

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Springs Road Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1527 Springs Rd 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for a census of 58 when:1. Dietary Supervisor (DS) and Dietary Aide (DA) 1 were not wearing a beard net while inside the kitchen.2. [NAME] residue was present on the floor surface of the food warmer.3. The top surface of the knife holder had accumulated dust and residue.4. Black residue was present on the floor beneath the dishwasher area.5. Three quarter size hotel pans were stacked wet while stored away.6. Flies were present in the kitchen area and dry storage area.7. Four lunch trays containing uncovered desserts were transported through the hallway. These failures had potential to cause food-borne illnesses in a highly susceptible population who received food from the kitchen. Findings:1. During an observation on 6/9/26 at 8:04 a.m. at the kitchen's initial tour, DS had a beard but was not wearing a beard net while in the kitchen during the initial tour. During an observation on 6/10/26 at 10:05 a.m. in the kitchen, DA 1 had a beard but prepared pudding for lunch without wearing a beard net. During a concurrent observation and interview on 6/10/26 at 10:22 a.m. with Registered Dietician (RD) in the dry storage area, the door leading to the kitchen displayed a sign stating, 'Proper hair restraint worn beyond this point.' RD stated that hair restraints included beard nets. During an interview on 6/11/26 at 9:33 a.m. with RD, RD stated that beard nets were worn in the kitchen for sanitation and infection control purposes. During a review of the facility's policy & procedure (P&P) titled, Food Preparation and Service, revised 4/26, the P&P indicated, 'staff must wear hair/beard covering during tray assembly.2. During a concurrent observation and interview on 6/9/26 at 8:06 a.m. during the kitchen's initial tour with DS, the food warmer's floor surface had brown residue. DS confirmed the presence of the residue.3. During a concurrent observation and interview on 6/9/26 at 8:09 a.m. during the kitchen's initial tour with the DS, the top surface of the knife holder had dust and residue. When wiped with a finger, the residue transferred onto the finger. DS confirmed the presence of the dust and residue and removed the knife holder from the wall. During an interview on 6/11/26 at 9:33 a.m. with RD, RD stated that equipment needed to be kept clean to prevent bacterial growth. During a review of the facility's P&P titled, Sanitation, Food Services, revised 10/24, the P&P indicated, '2. All utensils, counters, shelves and equipment shall be kept clean. 4. During a concurrent observation and interview on 6/9/26 at 8:13 a.m. during the kitchen's initial tour with DS, the floor beneath the dishwasher area had black residue. The DS confirmed the presence of black residue. During an interview on 6/11/26 at 9:33 a.m. with RD, RD stated that it was important to keep the kitchen area clean for infection control purposes and to prevent bacterial growth. During a review of the facility's P&P titled, Sanitation, Food Services, revised 10/24, the P&P indicated, '1. All kitchen, kitchen areas, shall be kept clean. 16. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule to prevent accumulation of grime. 5. During a concurrent observation and interview on 6/9/26 at 8:26 a.m. during the kitchen's initial tour with DS, three quarter-size hotel pans were stacked while still wet. DS confirmed that the pans were wet and stated that they should have been air-dried before stacking. During an interview on 6/11/26 at 9:33 a.m. with RD, RD stated that stacking pans while wet (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	could promote bacterial growth and that the pans should be dried before stacking. The facility did not provide a P&P regarding storage of cleaned equipment and utensils. 6. During an observation on 6/10/26 at 12:20 p.m. during tray line in the kitchen, flies were observed in the kitchen area. DA 1 and DA 2 were observed waving the flies away from the tray line. DS confirmed that he had observed flies earlier. During an observation on 6/10/26 at 1:21 p.m. in the dry storage area/DS office, flies were observed in the dry storage area/office. The door leading from the dry storage area to the kitchen was wide open. DS confirmed the presence of flies in the dry storage area/office. During an interview on 6/11/26 at 9:33 a.m. with RD, RD stated flies should not be present in the kitchen because they could transfer bacteria and contribute to foodborne illnesses. During a review of facility's P&P titled, Sanitization, Food Services, revised 10/24, the P&P indicated, .1. All kitchen, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. 