STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Post Acute	1090 Rio Lane Sacramento, CA 95822

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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 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. Based on observation, interview and record review, the facility failed to store, handle, and prepare food in the facility kitchen in accordance with food standards when:Foods were not properly labeled with the use by or open dates;Proper hand hygiene was not followed by kitchen staff;Cold foods were not maintained at safe temperatures during food service and,Wet stainless steel pans were stacked before allowing to dry.These failures had the potential for residents to receive food outside the safe use by dates and for the spread of food borne illness in the kitchen to 42 residents receiving food from the kitchen service.1.During an observation on 6/14/26, at 8:08 a.m., in the kitchen freezer, frozen dessert puffs were in an open plastic bag with no open date or use by date.During an interview on 6/14/26, at 8:10 a.m, with Dietary Aid (DA 1), DA 1 stated he did not see a date on the frozen puff dessert, and it should have the date it was opened and a use by date on it.During an observation on 6/14/26, at 8:15 a.m., in the kitchen freezer, an opened bag of frozen peas was noted with no dates on the bag.During an interview on 6/14/26, at 8:15 a.m, with DA 1, DA 1 stated he did not see any dates on the bag of peas and they should be dated with the open and use by dates.During an interview on 6/14/26, at 8:26 a.m., with Certified Dietary Manager (CDM), CDM stated the staff label and date foods when they are received, and when the item is opened, they will put the open date and use by date.A review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage dated 2022 indicated, Foods shall be received and stored in a manner that complies with safe food handling practices.1. All foods stored in the refrigerator and freezer are covered, labeled and dated (use by date).2. During an observation on 6/15/26, at 10:18 a.m., in the kitchen. DA 2 was observed entering the kitchen and did not perform hand hygiene prior to beginning to work in the kitchen.During an observation on 6/15/26, at 10:35 a.m., in the kitchen, [NAME] 2 finished portioning the lunch item of coleslaw into serving containers while wearing gloves. [NAME] 2 removed the gloves and threw them into the trash can while touching the handle of the trash with bare hands, and was observed to return working with food without washing their hands.During an interview on 6/15/26, at 10:36 a.m., with [NAME] 2, [NAME] 2 stated, he should have washed his hands after removing the gloves and throwing them away.During an observation on 6/15/26, at 12:10 p.m., in the kitchen, DA 2 was observed returning to the kitchen after delivering a food cart to the nursing staff. DA 2 did not wash his hands upon entering the kitchen and was seen placing gloves on with dirty hands and returning to work with food.During an interview on 6/15/26, at 12:10 p.m., with CDM, CDM stated, DA 2 needed to wash his hands.A review of the facility's P&P titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices dated 2022 indicated, Food and nutrition service employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness.1. Employees must wash their hands.c. whenever entering or re-entering the kitchen.g. during food preparations, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.Gloves and Direct food contact .2 gloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed and gloves are replaced.3. During an observation on 6/15/26, at 11:59 a.m, the kitchen food service for lunch was observed. [NAME] 1 checked the temperature of the lunch item corn coleslaw' which read 41 degrees (continued on next page)

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	Fahrenheit (F) at the start of food service. The corn coleslaw were divided into singe serving plastic containers placed on a sheet tray on the kitchen counter, with no ice bath or cooling methods noted.During a concurrent observation and interview on 6/15/26, at 12:29 p.m., with CDM and Registered Dietician (RD) in the kitchen, the last tray plated was observed for a temperature check. The corn coleslaw was checked with a thermometer which was calibrated by [NAME] 1 prior to food service and noted to be 47F. The CDM and RD both stated they believe the high temperature is okay, because it was the proper temperature while it was in the refrigerator. A review of the facility's recipe titled, Corn Coleslaw indicated, Directions: .4>. Cover and refrigerate for 1 hour. Hold at less than 41 F until service. 5. Serve on trayline at the recommended temperature of 41F or less.4. During an observation on 6/15/26, at 10:34 a.m., in the kitchen, [NAME] 1 removed a stainless steel square pan from the shelf in the center of the kitchen and liquid was noted to drip consistently from the removed pan. On observation 3-4 other pans stacked underneath the first pan noted multiple wet pans stacked on the shelf.During an interview on 6/15/26, at 10:35 a.m., with [NAME] 1, [NAME] 1 stated the pans were still wet and they should be completely dry before stacking them.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of 17 sampled residents (Resident 41 and Resident 42) received treatment and services to prevent or minimize a decline in functional abilities when:1. The facility did not clarify Resident 41's physician order for Restorative Nursing Assistant (RNA- nursing aide program that helps residents to maintain their function and joint mobility) exercise program and did not communicate the physician order to RNA; and2. Resident 42's order for left hand splint did not include how many hours per day to be applied and it was not documented how long it was worn per day. These failures resulted in Resident 41 not receiving needed services for 8 months and had the potential to place the resident at risk for further functional decline and resulted in Resident 42's hand splint application to not be monitored for effectiveness or for any changes in application. 1. A review of the admission record indicated the facility admitted Resident 41 in 2025 with multiple diagnoses which included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and muscle weakness. A review of Resident 41's clinical record contained a physician's order dated 10/3/25 for occupational therapy (OT, type of therapy that helps people do everyday activities independently) evaluation and to transition Resident 41 to RNA services. The order indicated that it was completed on 10/3/25. In addition, the order did not contain clarification regarding specific interventions of which extremities and the frequency of the services Resident 41 was to receive. A review of Resident 41's annual Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 1/19/26 indicated that the resident scored 15 out of 15 on a Brief Interview for Mental Status, which indicated that he was cognitively intact. Section O of the MDS indicated that Resident 41 did not receive any therapy services and was not on Restorative Nursing Programs (RNA services). A review of the quarterly MDS assessment, Section O dated 4/21/26 indicated that Resident 41 did not receive any therapy services and was not on Restorative Nursing Programs (RNA services). A review of the undated care plan with the focus on activities of daily living (ADLs, activities done every day such as eating, personal hygiene, bathing, dressing, and toileting) indicated that Resident 41 required assistance with ADLs related to his clinical condition. The care plan goal indicated that the resident will not experience a decline in self care. One of the interventions indicated, Restorative Nursing as ordered. A review of Resident 41's 'At risk for falls and injuries' undated care plan indicated the following interventions, Refer resident to physical therapy and occupational therapy if indicated.Encourage resident to participate in activities that promote exercise and physical activity for strengthening and improved mobility. A review of Resident 41's clinical records indicated no documented evidence the resident had received RNA services since 10/3/25. During a concurrent observation and interview on 6/14/26 at 10:28 a.m., Resident 41 was observed in (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed. Resident 41 answered appropriately to all questions and was able to carry out a meaningful conversation. Resident 41 stated that he was too weak to get out of bed and did not receive therapy services for several months. Resident 41 stated it was upsetting to him