STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055222	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs Road Healthcare	1527 Springs Road Vallejo, CA 94591

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to provide professional standards of care for one of three sampled residents (Resident 1) when the x-ray (used to detect broken bones) order for Resident 1 was not carried out correctly.This failure resulted to an x-ray performed on Resident 1's right knee instead of the left knee. Resident 1's x-ray on the left knee indicated a fracture of the distal femur (a break in the thigh bone just above the knee joint) which required further evaluation and treatment in the acute care hospital.A review of the admission Record indicated Resident 1 was admitted April of 2023 with diagnoses including type 2 diabetes mellitus with diabetic polyneuropathy (long -term high blood sugar damages multiple nerves which leads to pain, tingling, burning, or numbness in the feet or hands) and weakness.A review of Resident 1's Brief Interview for Mental Status (BIMS- an assessment tool to screen and identify memory, orientation, and judgement status) dated 2/17/26 indicated Resident 1 was cognitively intact with a score of 14.A review of Resident 1's Order Summary Report indicated the following physician orders:- on 2/18/26 the order indicated, May X-ray (L) knee r/t [related to] pain.; and,- on 2/22/26 the order indicated, Monitor (L) thigh skin discoloration for any changes [every] shift. A review of Resident 1's Nurse's Note dated 2/18/26 at 3:40 p.m. indicated, [Resident 1] verbalize [sic] that he bumped his Left knee at the church bathroom last Sunday 2/15/2026.Asked resident if he fell outside facility and said NO. Noted Left knee more prominent that [sic] right knee. No redness noted on left knee, skin intact, with faint yellowish skin discoloration noted on the left lateral thigh. Able to move left foot and able to wiggle toes. Medicated x1 with PRN [as needed] Norco [used to treat moderate to severe pain] for 7/10 [7 out of 10, ten being worst pain ever] left knee pain with relief noted. Supported LLE [left lower extremity] with pillow. Seen and examined by visiting MD [Medical Doctor] with order for x ray on left knee.Further review of Resident 1's clinical records did not indicate follow up monitoring of Resident 1's left knee from 2/19/26 to 2/22/26.A review of Resident 1's Nurse's Note dated 2/24/26 at 12:13 a.m. indicated, Xray [sic] of left knee taken tonight and fracture of the left knee is found. Reported to [name of physician] and ordered to be sent to [name of hospital] for treatment.given Norco around 2017 [8:17 p.m.] with c/o [complained of] 8/10 left knee pain with some relief. Was refusing to be changed because of pain when he is moved. Transferred to ER [Emergency Room] around 2235 [10:35 p.m.] .A review of Resident 1's Medication Administration Record (MAR) for February 2026 indicated Resident 1 received Norco once or twice from 2/16/26 to 2/23/26 for pain between 7 to 8.A review of the Interdisciplinary (IDT) Note dated 2/25/26 indicated, .On 2/19/26, due to a data entry error on the diagnostic requisition, the X-ray was performed on the right knee, which showed no fracture.On 2/23/26.[Resident 1] stated he had fallen on 2/15/26 while at church but was unable to describe how or where the alleged fall occurred.The corrected X-ray on the left knee was completed on 2/23/26 and revealed an acute [sudden onset] mildly displaced supracondylar fracture of the distal femur [break on the thigh bone just above the knee joint where the bone pieces are slightly out of alignment] .The MD (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was notified of the results during the evening shift on 2/23/26 and ordered to transfer to [name of hospital] for further evaluation and treatment. Follow-up with [name of hospital] confirmed that [Resident 1] was admitted .following surgery for retrograde intramedullary nailing of the left femur [surgical procedure where a metal rod is inserted into the broken thigh bone through the knee and into the bone cavity to stabilize the fracture].During a concurrent interview and record review on 2/25/26 at 12:49 p.m. with the Director of Nursing (DON), Resident 1's Nurse's note and IDT note were reviewed. The DON stated Resident 1's x-ray order was on the left knee and for some reason the nurse clicked on the right knee. The DON further stated the x-ray on the left knee was done on 2/23/26. During an interview on 2/25/26 starting at 1:03 p.m. with the Licensed Nurse 1 (LN 1) and DON, in the conference room, the LN 1 stated she wrote the Nurse's Note on 2/18/26 for Resident 1. The LN 1 further stated she called the physician and the physician ordered x-ray of the left knee because Resident 1 was complaining of pain. The LN 1 added, another licensed nurse carried out the order, and the x-ray request was made for the right knee instead of the left knee. The LN 1 acknowledged there were no follow up notes made regarding Resident 1's left knee. The DON stated there should be a follow up note after 2/18/26 when Resident 1 verbalized he bumped his left knee while at church on 2/15/26. The LN 1 and the DON acknowledged Resident 1 could have been sent out in the hospital earlier if the x-ray was done on the right body part [left knee]. A review of the facility's policy and procedure revised April 2007 and titled, Request for Diagnostic Services indicated, .Orders for diagnostic services will be promptly carried out as instructed by the physician's order.