistently used he/him pronouns, CNA B's tone became very loud and stated," I have no issues with him or people like that." CNA B's tone became aggressive, rapid in pace, and sounded angry while stating "I don't have any problems with him!"	C0990		
C1630	Dietetic Service--Food Service CFR(s): T22 DIV5 CH3 ART3-72335(a)(7) (a) The dietetic service shall provide food of the quality and quantity to meet each patient's needs in	C1630		

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C1630	Continued from page 8 accordance with the physicians' orders and to meet "The Recommended Daily Dietary Allowance," the most current edition, adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, and the following: (7) Recipes for all items that are prepared for regular and therapeutic diets shall be available and used to prepare attractive and palatable meals, in which nutritive values, flavor and appearance are conserved. Food shall be served attractively, at appropriate temperatures with appropriate eating utensils and in a form to meet individual needs. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure food was served at an appropriate temperature when: 1. Resident 1's family member (FM) and responsible party (RP, decision maker) stated, "food was often served cold," 2. Resident 2 stated "the food is always cold," and 3. The food and nutrition department did not consistently record food temperatures prior to serving meals. This had the risk of foodborne illness (illness that can be caused by undercooked food), unintended weight loss, and to negatively impact resident's psychosocial well-being. Findings: 1. A review of the facility's policy and procedure (P&P) titled, "Food and Nutrition Services," revised 10/1/17, indicated, the food and nutrition department would ensure food was served at an appetizing and safe temperature. A review of the facility's P&P titled, "Food Preparation and Service," revised 11/1/22, indicated, safe handling practices were adhered to. The P&P indicated, examples of potentially hazardous foods that had the potential for foodborne illness included poultry (chicken, turkey) and milk. A review of the facility's P&P titled, "Preventing Foodborne Illness-Food Handling," revised 7/1/14,	C1630		

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C1630	Continued from page 9 indicated, potentially hazardous foods would be cooked to the appropriate temperatures. During an interview on 10/9/25 at 3:30 pm, FM stated, Resident 1, "complained the food was cold often" and confirmed FM was present when Resident 1 was served cold food. During an interview on 10/9/25 at 4:53 pm, Resident 1's RP stated, "I would assist [Resident 1] with eating while being present in the facility and often the food was cold." 2. A review of the "Admission Record," dated 2/1/23 indicated Resident 2 was admitted to the facility on 2/1/23 with the diagnoses of hypertension (high blood pressure) and major depressive disorder (a sad mood). Resident 2 was her own RP. A review of the Minimum Data Set (MDS, a resident assessment tool), dated 8/20/25, indicated a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was performed. Resident 2's BIMS score was 15 out of 15, indicating good memory. During a concurrent observation and interview on 10/10/25 at 1:04 pm, Resident 2 was observed in her room with her lunch tray. There was a chicken breast on a bun observed on the plate. Resident 2 stated, "food is cold all the time, it's barely warm now. I was really excited about lunch today." Resident 2 was observed pushing the lunch tray away and shaking her head back and forth while looking at the floor. Resident 2 stated, "I go to Resident Council [a meeting where residents can discuss their concerns], we complain about food, and they always have an answer for reasons the food is cold, or the milk is warm." 3. During a concurrent observation, interview, and record review, on 10/10/25 at 1:21 pm, with Certified Dietary Manager (CDM), the "Daily Food Temperatures Log" (temp log) dated 10/10/25 was reviewed. CDM acknowledged resident complaints of cold food. Temp logs were requested for review. Two minutes after the temp logs had been requested, CDM was observed through the window, writing on papers that were in a binder. CDM confirmed, CDM was writing temperatures on the temp log prior to providing the requested documentation. CDM stated, "writing on temp log for dessert, milk, and juice. The temps were taken prior to providing residents their meals, they just didn't write it." CDM	C1630		

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C1630	Continued from page 10 reviewed the temp logs, dated 8/3/25, 8/9/25, 8/10/25, and 10/6/25. CDM confirmed, the temp logs were missing temperatures for all food and drinks served for lunch. CDM reviewed the temp log dated 9/1/25 and confirmed, there was no temperature written in the dinner area for vegetables and starch (food like pasta, bread, rice, or potatoes) and stated, "if there is no temp they didn't serve that item." CDM reviewed the, "Good For Your Health Menu," dated 9/1/25, and confirmed, macaroni salad had been served and there should have been a temperature taken for starch. During an interview on 10/10/25 at 3:28 pm, the Cook stated, "food temperatures were taken when the tray line is ready, just before we start the tray line, and is to be documented before we plate any food." During an interview on 10/10/25 at 3:40 pm, Registered Dietician stated, "When food came out of the oven, they take a temperature and document it prior to tray line" (where each resident's plate was assembled with food and drinks).	C1630		
C2185	Pharmaceutical Service--Staff CFR(s): T22 DIV5 CH3 ART3-72375(c) (c) A pharmacist shall review the drug regimen of each patient at least monthly and prepare appropriate reports. The review of the drug regimen of each patient shall include all drugs currently ordered, information concerning the patient's condition relating to drug therapy, medication administration records, and where appropriate, physician's progress notes, nurse's notes, and laboratory test results. The pharmacists shall be responsible for reporting, in writing, irregularities in the dispensing and administration of drugs and other matters relating to the review of the drug regimen to the administrator and director of the nursing service. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility's Consultant Pharmacist (CP) did not ensure a Physician's order for one out of three sampled residents (Resident 1) was free from irregularities (mistakes) when cyclobenzaprine (a muscle relaxant) was ordered to be given for pain or muscle spasms. This failure caused ineffective medication monitoring and could lead to negative clinical outcomes. Findings:	C2185		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDDING POST ACUTE	1836 GOLD STREET , REDDING, California, 96001

