STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055308	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk Grove Post Acute	9461 Batey Avenue Elk Grove, CA 95624

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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 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 remove from use discontinued medications for a census of 129 residents, when medications belonging to discharged residents were stored with active residents' medications.This failure increased the facility's potential to administer discontinued medications.Findings:During a concurrent observation and interview on 5/14/26 at 8:32 a.m. with Licensed Nurse (LN) 8 inside the medication room at nurses' station one, LN 8 confirmed a vial of regular insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) was found inside the refrigerator. LN 8 stated the insulin vial belonged to a resident who was discharged from the facility.During a concurrent observation and interview on 5/14/26 at 11:55 a.m. with LN 4, the southeast medication cart was inspected. LN 4 confirmed a bottle of dexamethasone (medication used to treat inflammation and allergic reactions) oral solution and a pack of ipratropium bromide-albuterol sulfate (combination of medication used to manage breathing difficulties and airflow blockages in the lungs) inhalation solution were stored in the cart. LN 4 stated the medications belonged to residents who were discharged from the facility.During an interview on 5/14/26 at 2 p.m. with the Director of Nursing (DON), DON stated medications belonging to discharged residents should have been removed, disposed of or stored separately from those assigned to active residents to prevent medication administration errors.A review of the facility's policy titled, Medication Storage in the Facility, revised in 1/2025, indicated, Medication storage . are monitored on a routine basis . and corrective action taken if problems are identified . medications are immediately removed from stock, disposed of according to procedures for medication disposal .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to follow the recipe for nine residents of a census of 129, when [NAME] (C) 1 added unmeasured amounts of water and milk to pureed (smooth, lump-free, moist food with the consistency of pudding) meals.This failure decreased the facility's potential to serve food that was easy to swallow and retained its nutrients.Findings:A review of the facility's lunch menu titled, Week-at-a-Glance - Spring 2026, dated 5/13/26, indicated the menu consisted of barbeque pork ribs, baked or mashed potatoes, collard greens, cornbread, and Texas sheet cake.A review of the facility's recipe titled, BBQ Pork Rib: Puree, dated 2026, indicated a maximum of 14.4 ounces [(oz.- a unit of measure) 1.8 cups] of hot water was to be added to 12 servings of pork.A review of the facility's recipe titled, Cornbread: Puree, dated 2026, indicated the maximum amount of warm milk to be added for 12 servings of cornbread was 19.2 oz (2.4 cups).During a concurrent observation and interview on 5/13/26 at 10:29 a.m. with C 1 and Registered Dietician (RD), lunch preparation for pureed food was observed. C 1 stated she was preparing 12 servings of pureed meals. C 1 measured 12 servings of barbeque pork and put the meat in a blender, then added warm water in increments using two different sized eating spoons and a Styrofoam cup. C 1 then prepared the cornbread, adding four cups of warm milk in increments, alternating adding an unmeasured amount of milk six times. The cornbread mixture was thick and stiff. C 1 stated she should have followed the recipes for adding the correct water and milk amounts.During an interview on 5/13/26 at 11:14 a.m. with RD, RD stated C 1 added unmeasured amounts of water to the pork and added unmeasured amounts of milk to the cornbread and confirmed C 1 did not follow the recipe. RD also stated the bread's consistency was inadequate for residents with swallowing problems (potential for choking), and residents on pureed diets might not get essential nutrients if the food had excess liquids.A review of the facility's policy and procedures (P&P) titled, Therapeutic Diets, revised October 2022, indicated, Therapeutic diet is . ordered by a physician, or delegated registered or licensed dietitian, as part of treatment for a disease or clinical condition . to [modify] specific nutrients in the diet, or to provide food that a resident is able to eat .A review of the facility's P&P titled, Food: Quality and Palatability, revised February 2023, indicated, Food will be prepared by methods that conserve nutritive value . Food and liquids are prepared and served in a manner, form and texture to meet resident's needs.

