

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Vacaville Ranch Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 S Orchard Ave Vacaville, CA 95688	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety when: 1. Several metal sheet pans in clean and ready-to-use storage areas: a. Were stacked wet while stored away b. Had food debris and brown substance on outside surface; 2. There were opened bags of food items in dry storage, refrigerator, and freezer with issues: a. 12 opened bottles of spices did not have a use by date b. One opened bin of chicken soup base did not have a use by date c. One opened loaf of bread did not have a use by date d. Four pallets of bread did not have a receive date e. One package of thawed country fried steak did not have a pull date f. One opened box of frozen beef patties did not have an open or use by date g. One opened package of frozen cookie dough had an illegible open and use by date 3. The ice machine was not clean; and, 4. The concentration of the sanitizer solution for the sanitation (red) bucket was not in range. These failures had potential to cause food-borne illness in a highly susceptible population of 47 out of 47 residents who received food from the kitchen. Findings: 1. During an initial tour concurrent observation and interview with the Dietary Manager (DM) and the Registered Dietician (RD) on 8/5/25 at 8:57 a.m. at the kitchen, several metal sheet pans stored at the clean and ready-to-use storage areas were observed stacked wet, had food debris, and brown substance. The metal pans included: -2 full sheet pans (wet)-2 full sheet pans (food debris and brown substance outside) The RD confirmed the metal sheet pans were wet, had food debris, and brown substance. The RD stated the pans should have been completely air-dried and clean before being stored away. During an interview on 8/7/25 at 1:41 p.m. with RD, RD stated the expectation was for pans to be clean, dry and free from debris. RD acknowledged there was a risk for bacteria and food contamination when pans were stored wet and dirty. During a review of the facility's policy and procedure (P&P) titled, Dish and Utensil Procedure, revised 3/3/2020, the P&P indicated, .dishes, trays, and utensils shall be routinely checked for stains or spots. shall be air dried before storage. any tray with debris should not be used. Send back to the dish room to be properly washed and sanitized. 2. During a concurrent observation and interview with DM and RD on 8/5/25 at 9:00 a.m. at the kitchen's initial tour, 12 opened bottles of spices did not have a use by date, one opened bin of chicken soup base did not have a use by date, one opened loaf of bread did not have a use by date, and four pallets of bread did not have a receive date. RD confirmed the food items were not labeled with a receive or use by date. RD acknowledged opened packages of food should have been labeled with a use by date and bread should have been labeled with a receive date. During an initial tour concurrent observation and interview with DM and RD on 8/5/25 at 9:11 a.m., at the kitchen, one package of thawed country fried steak did not have a pulled date (date food was removed from freezer for thawing). RD confirmed the food items were not labeled with a pull date. RD acknowledged food pulled from freezer for thawing should have been labeled with a pull date. During an initial tour concurrent observation and interview with DM and RD on 8/5/25 at 9:17 a.m., at the kitchen, one opened box of frozen beef patties did not have an open or use by date, and one opened package of frozen cookie dough had an illegible open and use by date. RD confirmed the food items were not labeled with open or used by date. RD acknowledged opened packages of food should have been (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	labeled with open or use by date. During an interview on 8/7/25 at 1:41 p.m. with RD, RD stated the expectation was for food to be labeled with received, open, pull, and use by dates. RD further stated there was a risk for expired foods being served to residents when food was not labeled correctly. During a review of the facility's P&P titled, Food Storage revised 7/11/24, the P&P indicated, .All products should be dated upon receipt, when open, and when prepared. Use Use-By dates on all foods stored. Frozen Meat/Poultry and Foods. label and date all food items. date when meat was taken out of freezer. Dry Storage. any opened products. should be labeled and dated. label and date all storage containers or bins. 3. During a concurrent inspection and interview on 8/5/25, at 11:30 a.m., with Maintenance Supervisor (MS) of the ice machine, MS stated he was responsible for the weekly cleaning and sanitizing of the ice machine. The MS removed the top access panel. There was a slimy grey substance on the upper right portion of the water