that he was getting weaker and weaker. A review of Resident 41's clinical record contained a document titled, Occupational Therapy [OT] Evaluation and Plan of Treatment, dated 10/3/25. The OT documented that Resident 41 expressed wanting to maintain functional abilities. The OT documented that Resident 41 had good potential for achieving rehabilitation (therapy given to restore an individual back to their highest possible level of physical well-being). The OT evaluation indicated, Focus of Plan of Treatment=Skilled therapy.Patient able to increase/improve functional status with increased participation. RNA program re-established. During an interview with Certified Nursing Assistant (CNA 3) on 6/16/26 at 4:25 p.m., CNA 3 described Resident 41 as alert, oriented and able to verbalize his needs. CNA 3 was not able to recall if Resident 41 was on RNA services recently. During an interview and record review on 6/17/26 at 12:25 p.m., the Director of Rehab (DOR) stated that it has been a while since Resident 41 had therapy. The DOR stated that Resident 41 had an OT evaluation on 10/3/25 and was transitioned to RNA services. The DOR stated that the referral for RNA services was placed on 10/3/25 and Resident 41 should have been receiving RNA services since 10/6/25 until present. During an interview on 6/17/26 at12:30 p.m., with Restorative Nursing Assistant (RNA 1), RNA 1 was asked how the RNA referrals and orders were communicated to RNAs when the residents were transitioned from OT to RNA services. RNA 1 explained that therapist would communicate the physician order and referral to Director of Staff Development (DSD) who would place an order into resident's clinical record and notify RNA of resident's referral. RNA 1 stated that Resident 41 had not been receiving RNA services for several months. RNA 1 stated that she was not aware if Resident 41's clinical record contained any order for RNA services. During an interview and record review on 6/17/26 at 1:37 p.m., the DSD stated stated RNA program was guided by therapy department and the DSD was overseeing it. The DSD explained the process, I get referral from therapy from Director of Rehab.I put RNA orders in [resident's clinical chart] and put [RNA referral] into task in resident's clinical records. The DSD stated, I don't remember if he [Resident 41] is receiving RNA services. Upon reviewing Resident 41's clinical record, the DSD stated that he was unable to find any orders for RNA services. The DSD reviewed 10/3/25 order to transition Resident 41 to RNA services and stated, It shows that it was completed the same day, 10/3/25. It did not populate. The DSD stated that the order for RNA was not clear and added that it did not contain specific resident's needs what to do and how often [RNA services] were to be offered, whatever the goal was for the resident. The DSD stated the order should have been clarified with physician, but it was not done and Resident 41 did not receive needed services since 10/3/25. A review of the facility's policy and procedure (P&P) titled, Restorative Nursing Services, revised 7/2017, indicated, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. The P&P indicated that residents would receive restorative nursing program at any time during their stay and the resident should be included in determining restorative goals. During an interview with Director of Nursing (DON) on 6/17/26 at 1:35 p.m., the DON was informed that Resident 41 had not received the ordered RNA services for approximately 8 months. The DON (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acknowledged the concern and stated that the resident should have been receiving the restorative program in accordance with the physician orders and care plan. The DON acknowledged that failure to provide the RNA services could have placed the resident at risk for functional decline. 2. A review of Resident 42's admission Record indicated Resident 42 was admitted to the facility in May 2013 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke- disrupted blood flow to the brain causing brain cell death), contracture (tightening of muscles, tendons, and tissues that causes the joints to shorten and become stiff) of left hand, osteoarthritis (arthritis caused by cartilage on the ends of the bones that wears down), and diabetes (too much sugar in the blood). A review of Resident 42's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 5/26/26, indicated Resident 42 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 13 out of 15 that indicated Resident 42 was cognitively intact. A review of Resident 42's physician order, dated 4/11/25, indicated .Restorative Nursing Program-Splint to SPECIFY (Left wrist/hand) every day as tolerated. every day shift . A review of Resident 42's Task: NURSING REHAB RNA PROGRAM: Assistance with Splint left wrist/hand as tolerated, for 5/18/26 to 6/16/26, indicated Amount of minutes spent providing splint or brace assistance was 2 minutes per day for 25 days and was not applied on 2 days. The Task did not indicate how long the splint was worn each day. A review of Resident 42's RNA Weekly Summary, dated 6/14/26, indicated .How many times this week was the resident seen by RNA for Splint or Brace application? 7 days . A review of Resident 42's Care Plan, dated 9/12/22 .Restorative Nursing Program: SPECIFY PROM [Passive Range of Motion], Splint /Brace Assistance To Address: . Potential for decline in range of motion, self-feeding skills .Interventions .Restorative Nursing Program- Splint/Brace Assistance: Palm Protector .Apply Left hand protector to be worn by the resident 7 days/week for minimum of 4 hrs [hours] or as tolerated for contracture management and to prevent nails from digging into the palm . During an observation and interview on 6/15/26 at 1:35 p.m. with Resident 42, observed that Resident 42 was not wearing left hand splint. When asked if staff applied the left hand splint today, Resident 42 did not state splint had been applied. During an observation on 6/16/26 at 9:01 a.m. of Resident 42, Resident 42 was asleep. Observed Resident 42 was not wearing left hand splint. During a concurrent interview and record review on 6/16/26 at 9:03 a.m. with Licensed Nurse (LN 3), LN 3 stated Resident 42 has left hand splint ordered and is usually on every day. Reviewed Resident 42's order for the left hand splint and LN 3 acknowledged the order did not indicate how long the splint is to be worn daily. During a concurrent interview and record review on 6/16/26 at 9:09 a.m. with the Director of Rehab (DOR), the DOR stated the referral for Resident 42's left hand splint was put in by the Occupational Therapist (OT), but the Director of Staff Development (DSD) puts in the actual order. The DOR stated the splint is put on by the RNAs and is to be worn throughout the day and removed at bedtime. The (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DOR stated there is no timeframe for the length of time splint is to be worn. Reviewed with the DOR Resident 42's order for left hand splint. The DOR acknowledged the order does not indicate when the splint should be applied, should be removed, or how long it should be worn daily. The DOR stated the order should be adjusted. During a concurrent interview and record on 6/16/26 at 9:24 a.m. with RNA 1 and RNA 2, RNA 1 stated Resident 42's left hand splint is applied by the RNAs and is supposed to be worn 6 to 8 hours per day but has not been applied today. Reviewed with RNA 1 and RNA 2 Resident 42's order for left hand splint and they acknowledged the order did not reflect when it was to be applied or how long it was to be worn. RNA 1 stated the order should indicate how long the splint should be worn [NAME]. RNA 2 stated they do not document in the Task section of the electronic chart when the splint was applied, when it was removed, or how long it was worn. During a concurrent interview and record review on 6/16/26 at 9:31 a.m. with the Director of Staff Development (DSD), the DSD stated he puts RNA orders in the system after he receives the referral from the therapy department. Reviewed Resident 42's order for left hand splint. The DSD acknowledged the order did not indicate how long the splint is to be worn daily. The DSD stated the order is not specific enough. Reviewed the Task section of the electronic chart that did not indicate when splint was applied or removed. The DSD stated it needs to indicate the time of application and the time of removal of the splint. The DSD stated that if there is no documentation as to length of time worn unable to determine if splint is effective or not. A review of the facility's Policy and Procedure (P&P) titled Resident Mobility and Range of Motion, revised 7/17, indicated .Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in mobility .the nurse will also identify conditions that place the resident at risk for complications related to ROM and mobility including . contractures .The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion .The care plan will include the type, frequency and duration of interventions, as well as measurable goals and objectives .Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs . A review of the facility's P&P titled Restorative Nursing Services, revised 7/17, indicated .Residents will receive restorative nursing care as needed to help promote optimal safety and independence .Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative care .Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care .Restorative goals may include .Adjusting or adapting to changing abilities .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medication error rates are not 5 percent of greater when the medication error rate was 15.38 % for four medication errors out of 26 opportunities observed during a medication pass for four of seven residents (Resident 73, Resident 13, Resident 17, and Resident 8):1. Resident 73 was not given Omeprazole (medication to treat acid in the stomach) 30 minutes prior to meal, and2. Resident 8 was not given Omeprazole 30 minutes prior to meal, and3. Resident 17 was given Metoprolol (medication to treat high blood pressure) without checking blood pressure prior to administration, and4. Resident 13's Clopidogrel (medication that prevents clots) was not given on time.This failure resulted in medications not given in accordance with the prescriber's orders and had potential to adversely affect the residents' clinical conditions.1.During an observation of medication pass on 6/15/26 at 7:34 a.m., Licensed Nurse (LN 3) was observed to prepare Resident 73's morning medications for administration. LN 3 was observed administering Omeprazole Oral Tablet Delayed Release 20MG (milligrams) -2 tablets to Resident 73 at 7:54 a.m. A review of Resident 73's order, dated 6/15/26, indicated Omeprazole Oral Tablet Delayed Release 20MG . Give 2 tablet by mouth one time a day for gastric acid reduction Give at least 30 min (minutes) prior to meal on an empty stomach. During an interview on 6/15/26 at 7:54 a.m. with LN 3, LN 3 stated the medication was due to be given at 7 a.m. LN 3 stated breakfast is delivered at 6:45 a.m. LN 3 stated Resident 73 had already eaten breakfast when he administered the omeprazole, and it was not given on an empty stomach per the prescriber's orders. LN 3 stated the omeprazole should have been given earlier. LN 3 stated his choices were to not give it or give it on a full stomach. LN 3 stated he chose to give it on a full stomach. During an interview on 6/15/26 at 4:20 p.m. with the Director of Nursing (DON), reviewed medication pass observation for Resident 73 omeprazole not being administered 30 minutes before a meal on an empty stomach per prescriber's order. The DON acknowledged that the medication was not given per the prescriber's order and the expectation is that medications will be given according to the prescriber's order. The DON stated may need to clarify the order with the physician and change the order. 2. During an observation of medication pass on 6/15/26 at 8:02 a.m., LN 3 was observed to prepare Resident 8's morning medications for administration. LN 3 administered Omeprazole DR (delayed release) 20 MG -1 capsule to Resident 8 at 8;07 a.m. A review of Resident 8's order, dated 5/30/26, indicated Omeprazole DR 20 MG Cap [capsules] Give 1 capsule by mouth two times a day for Gastro-esophageal reflux disease [GERD-stomach acid flows back up into the esophagus] . (Give 30 mins prior to morning and evening meal on an empty stomach). During an interview on 6/15/26 at 8:07 a.m. with LN 3, LN 3 stated the medication was due at 7 a.m. LN 3 stated he was late administering the omeprazole. LN 3 stated Resident 8 had already eaten breakfast. LN 3 stated Resident 8 did not receive the omeprazole 30 minutes prior to the morning meal on an empty stomach per the prescriber's orders. During an interview on 6/15/26 at 4:20 p.m. with the DON, reviewed observation of omeprazole for Resident 8 not being administered 30 minutes before a meal on an empty stomach per prescriber's order during medication pass observation. The DON acknowledged that the medication was not given per the prescriber's order and the expectation is that medications will be given according to the prescriber's order. The DON stated may need to clarify the order with the physician and change the order. 3. During an observation of medication pass on 6/15/26 at 8:29 a.m., LN 3 was observed to prepare Resident 17's morning medications for administration. LN 3 checked Resident 8's apical heart rate and administered Metoprolol Succinate ER (extended release) 24 hour 25 MG oral tablets- 0.5 tablet to Resident 17 at 8:32 a.m. LN 3 did not check Resident 8's blood pressure prior to administering the medication. A review of Resident 17's order, dated 3/10/26, indicated Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG . Give 0.5 tablet by mouth one time a day for Hypertension Hold if systolic [upper number in a blood pressure reading] is less than 100 HR [Heart Rate] less than 60. Do not crush or chew. A review on Resident 17's Blood Pressure Summary, for 6/15/26, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident 8's blood pressure was 156/74 at 6:36 a.m. During an interview on 6/15/26 at 8:36 a.m. with LN 3, LN 3 stated Resident 8's heart rate was 62. LN 3 stated Resident 8's blood pressure was taken at 6:40 a.m. and was 156/74. Reviewed Resident 8's medication order that indicated medication to be held if systolic was less than 100. LN 3 stated he did not check Resident 8's blood pressure prior to administering the medication. LN 3 stated he should have taken the blood pressure again to obtain a current blood pressure reading prior to administering the medication. LN 3 stated the blood pressure should be taken at the time the medication is given. During an interview on 6/15/26 at 4:20 p.m. with the DON, the DON stated if a medication has hold parameters for blood pressure, the blood pressure should be taken at the time the medication is given. 4. During an observation of medication pass on 6/15/26 at 8:51 a.m., LN 3 was observed to prepare Resident 13's morning medications for administration which did not include Clopidogrel Bisulfate Oral Tablet 75 MG- 1 tablet. LN 3 administered rest of morning medications to Resident 13 at 8:51 a.m. except clopidogrel. A review of Resident 13's order, dated 3/19/26, indicated Clopidogrel Bisulfate Oral Tablet 75 MG . Give 1 tablet by mouth one time a day for Thromboembolus Prophylaxis [prevention of clots]. During an interview on 6/15/26 at 8:51 a.m. with LN 3, LN 3 stated Resident 13's clopidogrel was due to be given at 8 a.m. but was not available in the medication cart to be given. LN 3 stated it was ordered three days ago and may have been delivered but was not placed in the medication cart. LN 3 stated he will need to find out if the medication had been delivered. LN 3 stated if available it will be given late. A review of Resident 13's Medication Administration Record (MAR), for 6/1/26 to 6/30/26, indicated Resident 13's clopidogrel was given at 9:36 a.m. on 6/15/26. During an interview on 6/15/26 at 4:20 p.m. with the DON, the DON stated that Resident 13's clopidogrel was placed in the wrong medication cart when it was delivered. Reviewed that Resident 13's medication was due at 8 a.m. but was not given until after 9 a.m. The DON acknowledged that the medication was administered late. A review of the facility's Policy and Procedure (P&P) titled Administering Medications, revised 4/19, indicated .Medications are to be prescribed in a safe and timely manner, and as prescribed .Obtain and record vital signs, when applicable or per physician's orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters .Ensure that the six rights of medication administration are followed .Right time . Right documentation .Review MAR to identify medications to be administered .Compare medication sources .with MAR to verify resident name, form, dose, route, and time .Administer within 60 minutes prior to or after scheduled time .Administer medications as ordered in accordance with manufacturer specifications .Provide appropriate amount of food and fluid .Sign MAR after administered. For those medications requiring vital signs, record vital signs .Correct any discrepancies and report to nurse manager .

