

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Folsom Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Mill Street Folsom, CA 95630	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46242 Based on observation, interview, and record review, the facility failed to ensure one of 24 sampled residents (Resident 16) was provided assistance with nail care when Resident 16 was observed with long untrimmed nails with a brown substance underneath. These findings had the potential for increased infections, shame, discomfort, and feelings of frustration for Resident 16. Findings: A review of Resident 16's admission record indicated Resident 16 was readmitted to the facility in 2021 with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a condition of excessive worry, fear, and nervousness that can interfere with daily life), dementia (a progressive state of decline in mental abilities), hepatitis C (a viral infection of the liver that leads to illness and can be spread by contact with the contaminated blood), nail dystrophy (a group of conditions that cause abnormal changes in the structure, appearance, and growth of the nails), and other nail disorders. A review of Resident 16's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/21/25, indicated that Resident 16 has severe cognitive impairment and needed assistance with personal hygiene and dressing. A review of Resident 16's care plans indicated a care plan titled The resident has an ADL [Activities of Daily Living] self-care performance deficit r/t [related to] Dementia, Limited ROM [Range of Motion], initiated on 12/13/24 and revised on 2/5/25. The care plan indicated, The resident is totally dependent on staff for personal hygiene and oral care. During a concurrent observation and interview on 2/11/25 at 9:58 a.m. with Resident 16 in her wheelchair by her bedside, Resident 16 was observed with long discolored nails with a brown substance underneath. Resident 16 stated that she would like to get her nails trimmed. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/14/25 at 8:39 a.m. with the Nursing Assistant (NA 1) and Unit Manager (UM 2) in Resident 16's room, Resident 16 was observed in her wheelchair at her bedside with long discolored nails with a brown substance underneath. NA 1 and UM 2 confirmed that the nails were long and had a brown substance underneath. NA 1 described nails as being 1 centimeter or longer, and she stated that nails could be cleaned with a wooden stick and filed down to the appropriate length. She also stated that she provided nail care whenever she sees that the nails are dirty. In an interview on 2/14/25 at 8:50 a.m. with Certified Nursing Assistant (CNA 2), CNA 2 confirmed that Resident 16 had long nails with a brown substance underneath and she planned on fixing it. She was not able to state the last time Resident 16 received nail care. In an interview on 2/14/25 at 11:21 a.m. the Director of Nursing (DON) stated that residents' nails should be clean and trimmed. DON also agreed that given Resident 16's medical condition her nail care should be more rigorous. The facility's policy on nail care was requested but was not received.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36624 Based on observation, interview, and record review, the facility failed to implement infection control and preventive practices when: 1. There was no infection control and preventive practices training provided by the Infection Prevention nurse (IP, who specializes in preventing and controlling infections in healthcare settings) during a norovirus outbreak (a very contagious virus that causes stomach inflammation, vomiting, diarrhea, and stomach cramps); 2. Resident 335's urinary catheter (a hollow tube inserted into the bladder (a hollow organ of the lower stomach that holds urine before it leaves the body) drainage bag (a bag that collects urine) was found on the floor; 3. Resident 335's intravenous (IV- a needle or tube inserted into a vein) tubing was not dated; and, 4. Licensed Nurse (LN) placed a dirty pillow under Resident 335's leg. These failures decreased the facility's ability to ensure infection would not spread among residents for a census of 83. Findings: 1. During a review of the facility's infection prevention and control program (IPCP, a set of policies and procedures implemented within a healthcare setting to minimize the spread of infections among patients, staff, and visitors) on 2/14/25 at 10:25 a.m., the facility's antibiotic stewardship program (ASP, a set of practices that ensure antibiotics are used appropriately) was reviewed. During a review of the facility's monthly infection control report: under Healthcare Associated Infection (HAI, infections that develop while receiving medical care), on 2/14/25 at 10:28 a.m., the HAI report indicated, norovirus outbreak line list for the month of December 2024, 15 residents were listed to have gastro-intestinal (G.I.) infection symptoms like nausea (a feeling of sickness or discomfort in the stomach), vomiting, and diarrhea (stools are loose and watery). During a review of the facility's document submitted by the IP nurse to the local health department dated 1/6/25 at 4:42 p.m., the report indicated, gastrointestinal (G.I.) outbreak summary information. The local health department in its response confirmed it had received the norovirus outbreak report submitted by the facility. The facility's training binder was reviewed on 2/14/25 at 10:15 a.m. The review did not show any documentation that preventive practices training and/or in-services about norovirus outbreak was implemented. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/14/25 at 10:25 a.m., with the IP Nurse, the facility's norovirus outbreak line list for the month of December 2024 and the monthly infection control report were reviewed. The IP nurse confirmed that in the line list, 15 residents have had norovirus-like symptoms of nausea, vomiting and diarrhea. The IP nurse was unable to show proof a norovirus in-service/training was provided during the outbreak to help protect both patients and healthcare workers from the spread of the infectious disease. The IP nurse stated she should have provided and documented the training but she did not. During an interview and record review on 2/14/25 at 11:19 a.m., with the Director of Staff Development (DSD), the monthly infection control report and the facility training binder were reviewed. The DSD confirmed the facility had a norovirus outbreak for the month of December 2024 but there was no norovirus training implemented to ensure the health and safety of the residents. During an interview on 2/14/25 at 11:32 with the Director of Nursing (DON), the DON confirmed the norovirus outbreak and stated when there was an outbreak, an infection prevention and control training should have been provided to ensure the health and safety of the residents. During a review of the facility's undated policy and procedure (P/P) titled, Infection Control Plan, the P/P indicated, .Work with the in-service director in educating staff on infection control, methods, programs and procedures . During a review of the facility's undated Infection Preventionist position summary: it indicated, the IP is accountable for decreasing the incidence and transmission of infectious disease between patients, staff, visitors and community . Essential duties and responsibilities included: .Authority and responsibility for ensuring appropriate intervention and education occurs with staff, volunteers and medical staff when healthcare infection trends, outbreaks or non-compliance to infection control are identified . 2. A review of Resident 335's admission record indicated admission to the facility in January 2025 with diagnoses which included retention of urine (a condition that prevents urine from leaving the bladder). A review of Resident 335's medical records indicated the following: -An Order Summary Report dated 2/5/25 indicated orders for the provision of urinary catheter with drainage bag. -A care plan initiated on 2/7/25 indicated, The resident has .Catheter due to urinary retention .Position .away from entrance room door .Check tubing for kinks each shift During an observation in room [ROOM NUMBER]-B, on 2/12/25 at 11:40 a.m., Resident 335's urinary catheter drainage bag was found on the floor, on the right side of the bed facing the entrance room door, and not properly hung from the bed rail with use of the drainage bag hook. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 02/12/25 at 11:49 a.m. with LN 1, LN 1 agreed to go to Resident 335's room as requested. LN 1 acknowledged that the urinary catheter drainage bag was on the floor. LN 1 confirmed that the drainage bag should not be on the floor, but that the drainage bag hook should be properly hung on the bed rail so that the drainage bag is positioned off the floor. LN 1 stated that by having the drainage bag on the floor could cause a potential infection control issue, and tripping hazard, which could lead to urine being spilled on the floor. An interview on 2/13/25 at 10:30 a.m. in the DSD's office, the DSD provided a copy of the new hire Certified Nursing Assistant (CNA) Skills Checklist which did not include checkoffs for urinary catheter care and catheter drainage bag positioning. DSD stated that it was important for staff to follow infection control prevention practices to avoid a potential illness outbreak between vulnerable residents. DSD provided a copy of the Competency/Procedure LN Checklist with checkoffs being done by the Director of Nursing (DON). The DSD conducted a three-way telephone call with the DON on 2/13/25 at 10:40 a.m. for an interview to discuss the Competency/Procedure LN Checklist. The DON stated that there are no objectives or syllabus (an outline of what is taught) associated with the Competency/Procedure LN Checklist. DON acknowledged that there is no LN checkoffs related to urinary catheter care and urinary catheter drainage bag positioning. 3. A review of Resident 335's admission record indicated diagnoses which included Bacteremia (a condition where bacteria is present in the blood). A review of Resident 335's medical records indicated the following: -An Order Summary Report dated 2/13/25 indicated orders for the provision of Cefazolin (an antibiotic used to treat serious bacterial infections) Sodium 2 gram IV two times a day. -A care plan initiated on 2/7/25 indicated, The resident is on IV medications Cefazolin .The resident will not have any complications related to IV therapy . During a concurrent observation and interview on 2/12/25 at 12:35 p.m. with Unit Manager (UM) in Resident 335's room, UM was observed hanging Resident 335's IV medication Cefazolin. UM stated that Resident 335 has this medication scheduled to receive at 12 noon and at 12 midnight every day. UM spiked the new medication bag with the previously hung IV tubing noted on IV pole. UM hung the IV medication with the tubing, gave medication to Resident 335's IV site for infusion, and was prepared to leave the room. UM did not notice that the previous IV tubing did not have a label. UM did not use a new IV tubing for infusion, and did not label the IV tubing with the current date and time when hung. UM acknowledged that the IV tubing was not labeled with a date and time, and stated that no label was required for IV tubing per facility policy. During an interview on 2/13/25 at 10:30 a.m. in the Director of Staff Development's (DSD) office, the DSD provided a copy of the Competency/Procedure LN Checklist with checkoffs being done by the Director of Nursing (DON). The DSD did a three-way telephone call with the DON on 2/13/25 at 10:40 a.m. for an interview to discuss the Competency/Procedure LN Checklist. The DON stated that there are no objectives of what was taught associated with the Competency/Procedure LN Checklist. DON acknowledged that there is no LN checkoffs related to IV tubing or IV tubing labeling. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During a concurrent observation and interview on 2/12/25 at 12:53 p.m. with LN 1 in Resident 335's room, it was noted that bed A (the roommate) was not occupied, the resident was discharged earlier in day, bed room area was not cleaned yet; as observation indicated that no linen was on bed, container of sanitizing wipes with discharged resident's name was left on dresser, and room area was not prepared for the next potential admission. LN 1 was observed taking a dirty pillow from bed A, placed a clean pillow case on the dirty pillow, and then positioned that pillow under Resident 335's right leg. LN 1 did not clean or sanitize the pillow before use on Resident 335. LN 1 acknowledged that the pillow was taken from bed A, and stated that bed A room area had been cleaned by housekeeping, and that the pillow used from bed A was clean. During an interview on 02/12/25 at 12:56 p.m. with Housekeeper (HK) in room [ROOM NUMBER]-A. HK stated that bed A had not been cleaned by housekeeping yet. HK stated that when a resident is discharged , the CNA strips the bed and remove a resident's personal items so that housekeeping can do a deep cleaning (terminal cleaning) of the bed, chair, wheelchair, dresser, floors, walls, and curtains. HK acknowledged that discharged resident's container of sanitizing wipes were left on dresser, and stated anything that the CNA forgot to remove, housekeeping would remove as part of the deep cleaning process. An interview on 2/13/25 at 10:30 a.m. in the Director of Staff Development's (DSD) office, the DSD provided a copy of the new hire CNA Skills Checklist which did not include checkoffs for cleaning items/pillows before resident use. DSD stated that it was important for staff to follow infection control prevention practices to avoid a potential illness outbreak between vulnerable residents. DSD provided a copy of the Competency/Procedure LN Checklist with checkoffs being done by the Director of Nursing (DON). The DSD did a three-way telephone call with the DON on 2/13/25 at 10:40 a.m. for an interview to discuss the Competency/Procedure LN Checklist. The DON stated that there are no objectives or syllabus (an outline of what is taught) associated with the Competency/Procedure LN Checklist. DON acknowledged that there is no LN checkoffs related to cleaning items/pillows before resident use. A follow up interview on 2/14/25 at 8:50 a.m. in the DON's office, the DON stated that the expectation of an LN is to follow infection control prevention practices by making sure that labels are placed on IV tubing with date and time hung, that dirty items/pillows are cleaned before use on a resident, and that urinary catheter drainage bags are hung properly from resident's bed frame and not touching the floor. DON stated that the facility does not have a urinary catheter policy and procedure (P&P), that had been requested, but that LNs follow the Lippincott Manual of Nursing Practice, Ninth Edition, related to urinary catheter care and catheter drainage bag positioning. An interview on 2/14/25 at 9:25 a.m. in the IP's office, the IP presented the past 4 months of facility's In-Service/Training/Seminar Records for staff which did not include inservices related to cleaning items/pillows before resident use, or urinary catheter care and urinary drainage bag positioning. IPN stated did not know enough about IV tubing to make a comment due to a certification as a LVN. IP stated that it was important for staff to follow infection control prevention practices to keep everyone safe from germs and illness. A review of the facility's Lippincott Manual of Nursing Practice, Ninth Edition, chapter General Procedures and Treatment Modalities, indicated, Maintaining a closed drainage system .2. Maintain unobstructed urine flow .c. Keep the bag off the floor . (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Pharmacy Intravenous Therapy Services Manual, dated 10/2020, Section 6, titled: N. I.V. TUBING indicated, .2. I.V. tubings shall be dated and timed when hung . A review of the facility's Infection Control Manual, dated 10/25/24, Section 6, titled, Housekeeping Department, indicated, Procedure for Cleaning .3. Terminal cleaning of a resident room must include: Cleaning . Decontamination .; Cleaning Routines .In certain areas, housekeeping will not be responsible for the care of specific .These items may be the responsibility of the nursing services personnel, . A review of the facility's Infection Control Plan Policy, undated, indicated, .Work with the In-service Director in educating staff on infection control methods, programs and procedures; . 