7. During a concurrent observation and interview on 6/9/26 at 12:13 p.m. outside the kitchen, food cart 2 was observed outside the kitchen. Minimum Data Set Coordinator (MDSC) removed a tray containing an uncovered dessert from the food cart and walked through the hallway to the dining room. Infection Preventionist A (IP-A) stated that the resident wanted to eat in the dining room instead of the resident's room, which was why MDSC removed the tray from the food cart. During a concurrent observation and interview on 6/9/26 at 12:21 p.m. with Certified Nursing Assistant (CNA) 1 outside of room [ROOM NUMBER], food cart 2 was placed right beside the door of room [ROOM NUMBER], IP-A handed a tray containing an uncovered dessert to CNA 1. CNA 1 confirmed that the dessert was uncovered and walked the tray from room [ROOM NUMBER], located at the end of the hallway, back to room [ROOM NUMBER]. At 12:22 p.m., IP-A took another tray containing an uncovered dessert and walked through the hallway to room [ROOM NUMBER]. During a concurrent observation and interview on 6/9/26 at 12:24 p.m., food cart 2 was still outside room [ROOM NUMBER], CNA 1 took a tray containing an uncovered dessert and walked it to room [ROOM NUMBER]. CNA 1 confirmed that the dessert was uncovered. During an interview on 6/9/26 at 12:32 p.m. with MDSC, MDSC confirmed that he took a tray from outside the kitchen to the dining room because the resident wanted to eat in the dining room instead of the resident's room. During an interview on 6/11/26 at 9:33 a.m. with RD, RD stated when distributing meal trays, the food cart should be wheeled to the resident's room and the tray removed and given to the resident. RD stated that all food should remain covered while being transported through the hallway to prevent contamination. During a review of the facility's P&P titled, Food Preparation and Service, revised 4/26, the P&P indicated, .all food trays must be covered at all times when transported from the kitchen or serving area to residents room. food must be protected from contamination. no uncovered food tray may be transported through the hallways. all trays must be covered with individual tray lids or transported in enclosed carts. cover must remain in place throughout transport and must not be removed until the tray is in front of the resident.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to secure resident medical records containing Protected Health Information (PHI, any individually identifiable health information held, transmitted, or maintained by the health facility), for four Residents (Resident 11, Resident 39, Resident 59, and Resident 69) out of census of 58 residents, when the Treatment Nurse (TN) left printed wound treatment records on top of an unattended cart. This failure had the potential for unauthorized access by visitors, families, and other residents to Resident 11's, Resident 39's, Resident 59's, and Resident 69's medical records containing PHI. Findings: During an observation on 6/9/26 at 9:49 a.m. in the hallway outside of rooms 25 through 28 the TN left a paper stack of resident medical records unsecured on top of the treatment cart. Visitors, family members, and residents were observed walking past by the treatment cart within a viewing distance of the open, unsecured, and unprotected resident medical records. During a concurrent observation and interview on 6/9/26 at 9:53 a.m. with the Infection Preventionist B (IP B) in the hallway outside of rooms 25 through 28, the IP B confirmed the presence of resident medical records containing PHI in the form of wound treatment documentation that had been sitting on top of the treatment cart with no staff present. The IP B confirmed that the documents were unsecured and had the possibility of unauthorized access by other residents and visitors. During a concurrent interview and record review on 6/9/26 at 9:57 a.m. the TN stated she had left the treatment documents unattended on the cart when she walked away from the cart. The TN acknowledged she should have locked the documents up so residents and visitors could not access them. The TN confirmed the medical records included resident names, status of wounds, and treatments ordered for Resident 11, Resident 39, Resident 59, and Resident 69. A review of facility policy and procedure titled, Protected Health Information (PHI), Management and protection of, revised April 2024, indicated, . It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure services meet professional standards of quality for four residents (Resident 16, Resident 39, Resident 74, and Resident 6) for a census of 18, when: Medications were given without meals, as prescribed for Resident 16, Resident 39, and Resident 74; Medication with a box warning ((also known as black