curtain (a plastic cover rest on the ice making panel of the top machinery component, the function is to prevent ice shooting out and redirect the ice to the ice storage bin). MS confirmed there was a slimy grey substance (dirty, not clean) on the water curtain. During an interview on 8/7/25 at 1:41 p.m. with RD, RD stated the expectation was for the ice machine to be clean. RD further acknowledged there was a risk for residents to receive contaminated ice when the ice machine components were not clean. During a review of the facility's P&P titled, Ice Machine revised 10/18/2018, the P&P indicated, .Weekly wash inside of the machine. make sure door liner, door gasket, and door frame are free of scale and/or mold. Ice Machine Cleaning Schedule. Clean inside of the ice machine. per manufacturer's instructions. According to 2022 FDA (Food and Drug Administration) Food Code, on section 4-602.11 Equipment Food-Contact Surface and Utensils, it stated equipment like ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms (a living thing that is so small it must be viewed with a microscope, such as bacteria or algae). 4. During a concurrent observation and interview on 8/6/25 at 8:36 a.m. with Dietary Aide (DA) 1 and DM, DA 1 checked the concentration levels of the red sanitizing bucket and it was at 0 ppm. DM stated the facility used Quat (Quaternary ammonium solution) as a disinfectant in the red sanitizing bucket. DM further stated the concentration range for red sanitizing bucket should have been 200-400 ppm. DM further stated there was a risk for cross contamination of bacteria when the Quat concentration was not within range. During an interview on 8/7/25 at 1:41 p.m. with RD, RD stated the expectation was for red sanitizing bucket to have appropriate disinfectant concentration. RD acknowledged there was a risk for food borne illness when the red sanitizing bucket was not within recommended FDA ranges. During a review of the facility's P&P titled, Sanitizer Use Concentrations for Food Service and Food Production Facilities revised 4/30/2020, the P&P indicated, .Use chemical sanitizers in accordance with the EPA-registered label. Sanitation buckets must be established with appropriate sanitizing solution. for quaternary solution, 150-400 ppm; or 200 ppm depending on the product.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure proper disposal of garbage for a census of 47, when garbage dumpsters were left uncovered. This failure had the potential to expose the facility to pests, disease, and odors. Findings: During a concurrent observation and interview on 8/6/25 at 8:43 a.m., with Dietary Manager (DM), two facility garbage dumpsters did not have a lid on and were open. DM confirmed the lids were open and should have been closed. During an interview on 8/7/25 at 1:41 p.m. with Registered Dietician (RD), RD stated the expectation was for the dumpster garbage lids to be closed. RD further stated there was a risk for contamination in the facility when the dumpster garbage lids were left open. During a review of the facility's policy and procedure (P&P) titled Garbage and Trashcans revised 05/20/2020, the P&P indicated, .All food waste must be placed in covered garbage and trashcans.the dumpster area must be free of debris.and the lid must be closed.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 14 of 17 sampled residents (Resident 16, Resident 30, Resident 32, Resident 37, Resident 43, Resident 60, Resident 4, Resident 57, Resident 58, Resident 59, Resident 2, Resident 6, Resident 9, and Resident 29) were offered an advance directive (a legal document where a competent adult specifies their future medical care wishes in the event they cannot communicate them themselves, often due to illness or injury). This failure had the potential to result in the residents' medical wishes not being honored. Findings: During a record review of Resident 16's admission Record (AR), Resident 16 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction (a condition where the blood flow to the parts of the brain is blocked, causing tissue damage to the brain), Unspecified dementia (a condition characterized by a progressive decline in cognitive functions, such as memory, thinking, language, judgment, and behavior). During a record review of Resident 30's AR, Resident 30 was admitted on [DATE] with diagnoses including Anoxic Brain Damage (brain damage occurs when the brain is deprived of oxygen), Aphasia (a neurological condition that affects a person's ability to communicate or speak). Review of Resident 16's and Resident 30's medical records, indicated there were no completed Advanced Directive (AD) documents found in Resident 16 and Resident 30's electronic medical records, nor in the physical medical records charts. During an interview with the Social Services Director (SSD) on 8/06/25 at 10:50 a.m., the SSD