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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 - Some	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 maintain proper kitchen and food safety measures for a census of 129 residents, when:1. Kitchen floors were wet for three days;2. Frozen waffles were stored unsealed in the reach-in refrigerator;3. Food boxes were stored directly on the floor and on top of upside-down milk crates in the walk-in freezer with food stored on rusty metal shelving;4. Four steam table pans were stored wet; one steam table pan was found with a clumpy beige residue on the outside; and5. Four spice bottles were stored with open lids.These failures decreased the facility's potential to ensure kitchen safety and safely store and serve food.Findings:1. During a concurrent observation and interview on 5/11/26 at 8:09 a.m. with Dietary Manger (DM) at the entrance hall of the kitchen, the kitchen area was inspected. DM confirmed there was a water trail leading from the main kitchen area and stated the floors should not be wet. DM expected kitchen crew to promptly mop up water spills. DM further stated the wet area was a fall hazard due to the large amount of water.During an observation on 5/12/26 at 8:41 a.m., a trail of water was noted on the kitchen floor in front of the hot steam table. At 2:08 p.m., a worker was seen pushing a cart loaded with dishes through a water trail in front of the dishwasher.During an observation on 5/13/26 at 10:29 a.m. in the kitchen, a standup Caution- Wet Floor sign was observed at the dirty dishes counter. The floor from the counter to the entrance door (approximately 40 feet) was wet and not been mopped. Wet shoe prints indicated someone had walked through the water.A review of the facility's policy and procedures (P&P) titled, Safety, revised September 2017, indicated, The kitchen . will be properly maintained and that all Dining Services staff follow safe operating practices . Floor mats and wet floor signs will be used, as appropriate.2. During a concurrent observation and interview on 5/11/26 at 8:25 a.m. with DM, the reach-in refrigerator was inspected. A large bag of frozen waffles was found unsealed. DM stated the waffles should have been sealed to keep the food protected.3. During a concurrent observation and interview on 5/11/26 at 8:35 a.m. with DM, the walk-in freezer was inspected. 11 boxes of food were stored directly on the freezer floor. Six boxes were also stored on four upside-down milk crates and a metal shelving unit had a reddish-brown material that resembled rust on the bottom shelf and corner pole. DM stated the boxes should have been stored on appropriate shelving, as stacking on the floor, plastic crates, and rusty shelving could contaminate the food.During an interview on 5/13/26 at 2:12 p.m. with Registered Dietician (RD), RD expected kitchen staff to store food properly. RD stated boxes stacked on top of each other in the walk-in freezer could topple and injure an employee in addition to being contaminated from sitting on the freezer floor.A review of the facility's P&P titled, Food Storage: Cold Foods, revised February 2023, indicated, All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the Food and Drug Administration (FDA) Food Code . All food items will be stored six inches above the floor . All foods will be stored wrapped or in covered containers, labeled and dated, and stored in a manner to prevent cross contamination.4. During a concurrent observation and interview on 5/11/26 at 8:46 a.m. with DM, four quarter-sized steam table pans were found stored wet, and one half-sized steam table pan was found with a soft, clumpy beige residue. DM stated kitchenware run through the dishwasher should have been thoroughly dried and cleaned before storing. During an interview on 5/13/26 at 2:22 p.m. with RD, RD stated kitchen staff should have followed protocol for storing cooking pans safely to ensure sanitary food service to residents.A review of the facility's P&P titled, Warewashing, revised December 2024, indicated, All dishware, service ware, and utensils will be cleaned and sanitized after each use . The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware . All dishware will be air dried and properly stored.5. During a concurrent observation and interview on 5/11/26 at 9:15 a.m. with DM, four spice bottles were found stored with open lids. DM stated the cooks should have (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	closed the lids after use because the spices could become contaminated.A review of the facility's P&P titled, Food Storage: Dry Goods, revised February 2023, indicated, All packaged and canned food items will be kept clean, dry and properly sealed.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained for a census of 129 residents, when garbage dumpsters were left uncovered for three consecutive days. This failure decreased the facility's potential to maintain sanitary conditions in the garbage storage area and reduce the risk of pest infestation. Findings: During an observation on 5/11/26 at 7:38 a.m. in the backyard of the facility, garbage dumpsters were observed. One recycle dumpster was over filled to close the lid and some empty boxes were found on the ground next to it. Two garbage dumpsters were left opened and a few empty boxes and buckets were found around on the ground. No staff was observed using the dumpsters. During a concurrent observation and interview on 5/12/26 at 10:40 a.m. with Maintenance Supervisor (MS), garbage dumpsters were observed. One recycling dumpster was over filled to close the lid and two garbage dumpsters were left opened. MS confirmed recycling