STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055491	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Healthcare Center	310 Oak Ridge Drive Roseville, CA 95661

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to deliver care within professional standards of practice when spironolactone (a medication used to manage high blood pressure and heart failure) was administered to Resident 45 despite low blood pressure readings, and the order was not clarified.This failure increased the risk for disease complications and adverse effects associated with hypotension (low blood pressure).Findings:A review of Resident 45's clinical record showed the resident was admitted on [DATE] with the following diagnoses: hypertensive heart disease with heart failure (high blood pressure that has weakened the heart) and myocardial infarction (heart attack).A review of Resident 45's Medication Administration Record (MAR) from April 2026 through May 7, 2026, indicated the following physician orders: Spironolactone Oral Tablet 25 mg: Give 1 tablet by mouth one time a day for heart disease. Start date 4/1/2026. Monitor Blood Pressure: Check blood pressure every 12 hours for hypertension monitoring. Hold the medication for systolic blood pressure (SBP) less than 110 or pulse less than 60. Start date 4/27/2025.During an interview and concurrent record review on 5/7/26 at 10:30 a.m. at the Station 4 medication cart, Licensed Nurse (LN 3) was asked whether Resident 45 was receiving any blood pressure medications. LN 3 stated the resident was receiving spironolactone.LN 3 reviewed the resident's vital signs and confirmed that Resident 45's blood pressure on the morning of 5/7/26 was 100/59 mmHg and his pulse was 61 beats per minute. LN 3 stated spironolactone was administered that morning and acknowledged that it could further lower the resident's blood pressure.LN 3 identified a separate blood pressure monitoring order that instructed staff to hold blood pressure medication if the SBP was less than 110 mmHg. LN 3 stated the monitoring order was not tied to any specific medication, stating, It is a separate order. He acknowledged the order was hard to follow and stated, I need to clarify.During a concurrent interview and record review on 5/8/26 at 10:04 a.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) reviewed the clinical record, MARs from April through May 2026, and Resident 45's physician orders.The DON and ADON acknowledged there was a separate blood pressure monitoring order directing staff to hold blood pressure medications for SBP less than 110 mmHg.The DON and ADON confirmed spironolactone was administered to Resident 45 with the following documented blood pressure readings: May 2026: 8 a.m. BP 100/59; medication administered at 8 a.m. April 2026 (morning readings with 8 a.m. administrations):- 4/5/26: 99/60- 4/14/26: 104/62- 4/15/26: 102/60- 4/24/26: 102/66The DON was asked whether she would have administered spironolactone with these blood pressure readings. The DON stated she would have clarified with the physician before administering. She stated her expectation is that staff should have clarified the order with the physician.During a review of the facility's policies and procedures titled, Prescriber Medication Orders, effective date March 2018, indicated, B. Any dose or order that appears inappropriate considering the residents age, condition, allergies, or diagnosis is verified with the attending physician. C. The prescriber is contacted to verify or clarify an order (.there are contraindications to the medication, the directions are confusing.A review of the Prescribing information for Spironolactone tablets, revised November 2025, indicated, the medication is indicated for the following conditions, heart failure, hypertension, edema (swelling). WARNINGS and PRECAUTIONS: . (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hypotension and Worsening Renal (kidney function): monitor volume status and renal function periodically.A review of the prescribing information for spironolactone tablets, revised November 2025, indicated the medication is used for conditions including heart failure, hypertension, and edema (swelling). Under Warnings and Precautions, it states: Hypotension and worsening renal function: monitor volume status and renal function periodically.