confirmed the ADs were asked for from the residents or family members upon admission. If there were no ADs completed, the resident or family member would be offered an AD and if they need assistance in completing one, the SSD stated she would help the resident or family. After reviewing the medical records of both Resident 16 and Resident 30, the SSD confirmed there were no Advanced Directive documents on file for Resident 16 and Resident 30. The SSD confirmed she had no documentation the residents or family were offered the services to complete the Advanced Directive documents. During an interview with the Licensed Nurse 4 (LN 4) on 8/8/25 at 7:41 a.m., LN 4 stated if there were no completed Advanced Directive, then the SSD would be notified and the SSD will get in touch with the resident or the resident's Responsible Party (RP, an individual or entity that has the authority and duty to manage and control a specific situation, asset, or area, and is accountable for the outcomes) to see if they would need assistance in completing an Advanced Directive. During an interview with the Director of Nursing (DON) on 8/8/25 at 8 a.m., the DON stated residents who were admitted without an Advanced Directive were referred to the SSD for follow up in obtaining and completing an Advanced Directive document. The SSD will assist in completing an Advanced Directive A review of Resident 32's admission Record (AR), the AR indicated Resident 32 was admitted to the facility on [DATE], with diagnosis that included dementia (decline in mental ability), and history of falling. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 37's AR, the AR indicated Resident 37 was admitted to the facility on [DATE], with diagnosis that included depression and anxiety disorder. A review of Resident 43's AR, the AR indicated Resident 43 was admitted to the facility on [DATE] with diagnosis that included sepsis (a life-threatening condition, If not treated it may lead to organ failure, and death), and osteomyelitis (infection of the bone caused by bacteria, treatment requires a medical consult and antibiotics and sometimes surgery). A review of Resident 60's AR, the AR indicated Resident 60 was admitted to the facility on [DATE], with diagnosis that included Heart Failure (also known as congestive heart failure, a condition where the heart can't pump enough blood to meet the body's needs), and insomnia (a common sleep disorder characterized by persistent difficulty falling or staying asleep). During a concurrent interview and record review with the Social Services Director (SSD) on 8/6/25 at 10:55 a.m., the SSD reviewed the resident's electronic chart and physical charts and stated Resident 32, Resident 37, Resident 43 and Resident 60 did not have Advance Directives (AD) in their respective charts. During a review of Resident 4's admission record (AR), the AR indicated Resident 4 was admitted in July 2025 with several diagnosis including seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 57's AR, the AR indicated Resident 57 was admitted in June 2025 with several diagnosis including metabolic encephalopathy (a condition where brain dysfunction occurs due to a chemical imbalance in the body, often triggered by systemic illnesses or organ dysfunction). During a review of Resident 58's AR, the AR indicated Resident 58 was admitted in August 2025 with several diagnosis including osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 59's AR, the AR indicated Resident 59 was admitted in August 2025 with several diagnosis including fracture of left rib. During a review of Resident 4's, Resident 57's, Resident 58's, and Resident 59's clinical records, the clinical records did not have an advance directive or documentation that indicated an advance directive was offered. During a concurrent interview and record review on 8/8/25 at 9:05 a.m. with Social Services Director (SSD), SSD confirmed Resident 4, Resident 57, Resident 58, and Resident 59 did not have an advance directive or documentation that indicated an advance directive was offered. SSD stated the expectation was for advance directives to be offered at admission. SSD further stated there should have been documentation that indicated an advance directive was offered if residents did not have an advance directive. SSD further stated there was a risk for residents' medical wishes to be unclear when an advance directive was not available. During a review of Resident 2's admission record (AR), the AR indicated Resident 2 was admitted in April 2020 with several diagnosis including chronic respiratory failure (a chronic lung disease causing difficulty in breathing) and muscle weakness. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] with a diagnosis including Heart Failure (heart failure & the heart is unable to pump blood around the body properly). During a review of Resident 9's AR the AR indicated Resident 9 was admitted in April 2024 with a diagnosis of cerebral infarction (loss of blood flow to a part of the brain). During a review of Resident 29's AR, the AR indicated Resident 29 was admitted [DATE] with multiple diagnoses that included neuromuscular dysfunction of bladder (nerves controlling the bladder are damaged or not working correctly) and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's, Resident 6's, Resident 9's, and Resident 29's clinical records, the clinical records did not have an advance directive or documented evidence that indicated an advance directive was offered. During a concurrent interview and record review on 8/8/25 at 1 p.m. with Social Services Director (SSD), SSD confirmed Resident 2, Resident 6, Resident 9, and Resident 29 did not have an advance directive or documentation that indicated an advance directive was offered. SSD stated the expectation was for advance directives to be offered at admission and follow up documentation. During a review of the facility's policy and procedure (P&P) titled, "Advance Directives"; revised December 2016, the P&P indicated .Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so .Written information will include a description of the facility's policies to implement advance directives and applicable state law .Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advanced directives .Information about whether or not the resident has executed an Advanced Directive shall be displayed prominently in the medical record .If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives .The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision; Nursing staff will document in the medical record;the offer to assist and the resident's decision to accept or decline assistance; and plan of care for reach resident will be consistent with;advance directive;		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure that the menu was followed for the therapeutic diet for lunch on 8/6/25 when:1. 12 residents (Resident 5, Resident 6, Resident 9, Resident 15, Resident 18, Resident 21, Resident 29, Resident 31, Resident 35, Resident 39, Resident 41, and Resident 48) who were on a Mechanical Soft/Soft and Bite sized diet (a diet for people with mild to moderate chewing and/or swallowing difficulty) received whole green beans instead of soft and chopped green beans and hard bread instead of soft and buttered bread as indicated on the menu; and,2. Four residents (Resident 16, Resident 30, Resident 40, and Resident 57) who were on a Pureed diet (a diet for people with trouble chewing, swallowing, or fully breaking down food and usually ground, pressed, or strained to pudding like consistency) received 2.07 oz (ounces -unit of measure) serving of garlic bread instead of 2.78 oz serving of garlic bread as indicated on the menu. These failures had the potential to result in compromising the medical and nutrition status of the 16 residents. Findings: During an observation of lunch meal service on 8/6/25 beginning at 11:50 a.m., it was noted as follows:1. Resident 5, Resident 6, Resident 9, Resident 15, Resident 18, Resident 21, Resident 29, Resident 31, Resident 35, Resident 39, Resident 41, and Resident 48 who were on a Mechanical Soft/Soft and Bite sized diet did not receive soft and chopped green beans or soft and buttered bread respectively. A concurrent review of the facility spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) titled, Daily Spreadsheet, Wednesday, indicated that Mechanical Soft/Soft and Bite sized diet should have received herbed whole green beans as soft and chopped and garlic bread as soft and buttered. 2. Resident 16, Resident 30, Resident 40, and Resident 57 who were on a pureed diet, received 2.07 oz serving of garlic bread. A concurrent review of the facility spreadsheet titled, Daily Spreadsheet, Wednesday indicated that pureed diet should have received 2.78 oz serving of garlic bread. During an interview on 8/7/25 at 1:41 p.m. with the Registered Dietician (RD), the RD acknowledged the issues that were found during meal service. The RD stated, residents should have received food items as they were reflected on the menu. The RD further stated there was a risk for residents' nutrition to be affected when the menu was not followed. During a review the facility's policy and procedure (P&P) titled, Cycle Menus revised 3/27/24, the P&P indicated, .Menus meet the daily requirements of the Food and Nutrition Board. Menus must be followed as written with exception for when ethnic, cultural, geographic, or religious preferences of the residents require a substitution. During a review of facility document and job description, titled Cook, revised 9/21/2018, the job description indicated, .Specific responsibilities. ensure appropriate portioned servings according to portion control standards and recipes.		