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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 infection control precautions were followed for two of seventeen sampled residents (Resident 30 and Resident 46) when: 1.Enhanced Barrier Precautions (EBP-an infection control intervention to reduce transmission of [NAME]-drug resistant organisms, MDROs) were not followed for Resident 30 when enteral tube feeding formula (nutrition delivered directly into stomach) was administered without proper PPE (personal protective equipment- supplies such as gowns and gloves used to minimize exposure to infectious organisms), and 2. Contact Precautions (infection control measures used in healthcare settings to prevent the spread of diseases transmitted through direct or indirect contact, requiring gown and glove use before entering the room regardless of care or contact provided to resident) were not implemented timely for Resident 46 after his positive results for a wound infection were received by the facility. These failures increased the risk of spread of infection to other residents. 1.A review of Resident 30's admission Record indicated Resident 30 was initially admitted to the facility in August 2022 with multiple diagnoses including Parkinsons (movement disorder of the nervous system), neurocognitive disorder with Lewy bodies (a progressive dementia that leads to decline in thinking, reasoning, and independent function), carrier of carbapenem-resistant enterobacterales (bacteria resistant to antibiotic carbapenem making infections difficult to treat), and gastrostomy (G tube-surgical opening through the skin of the abdomen to the stomach to insert a tube in order to deliver nutrition directly into the stomach). A review of Resident 30's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 5/13/26, indicated Resident 30 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 6 out of 15 that indicated Resident 30 had severe cognitive impairment. A review of Resident 30's physician order dated 2/6/26, indicated . (EBP) Enhanced Barrier Precautions to reduce MDRO transmission due to increased risk of MDRO . A review of Resident 30's Care Plan, dated 8/26/25, .The resident is on (ESP) Enhanced Standard Precautions to reduce MDRO transmission due to increased risk of MDRO transmission r/t [related to] CARRIER OF CARBAPENEM-RESISTANT ENTEROBACTERALES .Interventions .Enhanced Barrier Precautions require the use of gown and gloves only for high contact resident care activities .Follow Enhanced Barrier Precautions (gloves/gown) during high-contact care activities .Place a sign for (EBP) near the entrance of the room . During an observation on 6/14/16 at 8:49 a.m. of Resident 30's room, observed EBP sign at door and PPE, including gowns and gloves, hanging on the door. During a concurrent observation and interview on 6/15/26 at 7 a.m. with Licensed Nurse (LN 3), observed LN 3 administering tube feeding formula through Resident 30's G tube. Observed LN 3 wearing gloves but was not wearing a gown. LN 3 stated Resident 30 is on Enhanced Barrier Precautions because he has a G tube. LN 3 acknowledged he was wearing gloves but was not wearing a gown when he administered the tube feeding. LN 3 stated he should have been wearing a gown when he administered Resident 30's tube feeding. During an interview on 6/16/26 at 9:44 a.m. with LN 5, LN 5 stated residents are placed EBP based on their diagnosis. LN 5 stated an orange EBP sign is placed outside the room to indicate EBP. LN 5 stated the sign tells the staff what precautions needed to be taken to care for resident and if (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. Building B. Wing	06/17/2026

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Cedarwood Post Acute	1090 Rio Lane Sacramento, CA 95822

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	providing direct patient care needed to wear gloves and gown. LN 5 stated if EBP not followed there could be possible contamination to other residents and staff. During an interview on 6/16/26 at 11:23 a.m. with the Infection Preventionist (IP), the IP stated if resident is on EBP should be sign at the door and PPE should be put on prior to providing direct care. A review of the facility's Policy and Procedure (P&P) titled Enhanced Barrier Precautions, revised 12/24, indicated .Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug resistant organisms (MDROs) during high contact resident activities .Indwelling medical devices include .feeding tubes .EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply .Gloves and gown are applied prior to performing the high contact resident care activity .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .device care or use (.feeding tube .) .Enhanced barrier precautions are in place for the duration of the resident's stay or until .discontinuation of the indwelling medical device .Staff are trained prior to caring for residents on EBPs . 2. During an observation on 6/14/26, at 10:32 a.m., outside Resident 46's room, an isolation precaution sign read Enhanced Barrier Precautions. A review of Resident 46's Wound Culture results, dated 6/9/26 indicated, Resident 46's wound was positive for Methicillin Resistant Staphylococcus Aureus (MRSA: type of staph bacteria that is highly resistant to many common antibiotics, making it significantly harder to treat than ordinary staph infections). The results indicated Resident 46's Provider signed the document on 6/9/26 indicating they were aware of the results on 6/9/26. During an interview on interview on 6/16/26, at 9:58 a.m., with Director of Nursing (DON), DON stated the facility was aware of Resident 46's wound being infected with MRSA on 6/9/26. DON stated, a resident who has MRSA needs to be on contact precautions, not enhanced barrier precautions, and the contact precaution was not ordered until 6/14/26 at 2300 (11p.m.). A review of Resident 46's Order summary report dated 6/14/26, indicated contact precautions were not started until 6/14/26.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to promote a dignified environment that maintained resident's dignity and privacy for one of 17 sampled residents (Resident 79), when Resident 79's urinary catheter tubing and bag (tubing which allows urine to drain from the bladder into a collection bag) was not placed in a privacy bag and its contents exposed while the resident was ambulated through the hallway.This failure violated Resident 79's rights to privacy and had the potential to compromise the resident's dignity and self worth.A review of the admission record indicated the facility admitted Resident 79 in the summer of 2026 following hospitalization for left knee joint infection.A review of Resident 79's physician's orders indicated an order dated 6/12/26 for foley catheter (a soft flexible tube inserted into a bladder to continuously drain urine) for wound management.During a concurrent observation and interview on 6/14/26 at 1:14 p.m., a urinary catheter bag was observed attached to Resident 79's bed frame. Resident 79 explained that she has been having lots of pain in her knee and it was difficult for her to turn self in bed, so the doctor ordered a catheter.During an observation on 6/15/26 at 11:48 a.m., two therapy staff were ambulating Resident 79 in the hallway. Another staff was walking behind Resident 79 pushing a wheelchair with catheter bag attached to the right side of wheelchair. The uncovered bag was half-filled with urine and was not placed in a privacy bag and not covered from public view. At the time of the observation, a visitor had entered the facility and was standing in the hallway for several minutes with an unobstructed view of Resident 79 and the exposed urinary drainage bag.During an observation and concurrent interview on 6/15/26 at 11:57 a.m., Licensed Nurse (LN 1) validated that catheter bag was uncovered and visible to residents, staff and a visitor who was standing in the hallway. LN 1 stated, Catheter should be in privacy bag. It's a dignity issue.During an interview with the Director of Nursing (DON) on 6/17/26 at 1:35 p.m., when DON was asked about the exposed catheter bag, the DON stated, Exposed catheter is a dignity issue whether it's in her room or in the public. The DON stated that staff should cover the urinary bag for privacy and dignity.A review of the undated facility's policy and procedure (P&P) titled, Dignity, indicated, Residents are treated with dignity and respect at all times .Each resident is cared for in a manner that promotes and enhances individuality, a sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated that staff is expected to promote dignity and protect resident's privacy during assistance with care and during treatment procedures.