and garbage dumpsters were left opened. During a concurrent observation and interview on 5/13/26 at 11:15 a.m. with MS and Infection Preventionist (IP), garbage dumpsters were observed. MS and IP confirmed recycling and garbage dumpsters were left opened. IP stated all dumpsters lids should remain closed when not in use. During an interview on 5/14/26 at 11:30 a.m. with the Administrator (ADM), ADM confirmed recycling and garbage dumpsters were left uncovered for three consecutive days. ADM expected staff to close the dumpsters' lids immediately after using to prevent pests infestation and spreading infection in the facility. A review of the facility's policy and procedure titled, Dispose of Garbage and refuse, revised on 2/2025, indicated, . The Director of Maintenance to ensure that the area surrounding the exterior of the dumpsters is maintained in a manner free of rubbish or other debris . All trash will be properly disposed of in external receptacles (dumpsters) with lids covered when not in use .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain safe operating condition for kitchen equipment for a census of 129 residents, when a damaged thermometer was used for the automatic dishwashing machine. This failure decreased kitchen staff's potential to know if dishware was sanitized for resident use.Findings:During a concurrent observation and interview on 5/11/26 at 1:03 p.m. with Dietary Aide (DA) 1 and the Regional District Manager (RDM), DA 1 ran dishware through the automatic dishwasher. The machine's thermometer reached 110 degrees Fahrenheit (F - a temperature measurement system) throughout three cleaning cycles and during nonuse. RDM stated the water temperature for both wash and rinse cycles needed to be at a minimum of 120 F to properly sanitize dishware. RDM obtained a new dishwasher thermometer which registered 137.7 F during the rinse cycle. RDM stated the thermometer on the dishwasher was broken and kitchen staff would not know if dishware was washed at the designated temperature to properly sanitize them for resident use.A review of the facility's undated log titled, Dish Machine Log - Low temperature (Chemical Sanitizer), Chemical Sanitizing (Low Temp): Wash: 120-140 F, Rinse: 120-140 F.A review of the facility's policy and procedures (P&P) titled, Warewashing, revised December 2024, indicated, All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for . low temperature machines.A review of the facility's P&P titled, Safety, revised September 2017, indicated, The kitchen and associated equipment will be properly maintained and that all Dining Services staff follow safe operating practices. All . kitchen equipment issues will be promptly reported to facility staff and recorded according to facility protocol.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit in a timely manner a Minimum Data Set (MDS, a federally mandated assessment tool) assessment for one of 30 sampled residents (Resident 17), when Resident 17's discharge MDS was completed after 14 days of discharge.This failure had the potential to delay the transmission of Resident 17's data to the Centers for Medicare and Medicaid Services (CMS).Findings:A review of an admission record indicated Resident 17 was admitted to the facility on [DATE] and discharged on the same date.During a concurrent interview and record review on 5/12/26 at 1 pm with the Assistant Director of Nursing (ADON), Resident 17's MDS assessments and progress notes, dated 11/24/25 were reviewed. ADON confirmed Resident 17's MDS entry and discharge assessments shared the same assessment reference date (ARD) but was completed and transmitted to CMS on 12/11/25, more than 14 days later.During an interview on 5/14/26 at 2 pm with the Director of Nursing (DON), DON expected the assigned staff to follow the required timeframes for MDS submission.A review of the facility's policy titled, Comprehensive Assessments, revised in 10/2023, indicated, Assessments for residents that has been admitted to the facility and was discharged return anticipated must be completed by the end of day 14.

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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 interview and record review, the facility failed to ensure a Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment was recorded accurately for one of 30 sampled residents (Resident 140), when Resident 140's resuscitation (the emergency act of reviving someone who is not breathing, or heart has stopped beating) instructions were inaccurately documented in the MDS.This failure decreased the facility's potential to maintain accurate assessments for Resident 140's end of life care, treatment, and preferences.Findings:A review of Resident 140's admission Record, dated [DATE], indicated Resident 140 was admitted to the facility in [DATE] with a diagnosis of quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury).A review of Resident 140's Order Summary Report (OSR), dated [DATE], indicated on [DATE] a physician order to do not resuscitate (DNR - a medical order written by a doctor to instruct health care providers not to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating). During a concurrent interview and record review on [DATE] at 2:51 p.m. with MDS - Registered Nurse (MDS-RN), Resident 140's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) and MDS were reviewed. Resident 140's POLST, dated [DATE] indicated DNR, but the MDS dated [DATE] indicated full resuscitation. MDS-RN confirmed resuscitation instructions were documented incorrectly and stated inaccurate documentation might compromise Resident 140's rights and disregard family's wishes.During an interview on [DATE] at 11:45 a.m. with Administrator (ADM), ADM confirmed the resuscitation instructions for Resident 140 were documented inaccurately in MDS. ADM expected staff to maintain accurate documentation for Resident 140 to provide correct care and treatment when needed.A review of the facility's policy and procedure (P&P) titled, Electronic Transmission of the MDS, revised in [DATE], indicated, . The MDS coordinator is responsible for ensuring that appropriate edits are made to MDS data .A review of the facility's P&P titled, MDS Error Correction, revised in [DATE], indicated, . Errors to the MDS are corrected promptly and within guidelines established by the Resident Assessment Instrument User's Manual .