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C2185	Continued from page 11 A review of the facility's undated policy and procedure (P&P) titled, "Medication Regimen Review," indicated, the CP reviewed medication orders for every resident upon admission and monthly to identify irregularities. The P&P indicated, medication without adequate monitoring would be identified and reported to the facility's Physician for review. A review of the "Admission Record," dated 7/3/25, indicated, Resident 1 was admitted to the facility on 7/3/25 with the diagnoses of presence of left artificial hip joint (left hip replacement) and chronic pulmonary edema (fluid in the lungs that built up over time). Resident 1 was not his own responsible party (RP, decision maker). A review of Resident 1's Medication Administration Record (MAR), dated 7/1/25 through 7/31/25, indicated, the Physician ordered cyclobenzaprine HCL (a medication that treated muscle spasms) 5 milligrams by mouth every eight hours as needed for pain and muscle spasms in both legs. A review of the Medication Regimen Review (MRR), dated 7/28/25, indicated that the CP performed a review of Resident 1's medications. No irregularities for cyclobenzaprine had been reported. During an interview on 10/21/25 at 10:10 am, CP confirmed, the facility's Physician ordered cyclobenzaprine HCL 5 milligrams by mouth every eight hours as needed for pain and muscle spasms in both legs. CP stated, "there is no documentation that indicated if it [cyclobenzaprine] was given for pain or muscle spasms, there should be an indication for why they used it, the MAR doesn't reflect why it was given, and it was a missed opportunity." CP stated, "indications for cyclobenzaprine could have been caught during the monthly medication review and the facility should have caught it also. I did one med review before [Resident 1] discharged [from the facility] and I didn't catch it on my end."	C2185		
C4490	Patients' Rights CFR(s): T22 DIV5 CH3 ART5-72527(a)(10) (a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the	C4490		

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C4490	Continued from page 12 public upon request. Patients shall have the right: (10) To be free from mental and physical abuse. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to follow their abuse policy when the California Department of Public Health (CDPH, a State agency that promoted the health, wellness, and safety of Californians), local Ombudsman (government official that protected resident rights), and the police department were not notified when an allegation of witnessed verbal abuse was made toward Resident 3. This failure caused a delay in investigating and placed Resident 3 at risk for continued alleged verbal abuse. Findings: A review of the facility's policies and procedures (P&P) titled, "Reporting Abuse to State Agencies and Other Entities/Individuals," revised 1/1/17, indicated, all suspected allegations of abuse would be reported to CDPH, the local Ombudsman's office, and the police department. A review of the facility's P&P titled, "Protection of Residents During Abuse Investigation," indicated, the facility would protect residents form further harm while investigating abuse allegations. A review of the "Admission Record," dated 7/8/25, indicated that Resident 3 was admitted to the facility on 7/8/25 with the diagnoses of dysarthria following cerebral infarction (difficulty with speech after having a stroke), transsexualism (transgender, a person's gender identity was different than their assigned birth gender), and aphasia (language disorder that affected the ability to speak). Resident 3 was her own responsible party (made own decisions). A review of Resident 3's undated care plan (a written plan of resident goals and care instructions for facility staff) titled, "psychosocial well-being," indicated, Resident 3 identified as a female. During a concurrent observation and interview on 10/10/25 at 9:52 am, Certified Nurse Assistant (CNA) A, CNA A stated, "I overheard [CNA B] tell [Resident 3] "to shut the [F word] up. Get it together, when you got here you were male, now you're female. I reported it to the charge nurse and Admin [administrator], [CNA B] was	C4490		