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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 follow guidelines for Enhanced Barrier Precaution (EBP, an infection prevention and control intervention and guidance on what and how to properly wear the PPE, [personal protective equipment]) to reduce transmission of multi-drug-resistant organisms) that utilize the use of gowns and gloves during direct care activities for three of 17 sampled residents (Resident 4, Resident 43 and Resident 29) when:1. Licensed Nurse (LN) 3 and Infection Preventionist (IP) did not wear gowns and gloves when they turned Resident 4 to her side;2. Physical Therapy (PT) staff did not wear a gown and gloves when he brought Resident 43 to the gym and back to her room; and,3. Certified Nursing Assistant (CNA) 2 and Physical Therapy staff did not wear gowns and gloves with Resident 29. These failures had the potential to spread multi-drug resistant organisms (MDRO's, bacteria that resist treatment with more than one antibiotic) among residents, staff and visitors. Findings: 1. During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnosis that included Pressure-Induced Deep Tissue Damage of Left Heel (severe types of pressure injury that appeared on the heel), and Diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4's "Order Summary" report dated 7/24/25, indicated, Resident 4 had a Catheter (urinary catheter - a tube designed to stay in the bladder and drain the urine). During a review of Resident 4's "Order Summary report," dated 8/4/25, indicated, "left heel pressure ulcer"; During an observation on 8/6/25 at 8:20 a.m., in Resident 4's room, there was an EBP signage posted by the door. The EBP signage indicated to wear gloves and a gown for "High-Contact Resident Care Activities." LN 3 and IP were observed not wearing gowns and gloves as indicated on the signage, as they touched and assisted Resident 4 to turn on her side. During an interview with LN 3, on 8/6/25 at 10:40 a.m., LN 3 confirmed that Resident 4 had a Foley Catheter and a wound to left heel which was an indicator to practice EBP to promote infection prevention. LN 3 acknowledged she did wear a gown and gloves when she helped the IP turn Resident 4 to her side. LN 3 stated she should have worn a gown and gloves while rendering direct care to Resident 4. During an interview with the IP on 8/6/25 at 11:35 a.m., the IP stated her responsibility is to educate the facility staff about infection control prevention and conduct in-services such as EBP guidelines. The IP confirmed Resident 4 was on EBP. The IP acknowledged she did not wear a gown when they turned Resident 4 to her side, and the IP explained that she should have worn a gown to prevent the spread of infection. The IP stated that she was embarrassed of her actions as she is the IP of the facility. 2. During a review of Resident 43's AR, the AR indicated, Resident 43 was admitted to the facility on [DATE] with diagnosis that included Sepsis (a life-threatening condition, If not treated it may lead to organ failure, and death), and Osteomyelitis (infection of the bone caused by bacteria, treatment requires a medical consult and antibiotics and sometimes surgery). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 43's "Order Summary," dated 7/18/25, indicated, "PICC (peripherally inserted central catheter, long, thin, flexible tube inserted into a vein. Used to administer medications) to right upper extremity," During a review of Resident 43's "Order Summary," dated 8/4/25, indicated, "Vancomycin (antibiotic) HCL (hydrogen chloride, a solution of hydrogen chloride in water) 650 mg (milligram, dosage) intravenously (through PICC) two times a day related to osteomyelitis. During a concurrent observation and interview with the PT, on 8/5/25 at 9:26 a.m., Resident 43 was seated in her wheelchair as the PT pushed the wheelchair back to her room and assisted Resident 43 transfer to her bed. The PT stated he picked up Resident 43 from her room and took her to the small gym via wheelchair to do leg, arms and strengthening exercises. The PT acknowledged Resident 43 was on EBP, and he did not wear a gown and gloves while assisting Resident 43. The PT further stated, he should have worn a gown and gloves to prevent contamination to keep the residents safe. During an interview with the Director of Nursing (DON), on 8/7/25 at 1:45 p.m., the DON stated, she expected the staff to always practice infection control to avoid the spread of infection. The DON continued, LN 3 and the IP should have worn gowns and gloves when rendering direct nursing care to residents with EBP for safety reasons. The DON expected the IP to be knowledgeable in promoting infection control to the facility staff. 