50282		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50541 Based on observation, interview, and record review, the facility failed to ensure 13 of 32 resident rooms (rooms 100/102, 101/103, 104/106, 105/107, 108/110, 112/114, 200/202, 201/203, 204/206, 205/207, 208/210, 209/211, and 212/214) accommodated no more than four residents in each room. This failure had the potential to result in inadequate space for the provision of care. Findings: During a review of facility letter, dated 2/11/25, the letter indicated thirteen rooms would accommodate five residents each, with one shared bathroom. The letter further indicated, .Every resident has a reasonable amount of privacy as well as appropriate furnishings and storage in the noted rooms .the rooms have sufficient space for nursing staff to provide care and for residents to ambulate and use assistive devices. During a tour of the facility on 2/11/25 at 8:07 a.m., multiple observations of rooms containing more than four residents per room were made. Rooms 100/102, 101/103, 104/106, 105/107, 108/110, 112/114, 200/202, 201/203, 204/206, 205/207, 208/210, 209/211, and 212/214 were configured with a solid wall from floor to ceiling dividing the space, with a shared bathroom and one exit door shared by five residents. Two beds were configured on one side of the wall and three beds were configured on the other side of the wall. Each bed had a privacy curtain to separate the residents. During a concurrent observation and interview on 2/13/25 at 9:50 a.m. with Maintenance Supervisor (MS) and Assistant Administrator (AA), measurements were taken of room [ROOM NUMBER]/110. room [ROOM NUMBER] was configured with two beds and a shared bathroom; the measured living space per resident was 117.5 sq. ft. room [ROOM NUMBER] was configured with three beds; the measured living space per resident was 88 sq. ft. per resident. During an interview on 2/11/25 at 12:09 p.m. with Resident 32 (Res 32) in room [ROOM NUMBER], when asked if there was enough space, Res 32 stated, I brought a lot of stuff with me .I have a lot of clothes .I make it work. Res 32 indicated she had adequate space in her room and could move about easily. During an interview on 2/13/25 at 3:21 p.m. with Resident 10 (Res 10) in room [ROOM NUMBER], Res 10 indicated the room had plenty of space. Res 10 further indicated she never had an issue with maneuvering in her wheelchair, getting into the bathroom, or transferring in and out of bed. During an interview on 2/13/25 at 3:51 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she was frequently assigned to rooms accommodating five residents. CNA 1 further stated she did not have issues with maneuvering residents. CNA 1 stated everything is accessible; she sometimes needed to move a bed temporarily for hoyer lifts, but it was still doable. (continued on next page)		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 02/13/25 at 03:51 p.m. with Licensed Nurse 3 (LN 3), LN 3 stated she had been assigned to provide care for rooms accommodating five residents frequently. LN 3 stated there was sufficient space for maneuvering five residents' beds and equipment. LN 3 further stated there is adequate space to assist residents with wheelchairs and walkers to the shared bathroom. LN 3 stated there were no complaints from residents' families regarding the space. The Department recommends granting a room waiver per the facility request.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50541 Based on observation, interview, and record review, the facility failed to ensure 11 of 32 resident rooms (rooms 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, and 310) met the minimum requirement of 80 square feet (sq. ft.) per resident. This failure had the potential to result in inadequate space for the provision of care. Findings: During a review of facility letter, dated 2/11/25, the letter indicated 11 rooms measure less than 80 sq. ft. per resident. The letter further indicated, Each resident will have a reasonable amount of privacy as well as appropriate furnishings and storage space .the rooms provide sufficient space for nursing staff to provide care and for residents to ambulate and use assistive devices. During a tour of room [ROOM NUMBER] on 2/11/25 at 8:52 a.m., staff was observed assisting a resident using a walker in the room. Both the staff member and resident had adequate space to maneuver without complaints. During an interview on 2/13/25 at 3:51 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she was frequently assigned to rooms 300-310. CNA 1 further stated she did not have issues with maneuvering residents or equipment. CNA 1 stated she sometimes moved equipment into the hallway temporarily when residents needed showers. CNA 1 could not remember any incidents of family or residents complaining about space. During an interview on 2/13/25 at 3:45 p.m. with Licensed Nurse 2 (LN 2), LN 2 stated she was frequently assigned to oversee staff assigned to rooms 300-310. LN 2 stated she had received no complaints from residents or family about space. LN 2 stated, When we are using lifts, we can move the bed. When we're not using lifts, there is enough space for residents to get to the bathroom either using their walkers or wheelchairs. LN 2 further stated staff kept the areas free of clutter and made sure the floors were clear. During an interview on 2/13/25 at 9:50 a.m. with Assistant Administrator (AA), AA stated he had received no complaints from residents or family about space in rooms 300-310. During a concurrent observation and interview on 2/13/25 at 9:50 a.m. with Maintenance Supervisor (MS) and Assistant Administrator (AA), measurements were taken of room [ROOM NUMBER]. room [ROOM NUMBER] was configured to accommodate two beds; the measured living space per resident was 72.5 sq. ft. The Department recommends granting a room waiver per the facility request.		