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C4490	Continued from page 13 very rude to [Resident 3], so I interrupted and put a stop to it." During an interview on 10/21/25 at 12:10 pm, with Admin and the Director of Nursing (DON), a copy of the 5-day abuse investigation report regarding allegations of staff witnessed verbal abuse was requested. Admin and DON both stated, "no one had ever reported this to us." Admin confirmed the allegation of verbal abuse was not reported to the required entities due to CNA A not reporting the allegation to Admin or DON.	C4490		
C4985	Patients' Health Records CFR(s): T22 DIV5 CH3 ART5-72543(h) (h) Patient health records shall be filed in an accessible manner in the facility or in health record storage. Storage of records shall provide for prompt retrieval when needed for continuity of care. Health records can be stored off the facility premises only with the prior approval of the Department. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility did not ensure medical records for one out of three sampled residents (Resident 1) were filed in an accessible manner when medical records could not be located. This failure caused a delay in medical record accessibility. Findings: A policy and procedure that pertained to medical records being complete, accurate, and present was requested and not provided. A review of the "Admission Record," dated 7/3/25, indicated, Resident 1 was admitted to the facility on 7/3/25 with the diagnoses of presence of left artificial hip joint (left hip replacement) and dependence on supplemental oxygen (extra oxygen that was breathed in along with normal air to help people breathe). Resident 1 was discharged from the facility on 8/18/24 and was not his own responsible party (RP, decision maker). A review of Resident 1's electronic medical records was conducted. There was no "Inventory of Personal Possessions" or an admission "History and Physical"	C4985		

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C4985	Continued from page 14 present. During an interview on 10/22/25 at 8:19 am, Director of Nursing (DON) stated, the "Inventory of Personal Possessions" and the admission "History and Physical" would be in the paper medical records chart in the medical record (MR) department. During a review of Resident 1's paper medical records chart, the "Inventory of Personal Possessions" and the admission "History and Physical" were not present. During a concurrent observation and interview on 10/22/25 at 10:00 am, MR was observed sitting at the desk looking through paperwork. MR confirmed, an inability to find the "Inventory of Personal Possessions" and the admission "History and Physical." During a concurrent interview and record review on 10/22/25 at 11:26 am, DON provided an undated "Inventory of Personal Possessions" and an admission "History and Physical" dated 7/3/25. DON stated, "the History and Physical was found in the Admissions office." No explanation was provided regarding where the "Inventory of Personal Possessions" had been found.	C4985		
C4990	Patients' Health Records CFR(s): T22 DIV5 CH3 ART5-72543(i) (i) The patient health record shall not be removed from the facility, except for storage after the patient is discharged, unless expressly and specifically authorized by the Department. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medical records did not leave the facility for one out of three sampled residents (Resident 1) when the facility's Physician took resident medical records home. This had the potential for medical records to become lost and caused a delay in locating Resident 1's "History and Physical." Findings: A policy and procedure that pertained to medical records being complete, accurate, and present was requested and not provided.	C4990		

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C4990	Continued from page 15 A review of the "Admission Record," dated 7/3/25, indicated, Resident 1 was admitted to the facility on 7/3/25 with the diagnoses of presence of left artificial hip joint (left hip replacement) and dependence on supplemental oxygen (extra oxygen that was breathed in along with normal air to help people breathe). Resident 1 was discharged from the facility on 8/18/24 and was not his own responsible party (RP, decision maker). A review of Resident 1's electronic medical records was conducted. There was no admission "History and Physical" present. During an interview on 10/22/25 at 8:19 am, Director of Nursing (DON) stated, "the admission "History and Physical" would be in the medical records (MR) department. DON confirmed, the requested documentation would be located on paper and not in the electronic medical record. During a review of Resident 1's paper medical records chart, the admission "History and Physical" was not present. Resident 1's discharge assessment from the Physician was present. During a concurrent observation and interview on 10/22/25 at 10:00 am, MR was observed sitting at desk looking through paperwork. MR confirmed, the admission "History and Physical" would be in the paper chart and confirmed an inability to find it. During a concurrent interview and record review on 10/22/25 at 11:26 am, DON provided an admission "History and Physical" dated 7/3/25. DON stated, "the History and Physical was found in the Admissions office, [the Physician] sometimes took History and Physicals home and brings them back."	C4990		
C5135	Content of Health Records CFR(s): T22 DIV5 CH3 ART5-72547(a)(5)(B) (a) A facility shall maintain for each patient a health record which shall include: (5) Nurses' notes which shall be signed and dated. Nurses' notes shall include: (B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, weekly nurses' progress	C5135		

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C5135	Continued from page 16 notes shall be written by licensed nurses on each patient and shall be specific to the patient's needs, the patient care plan and the patient's response to care and treatments. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility did not ensure "Daily Skilled Charting," (the nurse's daily assessment) were meaningful for one out of three sampled residents (Resident 1) when Resident 1's hearing was documented as being adequate (no hearing loss was present). This had the potential for Resident 1's specific care needs to go unmet. Findings: A review of the facility's policies and procedures (P&P) titled, "Resident Examination and Assessment," revised 2/1/14, indicated residents were assessed for abnormalities in health status. A policy and procedure that pertained to medical records being accurate was requested and not provided. A review of the "Admission Record," dated 7/3/25, indicated, Resident 1 was admitted to the facility on 7/3/25 with the diagnoses of presence of left artificial hip joint (left hip replacement) and dependence on supplemental oxygen (extra oxygen that was breathed in along with normal air to help people breathe). Resident 1 was discharged from the facility on 8/18/24 and was not his own responsible party (RP, decision maker). During a concurrent interview and record review on 10/22/25 at 8:19 am, with the Director of Nursing (DON) Resident 1's "Daily Skilled Charting," notes dated 7/17/25, 7/24/25, and 7/31/25 were reviewed. DON confirmed, the "Daily Skilled Charting" notes had indicated, Resident 1's hearing was adequate. Resident 1's "Weekly Progress Note," notes dated 7/17/25, 7/24/25, and 7/31/25 were reviewed. DON confirmed the nurses, "Weekly Progress Note," notes had indicated, Resident 1 was hearing impaired and hard of hearing. DON confirmed the assessments were inconsistent.	C5135		
C5215	Content of Health Records CFR(s): T22 DIV5 CH3 ART5-72547(a)(16) (a) A facility shall maintain for each patient a health	C5215		