box warning- the strictest, most serious safety alert mandated by the U.S. Food and Drug Administration (FDA [a federal agency of the United States government responsible for protecting public health]) was being administered for Resident 6 without monitoring for side effects to highlight severe, life-threatening, or permanently disabling risks)). These failures had the potential to cause: Residents 16, Resident 39, and Resident 74 to have adverse side effects related to medications being administered without meals; Staff not monitoring Resident 6 for side effects related to taking medications with a box warning; Findings: 1. A review of Resident 16's Face Sheet (a document indicating a resident medical information) indicated Resident 16 was admitted to the facility on [DATE] with diagnosis which included Herpesvirus infection (HSV, common, lifelong viral infections causing painful blisters or ulcers), and Asymptomatic Human Immunodeficiency virus infection (HIV, a virus that attacks the body's immune system). A review of Resident 16's Order Summary Report (OSR, indicates prescribed medication and treatment orders), for active orders dated 6/12/26, indicated, .Symtuza [antiviral medication] Tablet . Give 1 tablet by mouth one time a day . (with a meal) . A review of Resident 39's Face Sheet indicated Resident 39 was re-admitted to the facility on [DATE] with diagnosis, which included anemia (body lacks enough healthy red blood cells to effectively carry oxygen to vital tissues). A review of Resident 39's OSR, for active orders dated 6/12/26, indicated, .Ferrous Sulfate [iron supplement] Oral Tablet . Give 1 tablet by mouth one time a day for anemia. take with breakfast. A review of Resident 74's Face Sheet indicated Resident 74 was admitted to the facility on [DATE] with diagnosis, which included type 2 diabetes mellitus (high blood sugar). A review of Resident 74's OSR, for active orders as of 6/12/26, indicated, .Metformin [medication to manage blood sugar] . Give 1 tablet.w/ [with] meals. During an interview on 6/11/26 at 1:18 p.m., the Nurse Practitioner (NP) stated it was of utmost importance for nursing to follow prescriber direction for timing medication administrations, such as before meals, with meals, or on an empty stomach to prevent harm to the [resident]. During an interview on 6/11/26 at 3:50 p.m., the Dietary Supervisor (DS) stated lunch trays for residents in rooms 25 through 28 (where Resident 16, Resident 39, and Resident 74 resided) were served at approximately 12:15 p.m. on 6/10/26. During a phone interview on 6/12/26 at 12:50 p.m. the facility's Pharmacy Consultant (PC- a medication expert who advises healthcare providers on the safe and appropriate use of medications) stated when a prescriber provides directions for medication to be given with a meal, the medication should be provided with a meal, and clarified not just a snack but a meal, to prevent side effects and ensure treatment effectiveness. The PC further confirmed that Symtuza absolutely needs to be taken with a meal, Ferrous Sulfate should be taken with a meal especially in elderly populations for tolerability, and Metformin absolutely needs to be taken with a meal. The PC confirmed administering these medications between 11:06 a.m. and 11:34 a.m. when lunch was not served until 12:15 p.m. was not considered given with a meal and had the potential to cause side effects and treatment failure. A review of facility policy and procedure titled, Administering Medications, revised April 2025, indicated, .Medications are administered in a safe and timely manner and as prescribed medications are administered in accordance with prescriber orders . 2. A review of Resident 6's Face Sheet indicated Resident 6 was admitted to the facility in May 2026 with diagnoses including depression (mood disorder characterized by persistent feelings of sadness, emptiness, and a loss of interest in daily life). A review of Resident 6's care plan (CP- a personalized, written document that outlines how staff will manage a resident's medical, physical, and personal care needs daily) titled, Antidepressant (Sertraline)[a medication to treat depression].., initiated 5/9/26, indicated (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interventions/tasks staff were expected to perform included, ANTIDEPRESSANT BLACK BOX Warning: Suicidality and antidepressant drugs. Closely observe and appropriately monitor patients .for clinical worsening, suicidality, or unusual changes in behavior and Black Box Warning: Monitor S/E [side effects] such as sedation, dry mouth, urine retention, tachycardia [an abnormally fast heartbeat], muscle tremors, drowsiness, skin rash, agitation, dizziness, confusion, headache, blurred vision & notify MD [Medical Doctor] promptly.A review