3. During a review of Resident 29's admission Record, indicated, Resident 29 was admitted to the facility in May 2025 with multiple diagnoses that included neuromuscular dysfunction of bladder (nerves controlling the bladder are damaged or not working correctly) and dementia (a progressive state of decline in mental abilities). During an observation on 8/6/25 at 12:00 p.m. outside of Resident 29's room, a sign was posted by above resident name card by the door which indicated, Enhanced Barrier Precaution (EBP). During a concurrent observation and interview on 8/6/25 at 12:05 p.m. in Resident 29's room, CNA 2 and PT entered Resident 29's room without putting on gown and gloves. CNA 2 and PT were observed not wearing gowns or gloves while transferring Resident 29 from bed to wheelchair. PT observed to push Resident 29 to the hallway and CNA 2 started changing bed linens. CNA 2 confirmed that they did not wear gowns and gloves when assisting and transferring Resident 29 to bed. During a concurrent EBP document review and interview on 8/6/25 at 3:15 p.m. with Infection Control (IP), the IP confirmed that Resident 29 was on EBP precautions for foley catheter and open wounds. IP stated that provider and staff must wear gowns and gloves during high contact resident care activities such as transferring and changing linens. IP further stated staff need to wear gowns and gloves to prevent the spread of multi-drug-resistant bacteria on staff clothes to other residents. During a review of the facility's policy and procedures titled "Enhanced Barrier Precautions," revised June 2024, indicated, "Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents;EBPs employ targeted gown and glove use during high contact resident care activities; Staff are trained to care for residents on EBPs . Enhanced standard precautions (ESPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents .high contact care activities requiring the use of gown and gloves for EBP's include;transferring .changing linens &EBPs are indicated .for residents with wounds and/or indwelling medical devices .		

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NAME OF PROVIDER OR SUPPLIER Vacaville Ranch Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 101 S Orchard Ave Vacaville, CA 95688	
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a written notice of bed-hold at the time of transfer was provided for two of 17 sampled residents (Resident 54 and Resident 6). This failure resulted in Resident 6 and Resident 54 not being fully informed about bed-hold options and rights. Findings: During a review of admission Record (AR) indicated, Resident 54 was admitted to the facility on [DATE] with a diagnosis including Heart Failure (heart failure &ndash; the heart is unable to pump blood around the body properly.) A concurrent record review and interview on 8/8/25 at 11:12 a.m. with Director of Nursing (DON), the DON confirmed that there was no documented evidence Resident 54 received a document related to the facility's bed hold policy prior to her transfer to the hospital. During an interview on 8/8/25 at 1:49 p.m. with Social Services Director (SSD), the SSD stated, &ldquo;admission packet has the bed hold policy, but the facility does not provide bed hold policy upon transfer.&rdquo; The SSD further stated and confirmed Resident 54 was transferred to the hospital on 6/2/25, and there was no documented evidence Resident 54, or the resident representative was notified in writing of the facility's bed-hold policy prior to transfer to the hospital. During a review of admission Record (AR) indicated, Resident 6 was admitted to the facility on [DATE] with a diagnosis including Congestive Heart Failure (the heart is unable to pump blood around the body properly). A concurrent record review and interview on 8/8/25 at 11:12 a.m. with Director of Nursing (DON), the DON confirmed that there is no documented evidence Resident 6 received a document related to the facility's bed hold policy prior to her transfer to the hospital. During an interview on 8/8/25 at 1:49 p.m. with Social Services Director (SSD), stated, &ldquo;admission packet has the bed policy, but the facility does not provide bed hold upon transfer.