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C5215	Continued from page 17 record which shall include: (16) An inventory of all patients' personal effects and valuables as defined in Section 72545 (a) (12) made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure the inventory list for one out of three sampled residents (Resident 1) was complete when the inventory list was not signed by the responsible party (RP, decision maker) and the facility staff that completed it. This failure had the potential for personal belongings not to be accurately accounted for. Findings: A review of the facility's P&P titled, "Personal Property," revised 8/1/22, indicated the facility would ensure resident property was inventoried. A review of the "Admission Record," dated 7/3/25, indicated, Resident 1 was admitted to the facility on 7/3/25 with the diagnoses of presence of left artificial hip joint (left hip replacement) and dependence on supplemental oxygen (extra oxygen that was breathed in along with normal air to help people breathe). Resident 1 was discharged from the facility on 8/18/24 and was not his own responsible party (RP, decision maker). During a concurrent interview and record review on 10/22/25 at 11:26 am, with Director of Nursing (DON), Resident 1's undated "Inventory of Personal Possessions" (Inventory list) was reviewed. DON confirmed Resident 1's RP had not signed in the spaces provided for admission or discharge form the facility. DON was asked how the form was to be completed and stated, "the CNAs [Certified Nurse Assistants] do that." The name of the CNA that is responsible for completing this form was requested and not provided. DON confirmed there was an illegible signature on the discharge section of the document and could not identify who completed the form upon discharge from the facility. A review of the "General Note," dated 8/18/25,	C5215		

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C5215	Continued from page 18 indicated that Resident 1's RP was present in the facility during the discharge process. During an interview on 10/22/24 at 11:36 am, Resident 1's RP stated, "the inventory list was never reviewed or given to me at discharge or admission."	C5215		

Facility Name: Redding Post Acute
Citation Number: C0820
Regulation: Nursing Services – General
Date of Completion: November 8, 2025

DEFICIENCY:
Based on interview and record review, the facility did not ensure the accuracy of the admission Minimum Data Set (MDS), a resident assessment tool, for one out of three sampled residents (Resident #1) when the admission MDS indicated Resident #1's hearing was adequate (no hearing difficulty).

FACILITY'S PLAN OF CORRECTION:

1. Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #1 has been discharged from the facility.

2. Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
A 100% audit of all current residents' most recent MDS assessments was initiated to ensure accuracy of sensory and communication sections (hearing and vision). Any discrepancies identified were corrected, and care plans were updated accordingly.

3. Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.
All MDS staff and licensed nurses involved in assessment and data collection were re-educated on:

- Accurate completion of the MDS per RAI (Resident Assessment Instrument) guidelines.
- Verifying resident sensory status through observation, resident/family interview, and review of medical records prior to submission.
  The MDS Coordinator and DON will ensure that each admission and significant change MDS is reviewed for accuracy before final submission.

4. Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The MDS Coordinator or designee will conduct **weekly audits for four (4) weeks**, then **monthly for two (2) months**, of at least three (3) randomly selected MDS assessments to verify accuracy in the sensory section. Audit results will be presented during **QAPI (Quality Assurance and Performance Improvement)** meetings. Any errors identified will be corrected immediately, and staff involved will receive retraining as needed.

5. Element #5: Completion Date.
Date of full compliance: November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: Ashley Jorgenson RN/DON **Date:** 11/8/2025

Facility Name: Redding Post Acute
Citation Number: C0825
Regulation: Nursing Services – General
Date of Completion: November 8, 2025

DEFICIENCY:
Based on interview and record review, the facility did not develop a care plan (resident goals and written instruction for required care) for one out of three sampled residents (Resident #1) with hearing loss. This failure had the potential to place Resident #1 at risk for social isolation and mood or behavior disorders.

FACILITY'S PLAN OF CORRECTION:

1. Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #1 has been discharged from the facility

2. Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
A facility-wide audit was conducted of all residents identified with hearing deficits to ensure that appropriate, individualized care plan interventions are in place. Any missing or incomplete care plan items were immediately corrected by the IDT.

3. Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.
Licensed nurses and members of the IDT were re-educated on the requirement to develop and update individualized care plans that address all assessed resident needs, including sensory impairments such as hearing or vision loss.
The MDS Coordinator and DON will ensure that any sensory deficits identified on the MDS trigger an appropriate care plan intervention. Newly admitted residents with hearing or vision concerns will have their care plans initiated within 48 hours of admission.

4. Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The DON or designee will conduct **weekly audits for four (4) weeks**, then **monthly for two (2) months**, to verify that residents with hearing deficits have active, individualized care plan interventions addressing communication and social engagement needs.
Audit findings will be reported and reviewed during **QAPI (Quality Assurance and Performance Improvement)** meetings. Any identified deficiencies will be corrected immediately, and additional education provided as necessary.

5. Element #5: Completion Date.
Date of full compliance: November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: RN/DON **Date:** 11/8/2025

Facility Name: Redding Post Acute
Citation Number: C0900
Regulation: Nursing Services – Administration of Medication
Date of Completion: November 8, 2025

DEFICIENCY:
Based on interview and record review, the facility failed to ensure supplemental oxygen was administered as prescribed for one of three sampled residents (Resident #1) when oxygen saturation levels were outside of the physician's ordered range. This resulted in Resident #1 receiving too much oxygen, which had the potential to increase breathing problems, cause organ damage, and confusion.

FACILITY'S PLAN OF CORRECTION:

1. Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #1 has been discharged from the facility. Prior to discharge, the resident's condition was stable, and no adverse effects were noted related to the oxygen administration. The attending physician was notified of the incident and made aware of the resident's discharge status.

2. Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
All current residents receiving supplemental oxygen were reviewed to ensure oxygen is being administered per the current physician's order. Any discrepancies were immediately corrected, and physicians were notified as needed. No other residents were identified as affected.

3. Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.
A facility-wide in-service training was provided to all licensed nurses regarding proper administration and titration of supplemental oxygen according to physician orders, documentation of oxygen saturation readings, and the notification protocol for oxygen levels outside the ordered range. The Nursing Supervisor or designee will verify that all oxygen therapy orders clearly specify flow rate and target oxygen saturation range. All new and readmitted residents with oxygen orders will have those orders reviewed by the Director of Nursing (DON) or designee to ensure clarity and completeness.

4. Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The DON or designee will perform weekly audits for four (4) weeks, then monthly for two (2) months, to ensure residents receiving oxygen are administered therapy per physician orders. Audit results will be reviewed during the Quality Assurance and Performance Improvement

(QAPI) meetings. Any identified concerns will result in immediate corrective action, including retraining or disciplinary measures as appropriate.

5. Element #5: Completion Date.
Date of full compliance: November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: _____ **Date:** 11/13/2025

Facility Name: Redding Post Acute
Citation Number: C0990
Regulation: Nursing Services – Patient Care
Date of Completion: November 8, 2025

DEFICIENCY:
Based on observations, interviews, and record reviews, the facility failed to protect the rights of one out of three sampled residents (Resident #3) when Certified Nurse Assistant (CNA) A was witnessed making a verbally abusive statement toward Resident #3. This failure violated Resident #3's rights, caused fear, and had the potential to cause feelings of humiliation.

FACILITY'S PLAN OF CORRECTION:

1. Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #3 was immediately assessed by the licensed nurse for physical and emotional well-being following the incident. The resident denied injury or distress related to the event. Emotional support was offered if needed, and the attending physician was notified. The alleged perpetrator (CNA A) was immediately suspended pending investigation, and the allegation was reported to the California Department of Public Health (CDPH) and the Long-Term Care Ombudsman as required. The facility completed an internal investigation, and appropriate disciplinary action was taken based on the findings.

2. Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
All residents were interviewed and observed for signs of distress, fear, or mistreatment. No additional residents reported or displayed evidence of abuse or neglect. Staff were reminded to immediately report any allegations, suspicions, or observations of abuse to the charge nurse and administration per facility policy.

3. Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.
All facility staff will receive re-education on the **Abuse Prevention Policy**, including definitions, examples of verbal abuse, resident rights, and mandatory reporting procedures.

- Education emphasized that any form of disrespectful, degrading, or threatening language toward residents is strictly prohibited.
- The facility reinforced a zero-tolerance policy for abuse.
- New hires will receive abuse reporting training during orientation and annually thereafter. The DON and Administrator will ensure that all allegations are promptly investigated, and corrective actions are implemented as required by regulation.

4. Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The DON or designee will conduct **random staff and resident interviews weekly for four (4) weeks**, then **monthly for two (2) months**, to ensure that residents feel safe and that staff adhere to the facility's Abuse Prevention Policy.
All findings will be reported and reviewed during **QAPI (Quality Assurance and Performance Improvement)** meetings. Any identified issues will result in immediate corrective action and retraining.