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain professional standards of care for two out of 30 sampled residents (Resident 1 and Resident 139), when:1. Resident 139's blood pressure medication was not administered on time; and2. Resident 1 did not have an order for an indwelling urinary catheter (a tube placed in the bladder to drain urine which is collected in a bag).These failures decreased the facility's potential to follow physician orders for residents. Findings: 1. A review of Resident 139's admission Record, indicated he was admitted to the facility in April 2025 with multiple diagnoses including cerebral infarction (a type of stroke, loss of blood flow to a part of the brain) and dysphagia (difficulty swallowing). A review of Resident 139's Order Summary Report (OSR), dated 4/27/25, indicated an order for isosorbide mononitrate (a medication to treat high blood pressure) 10 milligrams (mg, unit of measurement) given through the gastrostomy tube (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) three times a day at 9 a.m., 1 p.m., and 5 p.m. During a concurrent observation, interview, and record review on 5/12/26 at 11 a.m. with Licensed Nurse (LN) 7, Resident 139's Medication Administration Record (MAR) and OSR were reviewed. LN 7 prepared Resident 139's medication by crushing, mixing with 30 milliliters (ml, unit of measurement) of water and administering through the g-tube. LN 7 confirmed the administration of Resident 139's blood pressure medication occurred later than the scheduled time at 9 a.m. During an interview on 5/14/26 at 2 p.m. with the Director of Nursing (DON), DON expected nurses to administer medications according to the physician's instructions, particularly those prescribed multiple times daily, to ensure residents' health needs were properly addressed. A review of the facility's policy titled, Medication Administration-General Guidelines, dated 10/2017, indicated, Medications are administered as prescribed in accordance with good nursing principles and practices . Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after) . 2. A review of Resident 1's admission Record, indicated he was admitted to the facility on [DATE] with diagnoses including a urinary tract infection (UTI- an infection caused by bacteria in the urinary system, which includes the bladder, urethra, and kidneys) and severe chronic kidney disease (a persistent, severe loss of kidney function). A review of Resident 1's Minimum Data Set (MDS – a federally mandated resident assessment tool), dated 3/30/26, indicated Resident 1's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) scored 15 out of 15 with intact cognition. During a concurrent observation and interview on 5/12/26 at 10:24 a.m. with Resident 1 in his room, Resident 1 had a urinary catheter hanging from the right side of his bed, draining clear medium yellow liquid. Resident 1 stated he had a urinary catheter for almost three months. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Care Plan Report, indicated he had an indwelling urinary catheter since 2/12/26. Care plan further indicated on 3/28/26 Resident 1 experienced an abdominal pain and his urinary catheter was not draining. A review of Resident 1's Progress Notes, dated 3/28/26, indicated Resident 1 was sent to the emergency department for abdominal pain and lack of urinary catheter drainage. The notes further indicated he returned from the hospital with a new urinary catheter and a diagnosis of UTI. During a concurrent interview and record review on 5/14/26 at 12:45 p.m. with LN 4, Resident 1's OSR dated 5/14/26 was reviewed. LN 4 confirmed there was no order for a catheter and stated an order was needed for nurses and certified nursing assistants (CNAs) to provide care and to monitor Resident 1's urine output and blood in urine. LN 4 further stated without an order, Resident 1 had a higher risk of getting another UTI and an increased possibility of leakage or catheter dislodgement if staff were unaware of its placement. During an interview on 5/14/26 at 12:49 p.m. with CNA 2, CNA 2 stated she cleaned Resident 1's urinary catheter daily and emptied and measured the urine. During a concurrent interview and record review on 5/14/26 at 1:01 p.m. with the Assistant Director of Nursing (ADON), Resident 1's medical record was reviewed. ADON confirmed there was no order for the urinary catheter and stated nurses missed the order. ADON further stated without an order, no one would know when the catheter was inserted. A review of the facility's policy and procedure (P&P) titled, Physician Orders, dated 3/22/22, indicated, Purpose: This will ensure that all physician orders are complete and accurate. A review of the facility's P&P titled, Urinary Catheter, dated 11/15/21, indicated, Purpose: To ensure there is a valid medical justification for use of an indwelling catheter and that the catheter is discontinued as soon as clinically warranted.