&rdquo; The SSD stated and confirmed that Resident 6 was transferred to the hospital on 2/11/25, 2/26/25, 6/12/25, and 6/27/25 respectively, and there was no documented evidence Resident 6, or the resident representative was notified in writing of the facility's bed-hold policy prior to transfer to the hospital. During an interview on 8/8/25 at 1:55 p.m. with Administrator (ADM), the ADM stated that no bed hold notification form was given upon transfer and stated per facility policy a bed hold notification must be given to the residents. During a review of the facility's policy and procedure (P&P) titled, Bed Hold, dated 11/16, the P&P indicated, &rdquo; It is the policy of this facility to provide resident the right to secure a bed hold during hospitalization or therapeutic leave from the facility&hellip;At the time of transfer to acute care hospitalization or as soon as feasible afterwards, the licensed nurse/designee shall obtain a copy of the original bed hold form and complete the bottom portion, second bed notice of bed hold. The facility indicates how the resident/representative was notified, and a copy of the form shall be sent to the representative and/or sent on transfer.&rdquo;		

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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. Based on observation, interview and record review, the facility failed to ensure care received for two of 17 sampled residents (Resident 58 and Resident 29) met professional standards, when:1) Nursing staff did not notify the physician of Resident 58's fluid imbalance; and2) Nursing staff did not document Resident 29's left heel wound accurately and completely. These failures had the potential to result in Resident 58 having fluid overload, electrolyte imbalance, or urinary retention and Resident 29's left heel to worsen. Findings: 1) During a review of Resident 58's admission record (AR), the AR indicated Resident 58 was admitted to the facility in August 2025 with multiple diagnosis including atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls). During a review of Resident 58's physician orders, dated 8/5/25, the physician orders indicated Resident 58 had a foley catheter (a flexible, sterile tube inserted into the bladder to drain urine) due to urinary retention (the inability to completely empty the bladder). During a review of Resident 58's Input and Output record (I/O record - a log used in healthcare to track all fluids a patient consumes [intake] and eliminates from the body [output] over a specific time, such as 24 hours), the I/O record indicated the following: On 8/3/25, input was 890 ml (milliliter- a unit of measurement), output was 150 ml, On 8/4/25, input was 900 ml, output was 360 ml, On 8/5/25, input was 810 ml, output was 200 ml, and On 8/7/25, input was 1250 ml, output was 625 ml. During a review of Resident 58's clinical record, the clinical record indicated no documented evidence of any notes indicating a physician was notified of Resident 58's fluid imbalance. During a concurrent interview and record review on 8/7/25 at 1:10 p.m. with Director of Nursing (DON), the DON confirmed Resident 58's input and output record indicated a fluid imbalance. The DON confirmed a physician was not notified of Resident 58's fluid imbalance and follow up was not done. The DON stated the expectation was for staff to notify the physician of any changes to resident's condition including a fluid imbalance. The DON further stated there was a risk for urinary retention, decreased kidney function and urinary tract infection when the physician was not notified of Resident 58's fluid imbalance. During a review of the facility's policy and procedure (P&P) titled "Catheter Care, Urinary"; revised September 2014, the P&P indicated, "Input/Output;Observe the resident's urine level for noticeable increases or decreases;report it to the physician or supervisor"; During a review of the undated document titled, "Nursing Practice Act Rules and Regulations, "the document indicated, "Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following: (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.&rdquo; (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing- Stated of California Department of Consumer Affairs). 2) During a review of Resident 29's admission Record indicated, Resident 29 was admitted to the facility in May 2025 with multiple diagnoses that included dementia (a progressive state of decline in mental abilities) and severe protein calorie malnutrition (calorie and protein intake are inadequate). During an observation on 8/6/25 at 11:53 a.m. in Resident 29's room, Resident 29 had eyes closed lying on his right side on a low air loss mattress (designed to distribute the body's weight over a broad surface and help prevent skin breakdown) with 6 pillows on the bed and positioned under his heels. During a record review of Resident 29's Order Summary Report (OSR), dated 8/8/25, Resident 29 had a wound treatment, indicated, &ldquo;TX [treatment] LEFT HEEL: DTI [Deep tissue injury] clean with NS [normal saline], pat dry, apply betadine, cover with foam dressing, every day and evening shift for pressure injury [localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence] until resolved.