5. Element #5: Completion Date.
Date of full compliance: November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: Ashley Jorgenson RN/DON **Date:** 11/8/2025

Facility Name: Redding Post Acute
Citation Number: C1630
Regulation: Dietary Services – Food Service
Date of Completion: November 8, 2025

DEFICIENCY:
Based on observations, interviews, and record reviews, the facility failed to ensure food was served at an appropriate temperature when:

1. Resident #1's family member and responsible party stated, "food was often served cold,"
2. Resident #2 stated, "the food is always cold," and
3. The Food and Nutrition Department did not consistently record food temperatures prior to serving meals.
   This failure had the potential to increase the risk of foodborne illness, contribute to unintended weight loss, and negatively impact residents' psychosocial well-being.

FACILITY'S PLAN OF CORRECTION:

1. Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #1 has been discharged from the facility. Resident #2 was educated on the option of asking for a newly made meal prepared at optimal meal temperatures. The Dietary Manager and Food Service Director immediately reinforced meal service temperature monitoring with all dietary staff.

2. Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
All residents in the facility have the potential to be affected. A review of the previous seven (7) days of temperature logs was conducted to identify any inconsistencies. No additional adverse findings were noted. The kitchen staff were instructed to verify and document meal temperatures before every tray line service to ensure food is served within the safe and acceptable temperature range.

3. Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.

A comprehensive re-education was provided to all dietary staff regarding proper food holding, monitoring, and serving temperatures in accordance with state and federal food safety standards.

- Staff were re-trained on the requirement to record and document hot and cold food temperatures before each meal service.

- The Food Service Director or designee will ensure temperature logs are completed, accurate, and maintained daily.
- Food holding equipment (steam tables, warmers, and cold wells) were checked for function, and maintenance was contacted to verify proper operating temperatures.
- CDM will attend resident council meetings upon invitation and take notes of room and cart numbers with food temp complaints to follow up on.
- A corrective action process will be initiated for any staff found not following temperature documentation or service protocols.

4. Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The Food Service Director or designee will conduct **temperature audits before each meal service daily for two (2) weeks**, then **three times per week for the following four (4) weeks**, and **weekly for two (2) months** thereafter.

- Audit results will be reviewed with the **Director of Nursing (DON)** and **Administrator**.
- Test trays will go out at least twice a week to varied staff with test tray slip to document temperature, presentation and taste. CDM will make corrections based off test tray notes.
- Findings will be presented during QAPI (Quality Assurance and Performance Improvement) meetings.
- Any deviations will result in immediate staff retraining or disciplinary action, as appropriate.

5. Element #5: Completion Date.
Date of full compliance: November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: _____ **Date:** 11/8/2025

Facility Name: Redding Post Acute
Citation Number: C2185
Regulation: Pharmaceutical Services – Staff
Date of Completion: November 8, 2025

DEFICIENCY:
Based on interview and record review, the facility's Consultant Pharmacist (CP) did not ensure a physician's order for one out of three sampled residents (Resident #1) was free from irregularities when cyclobenzaprine (a muscle relaxant) was ordered to be given for pain or muscle spasms. This failure caused ineffective medication monitoring and could have led to negative clinical outcomes.

FACILITY'S PLAN OF CORRECTION:

1. Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #1 has since been discharged from the facility.

2. Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
A comprehensive audit of all current medication orders was completed by the Director of Nursing (DON) and Consultant Pharmacist to identify any potential irregularities or incomplete medication indications. Any identified discrepancies were clarified with the attending physician, and orders were corrected as needed.

3. Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.

- The Consultant Pharmacist was re-educated on their regulatory responsibility to review all monthly medication orders for accuracy, appropriate indications, and potential irregularities.
- The Consultant Pharmacist has changed the protocol at the Pharmacy for any muscle relaxant medication to only be approved for a diagnosis of muscle spasms.
- Licensed nurses were re-educated on the requirement to ensure all PRN (as-needed) medication orders specify the indication for use (e.g., pain, spasm, anxiety) and to clarify any vague or incomplete orders with the prescribing provider.
- All new orders will be reviewed daily (Monday-Friday) using a order listing report at our IDT meeting. Any discrepancies will be corrected and/or clarified at that time.
- The DON will ensure new medication orders are reviewed upon admission and during monthly medication regimen reviews for accuracy and completeness.
- A process was implemented for the Consultant Pharmacist to document any identified irregularities and corresponding physician responses in the monthly review reports.

4. Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The DON or designee will conduct **monthly medication order audits for three (3) months** to ensure orders are complete, accurate, and free from irregularities.
Audit results will be reviewed during **Pharmacy & Therapeutics** and **QAPI (Quality Assurance and Performance Improvement)** meetings.
Any deviations will result in immediate correction and re-education. Continued compliance will be monitored through ongoing monthly pharmacist reviews.