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately code the skin condition section of the Minimum Data Set (MDS, a standardized assessment and care screening tool) for one of 17 sampled residents (Resident 41), when the MDS did not accurately reflect Resident 41's documented chronic neck wound and right lower extremity venous stasis ulcer (an open sore that develops because blood does not flow properly through the vein). This failure resulted in MDS assessment not accurately representing Resident 41's clinical condition and had the potential to affect care planning for the appropriate care needs. A review of the admission record indicated the facility admitted Resident 41 in 2025 with multiple diagnoses which included chronic peripheral venous insufficiency (when the leg veins (blood vessels) did not work properly, making it difficult for blood to return to the heart from legs, causing increased vein pressure and venous ulcers).A review of Resident 41's annual MDS assessment dated [DATE], indicated the resident was cognitively intact. The skin condition section of the MDS assessment indicated Resident 41 had no venous or arterial ulcers present and did not have any other skin issues, including open wounds.A review of Resident 41's physician's orders dated 1/3/26 indicated the following:Treatment to right leg venous stasis every day. The order indicated, Cleanse.Pat dry, apply calcium alginate [a natural seaweed derived fiber used in wound care], cover with bordered dressing. The order directed nursing staff to notify physician if Resident 41's wound gets worse or if the resident develops signs and symptoms of wound infection. Treatment to right neck, unknown etiology (cause of condition). The order indicated, Clean.Pat dry.Cover with Duoderm [a special type of dressing] every.2 days. The physician directed nursing to notify if Resident 41's wound gets worse or if the resident develops signs and symptoms of wound infection.A review of Resident 41's Treatment Administration Records (TARs) for January 2026 indicated that he received wound treatments to his right neck every other day and to left leg every day as directed by physician.During am observation and interview on 6/14/26 at 10;28 a.m., Resident 41 was observed lying in his bed with both lower legs elevated on pillows. Resident 41's left leg below knee was wrapped in kerlix. Resident 41 stated that he had issues with chronic wound to his left leg and another wound on his posterior neck upon admission and the wounds were not healing well.During a concurrent interview and record review on 6/17/26 at 11:56 a.m., the Regional MDS Consultant (RMDSC) explained that any open skin areas or wounds should be coded in Section M of the MDS assessment. The RMDSC stated that the MDS should accurately capture the resident's clinical condition during the 14 days look-back period and that existing wounds should be reflected in the MDS assessment if any were present during that timeframe.During continued interview and record review on 6/17/26 at 11:56 a.m., Resident 41's MDS assessment dated [DATE] was discussed with the RMDSC. The RMDSC reviewed section M of the MDS dated [DATE] addressing skin conditions for Resident 41 and validated that it was coded as zero, which indicated that the resident did not have skin issues, including open wounds or venous ulcers at that time. During a further review the RMDSC reviewed Resident 41's clinical records, including physician treatment orders dated 1/3/26 for neck and left leg venous ulcers and physician progress notes for 1/13 and 1/16/26 and stated the MDS was not accurate and was coded incorrectly. The RMDSC added that Resident 41's skin issues should have been captured when the MDS was completed and should not have been coded as ?0.'A review of the facility's policy and procedure (P & P) titled MDS Assessment Coordinator, revised 11/2019 indicated, A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (MDS). Each individual who completes a portion of the assessment MDS must certify the accuracy of that portion of the assessment. Any individual who willfully and knowingly certifies in material and false statement in the resident assessment is subject to disciplinary action and such incident must be promptly reported to the Administrator.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the residents received adequate supervision to prevent fall accidents and residents' environment remained free of accident hazards for two of 17 sampled residents (Resident 53 and Resident 76) when:The facility did not implement resident specific interventions to provide adequate supervision and safety for Resident 53 after the resident experienced fall with head contusion, and The facility failed to ensure Resident 76's (a non-verbal resident, dependent with care and unable to reposition self in bed or use call light) room was free from hazards when her call light string was observed on the back of her neck and pinned to her pillowcase.These failures resulted in Resident 53 experiencing another fall where she sustained cephalohematoma (blood-filled bump on the right side of her head), large skin tear on her right hand/wrist area, broken bone near the knuckle of the index finger to her right hand and had the potential for Resident 76 to sustain injuries from a string wrapped around the back of her neck and unable to reposition herself or call for help. 1. A review of the admission record indicated the facility admitted Resident 53 early 2026 with multiple diagnoses which included encephalopathy (a condition characterized by brain malfunction resulting in mental changes and confusion) and muscle weakness. A review of Resident 53's admission fall risk assessment dated [DATE] indicated the resident was at risk for falls. A review of Resident 53's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 3/19/26, indicated Resident 53 had moderate cognitive impairment. The MDS assessment indicated Resident 53 required assistance with activities of daily living (ADLs, activities done every day such as eating, personal hygiene, bathing, dressing, and toileting). A review of the comprehensive care plan (a guide that provides the direction on the type of needs the individual required) initiated 3/15/26 indicated Resident 53 was identified at risk for falls and injuries related to her underlying diagnoses, including encephalopathy. The interventions included anticipating and meeting resident's needs, encouraging resident to request assistance with transfers and ambulation, and monitoring for medications' side effects that may increase Resident 53's risk for falls. The care plan did not include interventions for Resident 53's oversight, necessary supervision, and monitoring to mitigate the resident's fall risks. A review of Resident 53's nursing progress note (NPN) dated 4/19/26 at 1:47 p.m., indicated that Resident 53's roommate informed nursing staff that the resident had a fall. LN 6 documented, .Noted that Pt [Resident 53] was on the floor. Roommate notified, Pt slipped from the w/c [wheelchair] .and since w/c was unlocked it was moved back and Pt hit the floor.Bump noted on the back of head. LN 6 documented that Resident 53 complained little discomfort on bump side and was transferred to hospital for further evaluation. A review of Resident 53's fall risk assessment completed post-fall on 4/19/265 indicated that the resident was identified at high risk for falls. Resident 53's at risk care plan was revised and a new intervention for 'lock the wheels of wheelchair' was added. There was no documented evidence that new interventions addressing Resident 53's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision and monitoring was added to 'at risk for falls care plan.' A review of the post fall evaluation by Interdisciplinary team (IDT, a group of professional disciplines that discuss resident plan of care and care needs) dated 4/20/26 indicated that Resident 53's risk factors for falls were reviewed by the IDT. The IDT document indicated, New Fall Intervention Implemented: TRANSFER TO ACUTE. Always lock the W/C [wheelchair]. The IDT evaluation did not list any new recommendations intended to prevent future falls for Resident 53. There was no documented evidence that IDT evaluated Resident 53's medications associated with increasing Resident 53's risk for falls as documented in the resident's 'At risk for falls' care plan. A review of Resident 53's NPN dated 5/7/26 at 1:30 a.m., indicated, At aprox [approximately] 0130, a loud bang was noted by staff. LN arrived to the room and noted patient [Resident 53] lying prone [face down] wedged in between bed and dresser. Upon assessment, significant bleeding was noted from dorsal [back] R [right] hand with a significant skin tear.Upon further assessment, patient was noted with a bump to R aspect of forehead in addition to small skin tear to R elbow. The NPN indicated that Resident 53 had uncontrolled bleeding from the injury to her right hand and the resident was sent to the hospital. A review of the post fall evaluation by IDT dated 5/8/26 did not indicate that the IDT identified a root cause for Resident 53's fall and New Fall Prevention Intervention Implemented documented on IDT evaluation indicated Send to ER. Resident 53's at risk for falls care plan was not revised and no new interventions to ensure the resident's safety were identified and documented. There was no documented evidence that IDT evaluated Resident 53's medications associated with increasing Resident 53's risk for falls as documented in the resident's 'At risk for falls' care plan. A review of Resident 53's clinical record contained a hospital record titled, TRAUMA DISCHARGE SUMMARY [TDS] dated 5/7/26. The document indicated that Resident 53 was admitted on [DATE] status post ground level fall where she suffered an open right hand metacarpal [palm bones] neck fracture with associated skin defect on the right dorsal [back] hand, and sustained cephalohematoma [collection of blood within the skull] to right side of the head. According to hospital record, Resident 53's wound to the back of her hand was cleaned and approximated [edges of the wound were brought together]. A review of physician progress note dated 5/9/26 indicated that Resident 53 sustained a contusion (a bruise/injury caused from impact that damages blood vessels under the skin) to her right forehead and laceration of her hand. The physician further documented, Patient underwent suturing of.portion of right hand. A review of Resident 53's clinical record contained an 'After visit summary' dated 5/19/26 which indicated that the resident was seen by orthopedic (doctor specializing in treating fractures) and a cast (hard protective shell placed around a broken bone to keep it from moving until it heals) was placed on his right-hand bone fracture. A review of Resident 53's clinical records did not contain any documented evidence that the resident's risk for