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu for two residents (Resident 6 and Resident 72) of a census of 129, when food items were omitted from lunch menus.This failure decreased the facility's potential to serve meals complete in nutrient value.Findings:A review of Resident 72's admission Record, indicated she was admitted to the facility in 2023 with a diagnosis of type two diabetes (a condition in which blood sugar is too high due to the pancreas' inability to make enough insulin) and dysphagia (difficulty swallowing).A review of Resident 72's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/24/26, indicated her Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) scored 10 out of 15 with moderate cognitive impairment. A review of Resident 72's Order Summary Report, dated 12/21/25, indicated Resident 72 was prescribed a carbohydrate controlled diet (a diet that involves counting carbohydrates and eating the same number each day) with soft and bite sized texture and thin consistency liquids.During a concurrent observation, interview, and record review on 5/11/26 at 12:45 p.m. with Resident 72 and Rehabilitative Nursing Assistant (RNA) 1 in the dining room, Resident 72 was served her lunch. Resident 72's meal ticket titled, Noon Meal, dated 5/11/26, indicated the lunch menu consisted of baked chicken and gravy, potato salad, buttered carrots, bread, Mandarin oranges, and beverage. Resident 72 stated she was not served Mandarin oranges as listed on her meal ticket, and she liked oranges and wanted them. RNA 1 stated Resident 72 should have been served Mandarin oranges.A review of Resident 6's admission Record, indicated he was admitted to the facility in April 2026 with diagnoses including type two diabetes and moderate protein-calorie malnutrition (a potentially life-threatening condition caused by an inadequate intake of protein and calories).A review of Resident 6's Order Summary Report, dated 4/14/26, indicated Resident 6 was prescribed a carbohydrate controlled, renal (kidney) diet, regular texture, thin consistency liquids with fluid restriction of 1500 milliliters (ml- a unit of measure).During a concurrent observation, interview, and record review on 5/13/26 at 12:18 p.m. with Dietary Aide (DA) 2 and Regional District Manager (RDM) in the kitchen, tray line was observed. Resident 6's meal ticket titled, Noon Meal, dated 5/13/26, indicated his lunch consisted of a pork chop with gravy, noodles, collard greens, bread, Texas sheet cake, and a beverage. Resident 6 was served his pork chop without gravy. DA 2 and RDM stated Resident 6 was supposed to get gravy on his pork chop.During an interview on 5/13/26 at 2:25 p.m. with Registered Dietician (RD), RD stated leaving out items of the menu could decrease a resident's intake of needed nutrients. A review of the facility's policy and procedures titled, Menus, revised October 2022, indicated, Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines . Menus will be served as written .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055308	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk Grove Post Acute	9461 Batey Avenue Elk Grove, CA 95624

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure call lights were available to use for two of 30 sampled residents (Resident 100 and Resident 140), when:1. Resident 140's touch pad call light was not within reach; and2. Resident 100's regular call light was not within reach. These failures decreased the facility's potential to assist residents in a timely manner when needed.Findings: 1. A review of Resident 140's admission Record, dated 5/13/26, indicated Resident 140 was admitted to the facility in April 2014 with a diagnosis of quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a concurrent observation and interview on 5/11/26 at 10:23 a.m. with Certified Nursing Assistant (CNA) 3 and Resident 140, Resident 140's touch pad call light was observed clipped to her gown and placed next to left hip. Resident 140 stated she was unable to reach her call light due to complete weakness in left arm and very little movement in right hand. CNA 3 confirmed Resident 140's call light was not within reach and stated the touch pad call light should have been placed on Resident 140's chest near her right hand so she can touch it when needed.During an interview on 5/12/26 at 10:37 a.m. with the Director of Nursing (DON), DON confirmed Resident 140's call light was not within reach. DON expected staff to place call light near Resident 140's right hand to use when needed.2. A review of Resident 100's admission Record, dated 5/14/26, indicated Resident 100 was admitted to the facility in August 2019 with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left side (total paralysis of the arm, leg, and trunk on the left side of the body).During a concurrent observation and interview on 5/12/26 at 12:06 p.m. with Unit Clerk (UC) and Resident 100, Resident 100 was yelling for help from her bed. Resident 100's call light was observed clipped and placed to the left side of her pillow. Resident 100 stated she was unable to reach her call light due to weakness in left arm. UC confirmed Resident 100's call light was not within reach to use when needed. During an interview on 5/14/26 at 11:30 a.m. with the Administrator (ADM), ADM confirmed Resident 100's call light was placed on left side and was not within reach. ADM expected staff to place Resident 100's call light near her right hand and stated call lights should be placed within residents' reach to meet their needs. A review of the facility's policy and procedure titled, Answering the Call Light, revised on 10/24/2024, indicated, . Ensure that the call light is accessible to the resident when in bed .