5. Element #5: Completion Date.
Date of full compliance: November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: Ally Jorgenson RN/DON **Date:** 11/13/25

Facility Name: Redding Post Acute
Citation Number: C4490
Regulation: Patient Rights
Date of Completion: November 8, 2025

DEFICIENCY:
Based on observation, interview, and record review, the facility failed to follow its abuse policy when the California Department of Public Health (CDPH), the local Ombudsman, and the police department were not notified when an allegation of witnessed verbal abuse was made toward Resident #3. This failure caused a delay in investigation and placed Resident #3 at risk for continued alleged verbal abuse.

FACILITY'S PLAN OF CORRECTION:

Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #3 was immediately assessed following the allegation of verbal abuse, and no injury or distress was noted. The alleged staff member was promptly removed from the work schedule pending completion of the investigation. The Administrator and DON conducted a full internal investigation, and all required notifications to CDPH, the Ombudsman were made upon identification of the oversight. The resident was notified of the facility's response and reassured that measures were taken to ensure safety and protection of rights.

Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
All residents have the potential to be affected by this deficient practice. A review of all abuse allegation reports from the past 60 days was conducted to ensure proper and timely notification to CDPH, the Ombudsman, and law enforcement. No additional discrepancies were identified. The facility confirmed that all other incidents were appropriately reported in accordance with regulatory requirements.

Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.

- All licensed nurses, department heads, and supervisors were re-educated on the facility's Abuse Prevention, Reporting, and Investigation Policy, emphasizing immediate reporting requirements to CDPH, the Ombudsman, and law enforcement within mandated timeframes.
- The Abuse Reporting Checklist was updated to include verification boxes for required notifications.

- The Administrator or designee will review all abuse allegations immediately upon receipt to ensure all required notifications are completed and documented.
- The Director of Nursing (DON) and Administrator will reinforce with all staff their obligation to report suspected or alleged abuse immediately and to follow reporting protocols exactly as written in policy.
- Abuse reporting procedures will be reviewed during new hire orientation and annually thereafter.

Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The Administrator or designee will review all incident and abuse reports **weekly for 8 weeks**, then **monthly for 3 months**, to verify compliance with required reporting and notification protocols.
Findings will be discussed during **QAPI (Quality Assurance and Performance Improvement)** meetings. Any identified noncompliance will result in immediate correction, additional staff education, and ongoing tracking to ensure sustained compliance.

Element #5: Completion Date.
November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: _____ **Date:** 11/8/2025

Facility Name: Redding Post Acute
Citation Number: C4985
Regulation: Patient's Health Records
Date of Completion: November 8, 2025

DEFICIENCY:
Based on observation, interview, and record review, the facility did not ensure medical records for one out of three sampled residents (Resident #1) were filed in an accessible manner when medical records could not be located. This failure caused a delay in medical record accessibility.

FACILITY'S PLAN OF CORRECTION:

Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #1's medical record was located and properly filed in the designated medical records storage area on the same day the issue was identified. The record was reviewed for completeness and accuracy, and no missing documentation was found. The resident experienced no negative outcomes related to this deficiency.

Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
All residents have the potential to be affected by this deficient practice. A facility-wide audit of both active and discharged medical records was completed to ensure all records were filed accurately and were easily accessible. No additional misplaced or inaccessible records were found.

Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.

- The Health Information Manager (HIM) and Medical Records Clerk were re-educated on the facility's policy and procedure for medical record management, including filing, accessibility, and secure storage.
- A Medical Record Location Log has been implemented for tracking temporary removal of charts (e.g., for audits, MD review, or IDT meetings).
- A sign-out system will be maintained to ensure all records are returned promptly to their designated storage area.
- The Administrator and DON will ensure that any new or updated records are filed daily.
- Education was provided to department heads on how to properly request and return resident charts through the HIM department.

Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.

The **Health Information Manager** or designee will conduct **weekly audits for four (4) weeks** of randomly selected medical records to ensure they are properly filed and accessible. After four weeks, audits will continue **monthly for three (3) months**.
Audit results will be reported and reviewed during **QAPI (Quality Assurance and Performance Improvement)** meetings. Any identified deficiencies will result in immediate retraining and corrective action.

Element #5: Completion Date.
November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: _____ **Date:** 11/8/2025

Facility Name: Redding Post Acute
Citation Number: C4990
Regulation: Patient's Health Records
Date of Full Compliance: November 8, 2025

DEFICIENCY:
Based on observation, interview, and record review, the facility failed to ensure medical records did not leave the facility for one out of three sampled residents (Resident #1) when the facility's Physician took resident medical records home. This had the potential for medical records to become lost and caused a delay in locating Resident #1's "History and Physical."

FACILITY'S PLAN OF CORRECTION

Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #1's medical record was promptly retrieved and returned to the facility upon discovery. The record was reviewed for completeness and accuracy, and no missing documentation was identified. Resident #1 experienced no adverse outcomes because of this deficient practice.

Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
All residents have the potential to be affected by this deficient practice. A complete audit of all current resident medical records was conducted to ensure that all records were on site and properly secured. No additional records were found to be missing or removed from the facility.

Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.