of Resident 6's OSR, dated 6/11/26, indicated an active order for, Sertraline HCl [hydrochloride] Oral Tablet 100 MG [milligram; a unit of measure] . Give 1 tablet by mouth one time a day for depression. No documented evidence of an order to monitor for the box warning risks and side effects.During an interview on 6/11/26 at 12:17 p.m., LN 5 stated some medications have serious side effects and adverse reactions. The medications with increased risks will have a box warning of side effects and adverse reactions that should be monitored. LN 5 stated nurses know to monitor for these box warning side effects and adverse reactions through an order in the eMAR. LN 5 clarified if there was not a monitoring order, she would not know to monitor for the box warning side effects or adverse reactions.During a concurrent interview and record review on 6/11/26 at 12:21 p.m., with the Director of Staff Development (DSD- a licensed nurse responsible for planning, implementing, and overseeing educational programs for nursing and support staff), Resident 6's OSR, care plans and eMar, dated 5/8/26 through 6/11/26 were reviewed. The DSD confirmed Resident 6 had an order for Sertraline. The DSD also confirmed Sertraline had a box warning care plan that indicated staff were to monitor side effects and adverse reactions, and he would expect to see an order for monitoring of those box warning side effects and adverse reactions. The DSD further confirmed there was no order for monitoring the box warning side effects and adverse reactions. A review of FDA document titled, Guidance for Industry: Warnings and Precautions, Contradictions, and Boxed Warning Sections of Labeling for Human Prescriptions Drug and Biological Products, dated 10/6/11, indicated, .A boxed warning is ordinarily used to highlight for prescribers. there is an adverse reaction so serious in proportion to the potential benefit form the drug (e.g., a fatal, life-threatening or permanently disabling adverse reactions) that it is essential that it be considered in assessing the risks and benefits of using the drug.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored in accordance with the accepted professional principles and current standard of practice for Resident 33 and Resident 22 and for census of 58 when:1. Resident 33 was found to have medications at the bedside.2. An opened, unlabeled box of Lidocaine Patches 5% was found in the medication cart, containing one unopened packet and 2 opened packets; and3. Resident 22's white envelope containing twenty-five dollars in cash were found inside the narcotic box in medication cart.These failures had the potential for diversion of unlabeled medications and risk resident's safety. Stored personal valuables in the narcotic cabinet compromise the security of the controlled medications.1.Review of Resident 33's Face Sheet (a summary page in a resident's medical record that contains key identifying information about the resident) indicated that Resident 33 was admitted May of 2026 with several diagnoses including atherosclerotic heart disease (a condition where arteries supplying blood to the heart muscle become narrowed or blocked by fatty deposits), Muscle weakness (generalized) and other abnormalities of gait and mobility. Review of Resident 33's Minimum Data Set-(MDS-a federally mandated resident assessment tool) dated 5/17/26, the MDS indicated that Resident 33 was cognitively intact. Review of Resident 33's Order Summary Report indicated no provider orders authorizing Resident 33 to store or self-administer medications at the bedside. Review of Resident 33's Interdisciplinary Team (IDT-a team of health professional that plans a Resident's care and updates a Resident's plan of care), the IDT notes dated 5/13/26, 5/20/26, 5/27/26 and 6/3/26 indicated no medication administration assessments were done. During an interview on 6/9/26 at 10:50 a.m. with Resident 33, observed medications on Resident 33's dresser beside her bed, which included an opened box of [Brand name topical pain relief patches], a container of opened [brand name vitamins] and a container of magnesium glycinate (a dietary supplement that helps with muscle and nerve function) 200 mg (milligram-a unit of measurement). Resident 33 stated her friend brought these to her. During an interview on 6/9/26 at 10:58 a.m. with Licensed Nurse (LN), LN 2 confirmed this finding and stated that Resident 33 should not have medications at the bedside. LN 2 stated that if a Resident brings medications from home the LN will secure the medications and send a message to the provider to obtain orders for Resident use and storage. LN 2 stated potential negative outcome of residents having medications at the bedside is other residents may take the medications and there is risk