falls assessment was completed after her fall on 5/7/26. During a concurrent observation and interview on 6/14/26 at 12:58 p.m., a fall floor mat (a soft cushioned mat to help reduce the injuries if the residents falls) was observed on the floor next to Resident 53's bed. Resident 53 was observed sitting in wheelchair in her room eating lunch. Resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	53's had a cast on her right hand/wrist wrapped in green ACE wrap. Resident 53 responded to all questions appropriately and explained, I fell at night.my head got wedged between bed and nightstand. Took all the skin off, it was like flapped. At ED [emergency department] they put something to glue it together.I also fractured fingers bone.Now I have this, pointed to her right wrist [cast]. Resident 53 stated that she needed to use a bathroom, and nobody was there to assist her and when she attempted to get up by herself, she slipped on the mat on the floor and fell. During an interview on 6/15/26 at 4:45 p.m., a Certified Nursing Assistant 1 (CNA 1) stated Resident 53 was alert with periods of forgetfulness. CNA 1 stated that Resident 53 required to have assistance with getting out of bed and ambulation when she needed to use the bathroom. CNA 1 stated, Occasionally she [Resident 53[would use the call light to call for help, other times her roommate calls when she sees that resident attempt to get up from wheelchair and walk to the bathroom. During an interview on 6/16/26 at 8:35 a.m., CNA 2 stated that Resident 53's balance was not stable when ambulating, and the resident required staff's assistance. CNA 2 added, She is forgetful.She attempts to stand up and walk by herself.needs frequent checking on her. During an interview on 6/16/26 at 8:43 a.m., LN 2 stated that Resident 53 was at high risk for falls due to her unstable balance, confusion and forgetfulness. LN 2 stated that staff should be rounding on Resident 53 every one to two hours to check for any needs and reminding the resident to call for assistance. A review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated 3/2018 indicated, Based on Previous evaluations and current data, the staff will identify interventions related to the residents specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The stuff. will implement a resident- centered fall prevention plan to reduce the specific risk factor (s) of falls for each resident at risk or with a history of falls. If falls recurs. staff will implement additional or different interventions. The staff will monitor and document each resident's response to interventions intended to reduce falling or their risks of falling. During an interview on 6/16/26 at 8:51 a.m., with Director of Nursing (DON), the DON explained that each resident was assessed for fall risks upon admission to see the resident's baseline and the level of assistance resident required. The DON further stated that after the assessment, the comprehensive care plan addressing resident's needs with interventions was developed. The DON was asked how IDT addressed residents' safety and he stated, We discuss falls during IDT meetings to address root cause of falls and recommend interventions to ensure resident's safety. During a continued interview and record review with DON on 6/16/26 at 8:51 a.m., the DON stated that Resident 53 had two falls since her admission. The DON stated that post fall IDT evaluation dated 4/20/26 included a recommendation to educate Resident [53] to make sure the wheelchair is locked before attempting to get up. The DON stated the IDT did not identify any other interventions to prevent or minimize Resident 53's falls. The DON confirmed that the post fall IDT dated 5/8/26 did not include any recommendations to ensure Resident 53's safety. The DON stated that post fall risk assessment for Resident 53 was not completed and there was no care plan addressing 5/8/26 fall and fracture. A review of the facility's P&P titled, Interdisciplinary Team Meeting, indicated, It is the policy of this facility to develop and maintain comprehensive, person-centered care plans through an interdisciplinary team (IDT) process. to ensure resident care is coordinated, individualized, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsive to changes in condition, needs. Comprehensive, person- centered care plans are based on resident assessments and developed by an interdisciplinary team. A review of the facility's P&P titled, Safety and Supervision of Residents, dated 7/2017 indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 2. A review of Resident 76's Facesheet indicated, Resident 76 had the following diagnoses: Nontraumatic intracerebral hemorrhage (bleeding directly into the brain tissue without any preceding physical trauma), Hypertension (high blood pressure), Hemiplegia affecting right side (severe or complete paralysis of one entire side of the body (left or right), caused by injury to the brain or spinal cord), hemiplegia of the left side, quadriplegia (paralysis affecting all four limbs, both arms and both legs, as well as the torso), and altered mental status. During an observation on 6/16/26, at 9 a.m., in Resident 76's room, Resident 76 was observed lying in bed, not able to respond or speak out loud. Resident 76 was observed to be visibly upset moving her head to the left and right repeatedly and was noted to be unable to move the rest of her body. Resident 76's hands were placed in supportive braces to keep her palms open to prevent deformities. Resident 76's call light device was noted to be a string attached to the wall and pinned with a metal clip onto Resident 76's pillow on her left side. The call light string was noted to be laying around the back of Resident 76's neck under her. During a concurrent observation and interview on 6/16/26, at 9:08 a.m., in Resident 76's room with Treatment Nurse (TN), Resident 76's call light was noted laying around the back of her neck and clipped onto the left side of her pillow. The TN stated the call light string location was a hazard for Resident 76 and removed the clip from her pillow and removed the string from the back of Resident 76's neck. TN stated she did not know if Resident 76 could even use the call light or if another device would be more appropriate. A review of the facility's policy and procedure titled, Safety and Supervision of Residents dated 2017 indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to provide appropriate care for one of 17 sampled residents (Resident 30) receiving enteral feeding (nutrition delivered directly into the stomach through a feeding tube) when Resident 30's head of bed was not elevated to 45 degrees at all times. This failure resulted in an increased risk of aspiration (when fluid, food, or gastric acid gets into the airways causing airway blockage or infection) for Resident 30. A review of Resident 30's admission Record indicated Resident 30 was initially admitted to the facility in August 2022 with multiple diagnoses including Parkinsons (movement disorder of the nervous system), dementia (loss of memory, language, and thinking abilities), gastrostomy (G tube-surgical opening through the skin of the abdomen to the stomach to insert a tube in order to deliver nutrition directly into the stomach), pneumonia, respiratory failure, dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (GERD-stomach acid flows back up into the esophagus). A review of Resident 30's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 5/13/26, indicated Resident 30 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 6 out of 15 indicated Resident 30 had severe cognitive impairment. A review of Resident 30's physician's order, dated 2/6/26, indicated .Aspiration Precautions: Elevate HOB [Head of Bed] 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding is stopped every shift . A review of Resident 30's physician's order, dated 5/25/26, indicated .Tube Feeding orders: Glucerna 1.2 [tube feeding formula] - 355 mL [milliliters] (1,5 carton) bolus 4 times a day + 30 mL water flush before and after each bolus every 6 hours .A review of Resident 30's Care Plan, dated 1/13/26, .The resident requires tube feeding r/t [related to dysphagia] . Interventions .The resident needs the HOB elevated 45 degrees during and thirty minutes after tube feed .A review of Resident 30's Care Plan, dated 1/19/26, .The resident has GERD .Interventions .Avoid Lying down at least 1 hour after eating. Keep HOB elevated A review of Resident 30's Care Plan, dated 1/31/26, .Ineffective airway clearance r/t excessive respiratory secretions and decreased level of consciousness .Interventions .Position pt [patient] with head of bed elevated as tolerated to promote airway patency and facilitated drainage of secretions . During an observation on 6/14/26 at 8:49 a.m., Resident 30 was observed in bed asleep. Observed head of bed elevated to less than 30 degrees. Observed sign posted on wall over the bed that indicated KEEP HEAD OF BED ELEVATED TO 45 DEGREES PLEASE.During a concurrent observation and interview on 6/14/26 at 9:27 a.m. with Licensed Nurse (LN) 6, LN 6 acknowledged that Resident 30's head of bed was elevated to 30 degrees or less. LN 6 stated Resident 30's head of bed should be elevated to 45 degrees at all times especially with bolus feedings to prevent aspiration. During an interview on 6/15/26 at 7 a.m. with LN 3, LN 3 stated Resident 30's head of bed should be elevated at all times not just during feeding due to high risk of aspiration for this resident. A review of the facility's Policy and Procedure (P&P) titled Enteral Tube Feeding via Syringe (Bolus), not dated, indicated .The purpose of this procedure is to provide nutritional support to residents unable to obtain nourishment orally .Review the resident's care plan and provide for any special needs of the resident .