- The facility's policy and procedure for medical record management was reviewed and revised to clearly state that resident medical records must always remain on facility grounds.
- The Medical Director and attending physicians were re-educated on this policy, with emphasis that no original records are to leave the facility under any circumstances.
- If a physician requires information for off-site review, photocopies or secure electronic copies will be provided by the Health Information Manager (HIM).
- The Health Information Manager and Administrator will monitor compliance by verifying that all records remain on-site.

- Staff will be reminded during orientation and annual training that removal of medical records from the facility is strictly prohibited.

Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The **Health Information Manager or designee** will perform **weekly audits for four (4) weeks** to verify that all resident medical records are accounted for and stored securely. Thereafter, audits will occur **monthly for three (3) months**.
Audit results will be presented during **QAPI (Quality Assurance and Performance Improvement)** meetings. Any identified noncompliance will result in immediate corrective action and retraining.

Element #5: Completion Date.
November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: _____ RN/DON **Date:** 11/8/2025

Facility Name: Redding Post Acute
Citation Number: C5135
Regulation: Content of Health Records
Date of Full Compliance: November 8, 2025

DEFICIENCY:
Based on interview and record review, the facility did not ensure "Daily Skilled Charting" (the nurse's daily assessment) was meaningful for one out of three sampled residents (Resident #1) when Resident #1's hearing was documented as being adequate (no hearing loss was present). This had the potential for Resident #1's specific care needs to go unmet.

FACILITY'S PLAN OF CORRECTION

Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #1 has since discharged from the facility.

Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
All current residents have the potential to be affected by this deficient practice. A facility-wide audit of current residents' "Daily Skilled Charting" was conducted to ensure that assessments accurately reflected residents' actual functional and sensory statuses. Any discrepancies identified were immediately corrected, and nurses responsible were re-educated on accurate documentation practices.

Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.

- All licensed nurses were re-educated by the Director of Nursing (DON) on the importance of completing accurate and meaningful daily skilled charting that reflects each resident's current condition, including hearing, vision, and communication abilities.
- The facility Daily Skilled Nursing Documentation Policy was reviewed and updated to include specific guidance on validating sensory documentation against current care plans and assessments.
- The MDS Coordinator will ensure consistency between MDS assessments, care plans, and daily skilled documentation.
- Any identified inaccuracies during documentation reviews will result in immediate correction and staff retraining.

Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The **DON or designee** will conduct **weekly audits for four (4) weeks** of randomly selected resident daily skilled charting to ensure documentation accuracy. Following this, audits will be conducted **monthly for three (3) months**.
Findings will be reviewed in **QAPI (Quality Assurance and Performance Improvement)** meetings. Identified issues will trigger further training and corrective action as necessary.

Element #5: Completion Date.
November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: Ashley Jorgenson RN/MN **Date:** 11/8/2025

Facility Name: Redding Post Acute
Citation Number: C5215
Regulation: Content of Health Records
Date of Full Compliance: November 8, 2025

DEFICIENCY:
Based on interview and record review, the facility failed to ensure the inventory list for one out of three sampled residents (Resident #1) was complete when the inventory list was not signed by the responsible party (RP) and the facility staff who completed it. This failure had the potential for personal belongings not to be accurately accounted for.

FACILITY'S PLAN OF CORRECTION

Element #1: How the corrective action will be implemented for residents affected by the deficient practice.
Resident #1 has since discharged from the facility.

Element #2: How the center will identify other residents having the potential to be affected by the same deficient practice.
All current residents have the potential to be affected by this deficient practice. The facility conducted an audit of all current residents' personal inventory forms to ensure each form was complete, current, and signed by both facility staff and the responsible party. Any missing signatures or incomplete forms were corrected immediately.

Element #3: What measure will be put into place or what systemic changes the center will make to ensure that the deficient practice does not recur.

- The Charge Nurses were re-educated on the facility's Resident Personal Property and Inventory Policy, emphasizing that both the staff member completing the inventory and the responsible party (or resident, if applicable) must sign and date the inventory form upon admission and discharge.
- The facility updated the Admission Checklist to include a verification step ensuring the inventory form is signed by both parties before completion of the admission process.
- The Social Services Director and Admissions Coordinator will ensure that any changes to resident belongings during the stay are documented and signed accordingly.
- The Director of Nursing (DON) will review the process quarterly to ensure compliance.

Element #4: How the center plans to monitor its performance to make sure that solutions are sustained.
The **Admissions Coordinator or designee** will conduct **weekly audits for four (4) weeks** of newly admitted residents' inventory forms to verify that all required signatures are present. After four weeks, audits will be conducted **monthly for three (3) months**.
Audit results will be reviewed during **QAPI (Quality Assurance and Performance Improvement)** meetings. Any identified noncompliance will result in immediate correction and staff retraining.

Element #5: Completion Date.
November 21, 2025

Facility Representative Name/Title: Ashley Jorgenson, Director of Nursing
Facility Name: Redding Post Acute
Signature: Ashley Jorgenson RN/DON **Date:** 11/8/2025