of overdose if the resident is left to manage his own medications. During an interview 06/12/2026 8:03 a.m. with the Director of Nursing (DON), the DON stated that residents should not have medications at the bedside unless a provider order is obtained, a cognitive and self-administration assessment is done by the Interdisciplinary Team. The DON further stated the potential negative outcome is that the resident could overdose and it is not safe for the resident. Review of the facility Policy and Procedure (P&P) titled, Self-Administration of Medications, dated December 2025, the P&P indicated, Residents have the right to self-administer medications if the Interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. 2. During a concurrent observation and interview on 6/9/26 at 1:38 p.m. with the Director of Nursing (DON) at medication cart Station One, an opened, unlabeled box containing one unopened packet and two opened packets of Lidocaine Patches 5% were found stored with the resident's medications. The DON confirmed the observation and stated Lidocaine Patch 5% patches were individually prescribed by the physician based on residents' diagnoses or complaints. The DON further stated all medications used in the facility should have been labeled with appropriate and cautionary instructions to keep residents safe, and that the nursing staff should have discarded the opened patches. 3. During a concurrent observation and interview on 6/9/26 at 1:40 p.m. with the DON at medication cart Station One, Resident 22's white envelope containing twenty-five dollars in cash was found inside the narcotic box. The DON stated Resident 22 had been discharged from the facility on May 29th, and the envelope should have been surrendered to the Business Office to be kept securely and returned to Resident 22 prior to discharge. The DON further stated personal belongings should not have been stored inside the narcotic box because doing so compromised the safety of controlled medications. During an interview on 6/12/26 at 1:05 p.m., the Pharmacy Consultant (PC) stated unlabeled medications should not have been kept in the cart to prevent medication errors and potential diversion. The PC further stated all medications should have been labeled and maintained in compliance with regulatory standards to ensure accurate dosage administration and resident safety. The PC added that medications such as Lidocaine Patches 5% were prescribed by the physician specific to the resident's diagnosis and use by other residents posed a risk. The PC also stated personal belongings, such as cash, should not have been kept inside the narcotic box because doing so introduced a risk of theft and cross-contamination of medications. During a review of the facility's policy and procedures, titled Labeling of Medication Containers, revised April 2025, indicated, All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations.1. Medications labels must be legible at all times.2. Any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy.3. Labels for individual resident medications include all necessary information, such as: a. The resident's name; b. The prescribing physician's name; c. name, address, telephone number of the of the issuing pharmacy; d. The name, strength, and quantity of the drug; e. The prescription number (if applicable); f. The date that the medication was dispensed; g. Appropriate accessory and cautionary statements; h. The expiration date when applicable; and i. Directions for use. During a review of the facility's policy and procedures, titled Storage of Medications, revised November 2025, indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner.3. The nursing staff is responsible for maintaining medication storage.8. Schedule 11-V controlled medications are stored in separately locked, permanently affixed compartments.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were implemented when: 1.Licensed Nurse (LN) 1 did not wear gown and gloves as indicated in Enhanced Barrier Precaution (EBP, an infection control intervention to reduce transmission of multi-drug-resistant organisms) guidance before entering the room and helped reposition Resident 9; 2. LN 3 took Resident 75's blood sugar and used disinfectant to clean the glucometers (hand-held devices that measure a person's blood glucose/sugar levels) that were not recommended by the manufacturer; Infection Preventionist (IP) B sanitized the glucometer using alcohol wipes before and after resident use; LN 3 stated she/he sanitized glucometer before and after resident use, using the alcohol wipes or the purple-top wipes (germicidal wipes); and, 3. Resident 48's nasal cannula was not stored in a bag. These failures had the potential to compromise resident's health and safety and potentially