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	055296	A. Building B. Wing	06/17/2026

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Cedarwood Post Acute	1090 Rio Lane Sacramento, CA 95822

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to provide necessary respiratory care consistent with professional standards of practice, goals and preferences for one of 17 sampled residents (Resident 77), when Resident 77's oxygen tubing was not labeled.This failure had the potential for Resident 77 to be exposed to respiratory infectious agents from old or dirty tubing.During an observation on 6/14/26, at 9:15 a.m., in Resident 77's room, Resident 77 was receiving oxygen through a nasal cannula (thin plastic tubing that provides oxygen to the nose) with no label or date on the tubing.During an interview on 6/14/26, at 9:20 a.m., with Respiratory Therapist (RT), RT stated she did not see a date or label on Resident 77's tubing, and there should be one, so we know how old the tubing is (period it has been in use).During an interview on 6/17/26, at 10:58 a.m., with Director of Nursing (DON), DON stated the oxygen tubing should be replaced every 7 days and labeled with the date. DON stated, they should chart in the residents medical record that they changed the tubing, and he does not see it charted for Resident 77, that the tubing was changed. A review of Resident 77's Order Summary Report dated 6/14/26 indicated, no order to change oxygen tubing.A review of the facility's policy and procedure titled, Oxygen Administration Policy undated, indicated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pain management that met professional standards of practice and residents plan of care for two of 17 sampled residents (Resident 77 and Resident 80) when:1. Nursing staff did not reassess Resident 77 timely after administering a PRN (as needed) pain medication to check for effectiveness, and 2. The facility did not follow physician's order to assess Resident 80's pain using a pain scale. This failure resulted in the facility being unaware of the effectiveness of the PRN pain medication administered to Resident 77 and had the potential for Resident 77's and Resident 80's pain to not be adequately managed. 1. During a review of Resident 77's Diagnosis information dated 6/16/26 indicated, Resident 77 had the following diagnoses: prostate cancer, major depressive disorder, osteoarthritis (painful joint disease where the protective cartilage on the ends of your bones gradually wears away) anxiety, fractured humerus (upper arm) with implant, artificial right hip, and an older spinal fracture. During an interview on 6/14/26, at 9:12 a.m., with Resident 77 in his room, Resident 77 stated his pain is almost constant and primarily in his hip, back and groin area since he had prostate cancer. A review of Resident 77's Medication Administration Record (MAR) dated 6/16/26 at 11 a.m., indicated, Resident 77 was given his PRN pain medication Oxycodone (controlled narcotic medication prescribed to treat moderate to severe pain) by Licensed Nurse (LN 5) at 0752 (7:52 a.m.). During an interview on 6/16/26, at 11:15 a.m., with Resident 77, Resident 77 stated the nurse did not come back in the room since she had given him his pain medication earlier this morning and stated he was still in some pain. During an interview on 6/16/26, at 11:35 a.m., with LN 5, LN 5 stated she gave Resident 77 his PRN pain medication at 0752. LN 5 further stated when they give PRN pain medications they are supposed to check after 30 minutes to an hour if the pain medication was effective and chart on the MAR. LN 5 stated she did not chart the pain reassessment (3 hours after administration) on the MAR and was not sure of Resident 77's pain level. A review of Resident 77's Care plan titled, Pain: At risk for alteration in comfort/pain. Interventions .Observe the effectiveness of pain medications for the control of pain. A review of the facility's undated policy and procedure titled, Pain Management Policy indicated, It is the policy of this facility to provide appropriate pain management for residents who require such services, consistent with professional standards of practice, the comprehensive assessment, the resident's goals and preferences.Pain monitoring and follow-up may be documented through the medication administration record and/or routine clinical documentation.Documentation reflects assessment findings and pain management approaches in the normal course of care. 2. A review of the admission record indicated the facility admitted Resident 80 in June of 2026 with multiple diagnoses including dorsalgia (a constant aching or burning back pain that radiates to other areas), spinal stenosis (narrowing of the spaces inside the backbone causing pain), and recurrent falls. A review of Resident 80's history and physical dated 6/8/26, indicated the resident was admitted to (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility for chronic back pain and pain management resulting after recent fall. A review of Resident 80's physician's order dated 6/5/26 indicated, Pain- monitor for presence of Pain Every Shift and as needed Using Pain Scale 0-10: 0=no pain, 1-2=Least Pain, 3-4= Mild Pain, 5-6=Moderate Pain, 7-8= Severe Pain, 9-10=Very Severe/Horrible/Worst pain. A review of the Nursing admission assessment dated [DATE] indicated Resident 80 was alert and oriented. During an observation and interview on 6/14/26 at 10:20 a.m., Resident 80 was lying in her bed. Resident 80 responded appropriately and was able to carry a meaningful conversation. Resident 80 was noted to be grimacing when she attempted to turn to her side. Resident 80 explained that she had chronic pain in her lower back and described that her pain on a scale from 1 to 10 was about 4-5. Resident 80 was asked about how her pain was managed by the facility and the resident stated she thought she had some pain medication ordered by her physician. Resident 80 did not reply when asked if nursing assessed her pain on a regular basis and offered pain medications. A review of Resident 80's undated care plan indicated that the resident had an alteration in musculoskeletal function related to spinal stenosis and dorsalgia. The interventions included administering pain medications as ordered by physician, monitoring and documentation pain medications effectiveness and side effects. The care plan did not contain any interventions for nursing staff to monitor Resident 80's pain every shift as ordered by physician. A review of Resident 80's Medication Administration Record (MAR) for the month of June, the MAR indicated that nurses did not assess Resident 80 for presence of pain using a scale from 1 to 10 as directed by resident's physician. According to Resident 80's MAR, it indicated that starting 6/5/26 nurses placed checkmarks (ˆ) instead of documenting Resident 80's pain level every shift. During an interview on 6/16/26 at 8:40 a.m., Licensed Nurse (LN 2) explained that each resident was assessed for pain using the scale from 1 to 10. LN 2 stated that if pain medication was administered, the resident was to be reassessed for effectiveness one hour after the administration. During a concurrent interview and record review on 6/16/26 at 1 p.m., the Director of Nursing (DON) stated that nurses were expected to assess resident's pain throughout the shift and document the highest level that resident reported on that shift using the numeric pain scale from 1 to 10. Upon reviewing Resident 80's medical history, the DON acknowledged that the resident was at risk for experiencing pain due to her diagnosed medical conditions. The DON further reviewed the physician's order requiring nursing staff to monitor and document Resident 80's pain using a numeric pain scale from 1 to 10. The DON validated that nursing staff did not follow physician's order and placed checkmarks instead of documenting resident's pain level using numeric pain scale from 1 to 10 as ordered by physician. The DON did not provide an answer when asked if the lack of physician ordered pain monitoring could delay the identification and management of Resident 80's pain. A review of the undated facility's policy and procedure (P&P) titled, Pain Management Policy, indicated, It is the policy of this facility to provide appropriate pain management for residents who require such services, consistent with professional standards of practice.Pain recognition, monitoring and interventions are. incorporated into the comprehensive person centered care plan.The facility uses a pain rating method appropriate to the residents cognitive and communication status, including verbal or non-verbal indicators.