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 pharmaceutical procedures were in place to meet the needs of a resident and to ensure accurate accounting of controlled substance medications (medications under tight government control due to high addiction and abuse potential) when:The facility did not have a procedure to ensure Resident 26's weekly clonidine patch (a medication patch used to help manage high blood pressure) was in place for continued delivery of the medication.Controlled Drug Record (CDR) sheets (an inventory log used to track the receipt, administration, and remaining inventory of controlled substances) did not reconcile for 2 out of 4 sampled records (Resident 45 and Resident 57).These failures increased the risk for medication errors, untreated high blood pressure, and inaccurate accountability and the potential for abuse/loss of controlled medication.Findings:1. A review of Resident 26's clinical record indicated he was admitted to the facility with diagnoses that included hypertension (high blood pressure) and chronic kidney disease stage 2 (mild damage to the kidneys). His Minimum Data Set (MDS, a care area assessment and screening tool), dated 3/5/2026, indicated he had a BIMS score of 15 (Brief Interview for Mental Status, a test given by medical professionals that helps determine a patient's cognitive understanding, scored from 1 to 15), which indicated his cognitive condition was intact.A review of Resident 26's physician order, dated 2/18/2026, indicated, Clonidine Transdermal Patch [a medication patch that provides continuous delivery of medication at a constant rate per day] Weekly, apply 0.2 mg (milligrams, a unit of measure) transdermally one time a day every Wednesday for HBP [high blood pressure].During an interview with Resident 26 outside his room on 5/7/2026 at 2:12 p.m. with Licensed Nurse (LN 1), when asked about the placement of the clonidine patch, Resident 26 motioned to his shoulder and stated the patch had come off in the shower a day or so ago. He stated he could not remember the exact date and stated the patch helps his blood pressure. LN 1 confirmed the clonidine patch was not on the resident.During an interview and concurrent record review with LN 1 at the medication cart outside Resident 26's room, when asked whether the nurse assessed the resident's skin that morning for patch placement, LN 1 stated the expectation is for the resident to tell me, and he did not. LN 1 stated the offˆgoing nurse at shift change did not report the missing patch and acknowledged there was no facility procedure requiring patch skin assessments. LN 1 reviewed Resident 26's clinical record and stated the patch was due every Wednesday. She confirmed the patch had been placed on the resident the previous day on 5/7/26 and came off sometime afterward. LN 1 confirmed the resident had a supply of patches in the cart and the patch was not re-applied.During a phone interview with the Consultant Pharmacist on 5/7/26 at 3:57 p.m., when asked about his expectations for monitoring patch placement, he stated staff need to monitor for placement and that, at other facilities, he has seen this reported during shift change.During an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/8/26 at 10:04 a.m. the DON confirmed currently there was no process for daily patch placement checks.A review of the Prescribing Information for clonidine patch, Revised November 2023, indicated, PATCH. Is designed to deliver the drug into the body through the skin. consistently for one full week (7 days). Further review indicated, The clonidine transdermal PATCH must be replaced with a new one on a fresh skin site if the one in use significantly loosens or falls off.2. During the survey, the Controlled Drug Record (CDR, an inventory sheet) for 4 residents receiving PRN (as needed) controlled medications was requested for review.During an interview with Licensed Nurse (LN 2) on 5/5/26 at 9:32 a.m. at the Station 4 Medication Cart, LN 2 stated that when administering controlled medications, he assesses the resident's pain level, and or the need matches the prescriber's orders, signs out the date and time the medication is removed on the CDR, administers the medication and documents the administration on the Medication Administration Record (MAR).a. During an interview with Licensed Nurse (LN 3) on 5/6/26 at 11:48 a.m. at the Station 3 Medication Cart, LN 3 confirmed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Resident 57 had two separate oxycodone medication cards with corresponding separate Controlled Drug Record (CDR) sheets. He stated that one card contained oxycodone 10 mg (1/2ˆtablets) [5 mg dose] and the other card contained 10 mg tablets that had been completed on 5/5/26. LN 3 confirmed that the CDR provided to the surveyor on 5/5/26 reflected the 10 mg tablets, and the final remaining tablet had been administered on 5/5/26. LN 3 opened the controlled substance cabinet, where the medication card containing the oxycodone 10 mg (1/2ˆtablets) was observed inside. A copy of the CDR for the 1/2ˆtablet oxycodone card (5 mg dose) for Resident 57 was obtainedOn 5/6/2026 beginning at 3:36 p.m., during a concurrent interview and clinical record review with the DON and the ADON, they verified the following physician orders listed on Resident 57's May 2026 MAR-Oxycodone 5 mg (a potent controlled pain medication), give 1 tablet by mouth every 6 hours as needed for moderate pain, dated 4/28/2025.