lead to the spread of communicable illnesses. Failure to sanitize glucometers with manufacturer's recommended disinfectants may damage the device and impair its performance. Findings: 1. During a review of the admission Record (AR) for Resident 9, the AR indicated Resident 9 and had been admitted to the facility on [DATE] with diagnoses including history of other infectious and parasitic diseases, and type 2 Diabetes (body cannot use insulin correctly and sugar builds up in the blood). During a review of Resident 9's Order Summary Report, (OSR) dated 6/3/26, the OSR indicated, Resident 9 had left calf pressure injury (happens on areas of the skin that are under pressure) and left knee multiple incision site monitored for signs and symptoms of infections. During a review of Resident 9's Care Plan, (CP) dated 3/5/26, the CP indicated, Resident 9 had a Mid/Low Risk Braden Scale score of 18 (clinical tool used to assess a patient's risk of developing pressure injuries). During a review of Resident 9's CP dated 5/11/26, the CP indicated Resident 9 had a left lower leg (calf) unstageable pressure injury as evaluated by the wound physician. During a concurrent observation and interview with LN 1 on 6/9/26 at 9 a.m., Resident 9's room had an EBP signage (guidance on what and how to properly wear the PPE) posted by the door and a bin that contained PPE supplies. LN 1 entered Resident's 9's room and did not wear gown and gloves. LN 1 proceeded with her task, touched Resident 9's pillow, touched Resident 9's left shoulder and assisted him to reposition on his bed. LN 1 did not sanitize her hands after assisting Resident 9. LN 1 confirmed Resident 9 is on EBP precautions and acknowledged that she did not wear gown and gloves while performing direct care to Resident 9. LN 1 acknowledged that she did not sanitize her hands after direct care and stated she should have practiced infection control to prevent the spread of infection to other residents. 2. During a review of the AR for Resident 75, the AR indicated, Resident 75 had been admitted to the facility on [DATE] with diagnoses including Bacteremia (presence of bacteria in the blood stream), and type 2 Diabetes. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 75's OSR dated 6/10/26, the OSR indicated, Resident 75 had an order for Blood Sugar Check per Finger Stick Q [every] AC [before meals] and HS [bedtime] During a concurrent observation and interview with LN 3 on 6/11/26 at 12 p.m., LN 3 used the facility's glucometer to check Resident 75's blood sugar level. LN 3 took out the wipes container [name of the wipes product] from her medication cart, pulled out one sheet, and cleaned the glucometer. LN 3 stated that she used the wipes (as she pointed out on the wipes container) all the time after utilizing the glucometer, and she did not know what the rest of the nursing staff used to clean the glucometer. During an interview with Director of Nursing (DON) on 6/12/26 at 1:26 p.m., the DON stated her expectations from the nursing staff were to promote infection control to prevent the spread of infection in the facility. The DON further stated that the EBP signage was posted by the resident's room to remind them to practice infection prevention and the bin contained with PPE for their use. The DON agreed that the facility did not use the manufacturer's recommendation to disinfect the glucometer and use other sanitizing wipes [name of sanitizing wipes] to clean the glucometer. During a review of the facility's policy and procedure titled, Enhanced Barrier Precaution, update 9/18/25, indicated, PURPOSE.To provide guidance and recommendations for implementing Enhanced Barrier Precautions (EBP) to include the use of glove and gown during high-contact care activities for residents with chronic wounds. in addition to residents who have an infection. During a review of the manufacturer's Healthcare Professional Operator's Manual (HPOM), the HPOM indicated, .NOTE: Only one disinfectant should be used on the device for the life of the device, as the effect of using more than one disinfectant interchangeably had not been evaluated. An EPA-registered disinfecting wipe such as [name of wipes]. The [name of wipes] disinfectant products have been shown to be safe in disinfecting the [name of the BSM] system. The facility was asked multiple times but failed to provide the facility's policy and procedure regarding disinfecting glucometer after use. 3. During a review of Resident 48's Face Sheet (FS-front page of the chart that contains a summary of basic information about the resident), the FS indicated Resident 48 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with exacerbation and acute respiratory failure with hypoxia (lungs suddenly stop working well enough to transfer oxygen