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review the facility failed to ensure residents received their prescribed therapeutic diet (a meal plan prescribed by a physician and tailored by a registered dietitian) for one of 17 sampled residents (Resident 39). When Resident 39 was served lunch with a salt packet, while on a no added salt diet during lunch mealtime. This failure had the potential for Resident 39's chronic medical conditions of high blood pressure and chronic kidney disease to worsen, causing negative health outcomes. During an observation on 6/14/26, at 12:30 p.m., in Resident 39's room, Resident 39 was eating her lunch while in bed, with her family member at bedside. A salt packet was noted on Resident 39's meal tray. Resident 39's meal tray ticket read NAS (No Added Salt).During an interview on 6/14/26, at 12:31 p.m., with Resident 39's family member, family stated, [Resident 39] is probably not supposed to have salt because she has high blood pressure.During an interview on 6/14/26, at 12:34 p.m., with Certified Dietary Manager (CDM), outside of Resident 39's room, CDM stated he checked the tray and [Resident 39] did receive the salt packet, she is on NAS and should not have gotten one.A review of Resident 39's Diet order, dated 6/2/26 indicated, NAS* diet SOFT & BITE SIZED.A review of the facility's policy & procedure (P&P) titled, Therapeutic Diets dated 2017 indicated, Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan od care and in accordance with his or her goals and preferences.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to maintain a system to monitor COVID-19 vaccination status of staff and education to staff related to benefits and potential side effects of the COVID-19 vaccine. This failure resulted in the facility not having accurate monitoring of the staff's COVID-19 vaccination status with the potential for infection to staff and residents. During an interview on 6/16/26 at 9:44 a.m. with Licensed Nurse (LN 5), LN 5 stated she has received information regarding the COVID-19 vaccine and that it was offered yearly. During an interview on 6/16/26 at 11:23 a.m. with the Infection Preventionist (IP), the IP stated he started as the IP at the facility in January 2026. The IP stated that COVID-19 vaccines are offered to the staff. Requested tracking or monitoring log for staff COVID-19 vaccination status and education. The IP stated the only tracking of staff vaccinations is currently in the personnel files. The IP stated the vaccination consents and declinations are in the personnel files. The IP stated if an employee reports to him that they have received a vaccination he will place that in the personnel file. The IP stated that currently he has to rely on the reporting of the staff to him to monitor and track vaccination status. The IP stated he relied on staff to report to him if received the vaccine from outside the facility. The IP stated there is no electronic or handwritten tracker to monitor staff vaccination status. The IP stated there is no record of education or screening of staff for the COVID-!9 vaccine. A review of the facility's Policy and Procedure (P&P) titled Employee Infection and Vaccination Status, revised 1/24, indicated .Prior to or upon and employee's duty assignment, the facility will assess the status of an employee's vaccination against infectious conditions . Vaccinations are documented on the Employee Record of Vaccination .Employees are offered or provided with vaccinations per state or local agency's policies/regulations .Employees are provided with educational materials to make informed decisions or non-mandated vaccinations . A review of the facility's Job Description for Infection Preventionist, revised 2/26, indicated .Duties and Responsibilities .Coordinate, implement, monitor, and update the infection prevention and control program in accordance with current regulations and guidelines governing skilled nursing facilities .Establish, implement and monitor data collection tools for process and outcome surveillance outcome .Assist and oversee the tracking, administering and recordkeeping of required employee immunizations .Establish immunization programs for staff and residents .Provide personnel with information concerning the facility's policies governing vaccinations .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain safe equipment for one of 17 sampled residents (Resident 40), when Resident 40's bed control power cord was frayed with exposed wires. This failure placed Resident 40 at risk for injury. A review of Resident 40's admission Record indicated Resident 40 was admitted to the facility in August 2025 with multiple diagnoses including metabolic encephalopathy (change in how the brain works due to an underlying condition causing confusion or memory loss), dementia (loss of memory, language, and thinking abilities that are severe enough to interfere with daily life), chronic obstructive pulmonary disease (lung condition that limits airflow into and out of the lungs), and dysphagia (difficulty swallowing). A review of Resident 40's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 4/14/26, indicated Resident 40 had a long-term and short-term memory problem and his cognitive skills for daily decision making were severely impaired. During an observation on 6/14/26 at 8:49 a.m., Resident 40 was asleep with head of bed elevated. Observed bed control power cord wrapped around bed rail and the power cord was frayed with exposed wires. During an observation on 6/15/26 at 11:05 a.m., Resident 40 was awake and listening to music. Observed bed control power cord wrapped around the bed rail and the power cord was frayed with exposed wires. During a concurrent observation and interview on 6/15/26 at 11:16 a.m. with Licensed Nurse (LN 5), LN 5 confirmed that Resident 40's bed control power cord was frayed with exposed wires. LN 5 stated the bed control was working but acknowledged that the frayed cord and exposed wires was a safety hazard to the resident. During an interview on 6/15/26 at 4:20 p.m. with the Director of Nursing (DON), the DON stated if a bed control power cord is frayed and wires are exposed his expectation was staff will contact maintenance to replace it. During an interview on 6/17/26 at 7:50 a.m. with the Maintenance Director (MD), the MD stated if there is an issue with equipment or the bed the staff will put it in the maintenance log kept at the nursing station. The MD stated Resident 40's frayed bed control power cord was not in the maintenance log. The MD stated it must have been missed by the Certified Nursing Assistant (CNA) because the bed control was still working. The MD stated it needed to be replaced. A review of the facility's Policy and Procedure (P&P) titled Maintenance Service, revised 12/2009, indicated .Maintenance service shall be provided to all areas of the building, grounds, and equipment .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . A review of the facility's P&P titled Safety and Supervision of Residents, revised 7/17, indicated .Our facility strives to make the environment as free from accident hazards as possible .Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes .Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents .Our individualized, resident-centered approach to safety, addresses safety and accident hazards for individual residents . A review of the facility's P&P titled Homelike Environment, not dated, indicated .Residents are provided with a safe, clean, comfortable, and homelike environment .