&rdquo; During a record review of Resident 29's Skin & Wound Evaluation, dated 6/14/25 and 7/19/25 respectively, Resident 29 had a left malleolus (ankle bone) stage 1- pressure injury (unbroken skin redness - intact skin with persistent, non-blanchable redness over a bony prominence, meaning the area of redness will not turn white when pressed, even when the pressure is removed.) During a record review of Resident 29's Skin and Wound Evaluation (assessment), dated 7/19/25, 7/28/25, 8/1/25, 8/4/25, and 8/8/25 respectively, indicated, the skin assessments were not completed and filled out by Licensed Nurse (LN) 5. During a concurrent interview and record review with LN 5 on 8/8/25 at 9:13 a.m., LN 5 confirmed Resident 29's original left malleolus wound location on 6/14/25 was documented wrong and was changed to the left heel on 7/19/25. LN 5 further confirmed documentation was inaccurate and incomplete on the Skin and Wound Evaluation assessments. LN 5 also confirmed the wound had worsened while Resident 29 was in the facility. During an interview with the Director of Nursing (DON) on 8/8/25 at 10:30 a.m., the DON stated the expectation for the licensed nurses is to document in all categories of the Skin and Wound Evaluation assessments. The DON confirmed LN 5 did not have a wound certification as part of continuing education. The DON further confirmed all the assessments were incomplete. During a review of the facility's policy and procedures (P&P) titled, Prevention of Pressure Ulcers/Injuries, revised July 2017, the P&P indicated, Conduct a comprehensive skin assessment&hellip;evaluate, report and document potential changes in the skin&hellip;&rdquo; During a review of American Nurse's Association document titled &ldquo;ANA's Principles for Nursing Documentation Guidance for Registered Nurses (https://www.nursingworld.org/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf), dated 2010, indicated &ldquo;Principle 1. Documentation Characteristics&hellip;high quality (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation is: clear, concise and complete…reflective of the nursing process…Principle 5. Documentation Entries…the health record…must be: accurate, valid and complete…”		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure discharged /discontinued controlled medications (substances that have the potential for abuse and addiction and are therefore regulated by law) were jointly counted by the outgoing nurse and an oncoming nurse. This failure had the potential for diversion (obtain or use of prescription medicines such as controlled medications illegally), medication errors, and/or misuse of controlled medications in the facility. During a concurrent observation and interview on 8/5/25 at 10:45 a.m. with Licensed Nurse (LN) 2 of medication carts for A hall and part of B hall, LN 2 unlocked the narcotic box that contained active (active means, in-patient narcotic medications) and discharged /discontinued narcotic medications. LN 2 stated, the outgoing night shift nurse and herself counted the active narcotic medications but did not count the discharged /discontinued narcotic medications. Observed, bubble pack (unit dose packaging, to organize medications into individual doses, typically sealed in compartments with protective bubbles) for the discharged /discontinued narcotic medications that did not have the narcotic count sheet attached as required in the policy and procedures. LN 2 was unable to explain how they can prevent diversion, ensure patient safety and maintain an accurate accounting of the discharged /discontinued controlled substances if they did not perform medication reconciliation during shift change. During an interview on 8/6/25 at 3:45 p.m., with the Director of Nursing (DON), the DON stated nurses must count the active and discharged /discontinued narcotic medications, as there should be an accountability for everyone's safety. The DON stated that the outgoing nurse and an oncoming nurse must count the physical medications together, documented and signed in the Narcotic Count Sheet to avoid possible drug diversion. A review of the facility's policy and procedure, titled Controlled Medication Storage, effective date March 2018, indicated, Medication included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. D. At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and is documented on the controlled medication accountability record. All discontinued and expired drugs are counted until they can be transferred to the director of nursing.		