causing low oxygen levels in the body). During a review of Resident 48's Order Summary Report (OSR), the OSR indicated, Resident 48 had an order for oxygen at 2 LPM (liters per minute-flow rate and volume of supplemental oxygen delivered per minute) via NC (nasal cannula-a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) PRN (given as needed or requested) to keep O2 sat (oxygen saturation-measurement of how much oxygen the blood is carrying as a percentage) above 90%. May titrate up to 5 L (liters) for SOB (shortness of breath)/wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs.) During a concurrent observation and interview on 6/9/26 at 9:09 a.m. with Licensed Nurse (LN) 1 in Resident 48's room, Resident 48's nasal cannula was resting on top of the oxygen concentrator and not in a bag. LN 1 confirmed that the nasal cannula was not stored in a bag and stated that it should be kept in a bag when not in use. (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Springs Road Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1527 Springs Rd 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.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/26 at 8:19 a.m. with Infection Preventionist A (IP-A), IP-A stated that the nasal cannula should be stored in a bag when not in use for infection control purposes to help prevent bacterial contamination. During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy)-Prevention of Infection, revised 11/25, the P&P indicated, .Infection Control Considerations Related to Oxygen Administration.8. Keep oxygen cannulae and tubing used PRN in a plastic bag when not in use.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop a communication/language barrier (an obstacle that prevents two or more people from understanding each other, that can lead to miscommunication) comprehensive care plan (CP- a personalized, written document that outlines how staff will manage a resident's medical, physical, and personal care needs daily) for one resident (Resident 6) out of 18 sampled residents, when there was no documented evidence of Resident 6's care plan addressing his preference to communicate in Spanish. This failure had the potential for miscommunication and misunderstanding when discussing medications, treatments, and care needs. Findings: A review of Resident 6's Face Sheet, indicated he was admitted to the facility on [DATE] and his preadmission document titled, [Resident initials] referral, uploaded to his chart on 5/6/26, indicated Resident 6 was Spanish speaking. During a concurrent observation and interview on 6/9/26 at 10:36 a.m., in the hallway outside of room [ROOM NUMBER], Resident 6 was greeted in English and asked if he could be interviewed. Resident 6 shook his head no and stated he speaks Spanish and understood little English. During an interview on 6/10/26 at 10:29 a.m. using a Spanish translator over the phone, Resident 6 stated he preferred to communicate with staff in Spanish. During an interview on 6/11/26 at 8:43 a.m., Licensed Nurse (LN) 5 stated accuracy of care plans (CPs) are important to understand the care and needs of each resident. During a concurrent interview and record review on 6/11/26 at 8:51 a.m., with the Director of Staff Development (DSD), Resident 6's care plan (CP) was reviewed. The DSD stated Resident 6's CP was important to be accurate since it outlined Resident 6's care and being inaccurate could lead to a negative outcome. The DSD stated he expected communication barriers, such as speaking different languages to be reflected on the resident's CP. The DSD confirmed no documented evidence of any care plan interventions relating to Resident 6's preference of communicating using Spanish language. During a concurrent interview, record review and observation on 6/11/26 at 9:03 a.m. with the Minimum Data Set Coordinator (MDSC- a licensed healthcare professional who oversees the clinical assessment process for facility residents), Resident 6's comprehensive CP, initiated 5/9/26, was reviewed. The MDSC talked to Resident 6 in his room, and Resident 6 stated in Spanish he preferred communication regarding medications and treatments to be in Spanish. The MDSC confirmed Resident 6's primary and preferred language was Spanish, that there was not a Spanish speaking/communication CP, and that there should be a comprehensive CP addressing the communication barrier and his preference for Spanish communications. During a concurrent interview and record review on 6/12/26 at 11:39 a.m. with the Admissions Coordinator (ADC), Resident 6's pre-admission document titled, [Resident initials] referral, that was uploaded to the resident's chart on 5/6/26, was reviewed. The ADC confirmed the document indicated Resident 6 was a Spanish speaker. A review of facility policy and procedure (P&P) titled, translation and/or Interpretation, revised 10/21/25, indicated, . Upon admission, staff shall assess and document each resident's preferred spoken and written language . Language needs shall be reviewed and updated as necessary and upon resident preference . A review of facility P&P titled, Resident participation-Assessment/Care Plans, revised December 2025, indicated, . The resident and his or her representative are encouraged to participate in the .development and implementation of the resident's care plan The care planning process will . Incorporate the resident's personal and cultural preferences .		

