STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055092	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yuba City Post Acute	1220 Plumas St Yuba City, CA 95991

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Medical Director (MD) and the resident was notified of a change in condition for one of three sampled residents (Resident 35) when Licensed Vocational Nurse (LN) J discovered exposed bone and a surgical screw in Resident 35's right lateral ankle wound . This failure had the potential to put Resident 35 at risk of infection and a decrease in quality of care. Findings:During a record review of facility policy titled Change in a Resident's Condition or Status dated October 2024, indicated The nurse will notify the attending physician when there has been a.significant change in the resident's condition.specific instruction to notify the physician of changes in the resident's condition. Facility policy further indicated A 'significant change' of condition is a major decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.impacts more than one area of the resident's health status. Facility policy also indicated A nurse or healthcare provider will inform the resident of any changes in his/her medical care.During a record review of LN J's job description titled Job Description: Licensed Professional Nurse/Licensed Vocational Nurse (LPN/LVN) dated 2/2024, indicated to Notify the resident's attending physician and next-of-kin when there is a change in the resident's condition. LN J signed this document on 10/1/21.During a record review of facility job description titled Job Description: Treatment Nurse Registered Nurse (RN)/LVN/LPN dated 10/2016, indicated to Accurately observe wounds and pressure sores with prompt notification of physicians of lack of progress in healing or deterioration with the current treatment and or signs/symptoms of infection. Facility job description further indicated to Notify family and attending physician of significant treatments related issues regarding their residents including sudden and/or marked adverse changes in skin condition or wounds; report significant findings or changes in condition and potential concerns to RN Supervisor and/or Director of Nursing (DON).During a record review of Resident 35's admission record, she was admitted to the facility on [DATE] with diagnoses that included unspecified fracture of right lower leg (when there is a break in one or more bones of the right lower leg), disruption of wound (a condition where a previously closed wound reopens or separates), and dysphagia (a language disorder that affects a person's ability to understand, speak, read, or write).During a record review of facility document titled Wound Evaluation and Treatment dated 9/3/25 12:41 pm, indicated LN J evaluated Resident 35's wound and documented there was bone exposed on the right lateral ankle. Facility document indicated, Upon weekly skin assessment surgical incision on right lateral ankle is noted with 8-centimeter (cm) x 2 cm with opening in bottom of incision around 2.2 cm x 1.8 cm x 0.2 cm. Incision deteriorated and the bone is exposed on ankle. Continue treatment order to apply xeroform and wrap with kerlix wrap.During a record review of progress note titled eINTERACT Summary for Providers (SBAR - a tool used for communication between direct care staff and the resident's provider) dated 9/5/25 2:58 pm, indicated Nursing observations, evaluation, and recommendations are: .Resident noted with open wound on right lateral ankle.resident noted with exposed metal hardware on right lateral ankle about 2.5 cm x 2 cm x 0.3 cm. No drainage noted and metal hardware is exposed. Called orthopedic office and talked with a medical assistant. She stated Physicians' Assistant (PA) wrote down an order in chart that if metal hardware exposed to send resident out to emergency room for further evaluation. MD was in [facility] and made aware.During a concurrent observation and interview with Resident 35 on 9/18/25 at 10:47 am, Resident 35 stated LN J did not tell her that there was exposed bone on her right lateral ankle on 9/3/25. Resident 35 stated LN J told her she needed to go to a local acute care hospital on 9/5/25 for right lateral ankle wound evaluation and treatment because there was a screw sticking out.During an interview on 9/18/25 at 12:30 pm, with MD, MD stated she expected staff to notify her immediately of Resident 35's change in condition. MD stated she was not aware LN J documented the discovery of exposed bone and orthopedic screw during the wound evaluation and treatment on 9/3/25. MD stated she expected to be notified on 9/3/25. MD confirmed LN J did not notify her of Resident 35's wound changes of condition until two days later on 9/5/25.During an interview on 9/18/25 at 1:11 pm, with LN J, LN J confirmed she documented exposed bone on 9/3/25. LN J stated she called Resident 35's orthopedist's office on 9/3/25, but it was late in the day, and no one answered. LN J confirmed she should have contacted MD immediately. LN J confirmed she did not notify the DON and should have. LN J stated she will notify MD immediately for future reference.During an interview on 9/17/25 at 9:30 am, with DON, DON confirmed LN J documented exposed bone on Resident 35's right lateral ankle