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NAME OF PROVIDER OR SUPPLIER Springs Road Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1527 Springs Rd Vallejo, CA 94591	
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure its medication error rate remained below five percent (5%) for two residents (Resident 25 and Resident 3) out of 18 sampled residents, when: Licensed Nurse (LN) 3 did not wear gloves when administering prescribed hazardous medication; and, LN 1 did not follow the physician's order when administering Resident 33's prescribed medications. These failures resulted in the facility's medication error rate of 6.45%, which had the potential for harm, worsening of existing conditions, or the development of new illnesses for Resident 25 and Resident 33. Findings: 1. During a medication administration observation on 6/9/26 at 8:45 a.m., in Resident 25's room LN 3 did not wear gloves when dispensing the medication into a cup, and administering Topiramate (primarily used to treat and prevent seizures [epilepsy] and to prevent migraine headaches) tablet 100 mg (milligram, unit of measure) to Resident 25. A review of Resident 25's Order Summary Report (OSR) dated 2/21/25, indicated, Topiramate Tablet 100 MG Give 1.5 tablet by mouth two times a day for seizure, must wear gloves when administering medication, and must wear gloves and mask if crushing medication. The Medication Administration Record, (MAR), dated 2/21/25, also indicated, Topiramate Tablet 100 MG Give 1.5 tablet by mouth two times a day for seizure, must wear gloves when administering medication. During an interview with LN 3 on 6/9/26 at 11:04 a.m., LN 3 acknowledged she did not wear gloves when she administered Topiramate tablet to Resident 25. She stated that she should have worn gloves because the medication is hazardous. During a phone interview on 6/12/26 at 1:13 p.m., with the Pharmacy Consultant (PC), the PC stated nurses should follow the doctor's order, and wear gloves when administering or dispensing Topiramate to Resident 25. The PC emphasized the importance of protecting themselves or possibly other residents, as this medication was classified as hazardous. The PC further stated, the nursing staff must know the drug action, and the precautionary measures of the medications they administer. 2. A review of Resident 33's OSR dated 5/10/26, indicated, Cosopt PF Ophthalmic Solution 2-0.5 % (Dorzolamide Hydrochloride and Timolol Maleate) instill 1 drop in both eyes two times a day for Glaucoma (caused by a buildup of fluid pressure inside the eye, which can lead to permanent vision loss or blindness). The MAR, dated 5/10/26 indicated, Cosopt PF Ophthalmic Solution 2-0.5 % (Dorzolamide Hydrochloride and Timolol Maleate) instill 1 drop in both eyes two times a day for Glaucoma. During a concurrent medication administration observation and interview on 6/11/26 at 9:39 a.m., inside Resident 33's room at bedside, LN 1 instilled one (1) drop of Dorzolamide Hydrochloride and Timolol Maleate Ophthalmic Solution (DHTMOS, a prescription used to lower high pressure in the eyes) to Resident 33's left eye. Afterward, LN 1 confirmed she instilled one eye drop of DHTMOS to Resident 33's left eye. When asked to recheck the DHTMOS label, LN 1 stated, she should have verified the medication against the physician's order before administering the eye drop. LN 1 acknowledged she should have instilled one eye drop to both left and right eye. During a phone interview on 6/12/26 at 1:13 p.m., with the PC, the PC stated nurses should follow the doctor's order and ensure they give the correct medication, dosage, route, time to the appropriate resident. During an interview on 6/12/26 at 1:26 p.m., with the Director of Nursing (DON), the DON stated that she expected the staff to follow the physician's order when administering prescribed medications. During a review of the facility's policy and procedures, titled Administering Medications (AM), revised April 2025, indicated, Medications are administered in a safe and timely manner, and as prescribed. 10. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		