-Oxycodone 5 mg, give 2 tablets [10 mg] by mouth every 6 hours as needed for severe pain, dated 4/28/2025.A review of Resident 57's May 2026 MAR with the DON and the ADON indicated nursing staff documented the following administrations:Oxycodone 5 mg on 5/3/26 at 4:54 a.m.Oxycodone 10 mg on 5/3/26 at 4:55 a.m.A review of Resident 57's CDRs for both the oxycodone 10 mg (1/2ˆtablet, 5 mg dose) and the oxycodone 10 mg tablets showed no corresponding signˆout entries for the 5 mg and 10 mg doses documented on the MAR. The DON and ADON confirmed the oxycodone administration entries did not reconcile with the controlled substance records. b. On 5/6/2026 beginning at 3:36 p.m., during a concurrent interview and clinical record review with the DON and the ADON, they verified Resident 45 had the following physician orders listed on the April 2026 MAR:-Hydrocodone-Acetaminophen (narcotic for pain) 5-325 mg, give 1 tablet by mouth every 8 hours as needed for moderate or severe pain, start date 11/3/25, discontinued date 4/22/26.- Hydrocodone-Acetaminophen 5-325 mg, give 1 tablet by mouth every 12 hours for moderate or severe pain, start date 4/22/26.-Hydrocodone-Acetaminophen 5-325 mg, give 1 tablet by mouth every 8 hours as needed for moderate or severe pain, start date 4/22/26.A review of Resident 45's CDR for hydrocodone-acetaminophen 5-325 mg and the April 2026 MAR indicated nursing staff removed 1 tablet of hydrocodone-acetaminophen 5-325 mg on 4/19/26 at 5:46 a.m. from the CDR with no record of the medication being administered. During a concurrent interview and record review on 5/6/2026 at 4:40 p.m. the ADON and DON acknowledged there was no documentation on the Resident 45's April 2026 MAR for the hydrocodone-acetaminophen removed from the CDR on 4/19/26 at 5:46 am.During a review of the facility's policy and procedure titled, Controlled Medications effective date, March 2018, indicated, The Director of Nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications Further review indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering the dose, completed after the medication is actually administered.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 45) was free from unnecessary medication. The resident received insulin lispro without monitoring for potential side effects and doses were held without clinical indication. These failures had the potential to result in uncontrolled blood sugars and complications related to hypoglycemia and hyperglycemia.Findings:A review of Resident 45's clinical record showed the resident was admitted on [DATE] with multiple diagnoses, that included: type 2 diabetes (a chronic disease causing high blood sugar), longˆterm insulin use (ongoing need for insulin injections), type 2 diabetes with circulatory complications (blood vessel damage), and polyneuropathy (nerve damage causing numbness or tingling).A review of physician orders indicated:Insulin lispro 3 units inject; three times daily before meals scheduled 6 a.m. 11 a.m. and 4 p.m. (start date 7/13/2025).Fingerstick blood sugar monitoring ordered daily with instructions to notify the physician if blood sugar was <60 or >300, and to treat hypoglycemia per protocol. Scheduled for 6 a.m. (order start date 12/31/2025),During an interview and concurrent record review on 5/7/2026 at 10:30 a.m., Licensed Nurse (LN 3) stated Resident 45's diabetes was monitored by checking blood sugars. LN 3 confirmed insulin lispro was ordered before meals with no parameters to hold the dose. While reviewing the May MAR, LN 3 stated checkmarks indicated doses were given and that a 4 meant Vitals Outside of Parameters for Administration and the dose was not given. LN 3 stated the morning blood sugar on 5/7/26 was 97 and was held that morning. LN 3 also confirmed insulin had been held multiple times in April without orders to do so and stated, I don't know why they are holding, they should give it. LN 3 reported blood sugar should be checked before meals.During an interview on 5/8/2026 at 9:18 a.m., Licensed Nurse (LN 2) stated insulin monitoring consisted of checking blood sugars and assessing diet intake. When asked what else was monitored, LN 2 stated, that is it.During a concurrent interview and record review on 5/8/2026 at 10:04 a.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) reviewed Resident 45's progress notes, MARs for March-May 2026, and physician orders. The DON and ADON confirmed insulin lispro was ordered three times daily before meals, blood sugar checks were ordered three times daily with a 6 a.m. morning check, and there were no orders to hold the insulin. They confirmed that a 4 entry meant the dose was not administered.A review of Resident 45's MARs for May, April, March 2026 indicated the following insulin doses documented as 4, indicating the medication was held:May 2026: 5/7 at 6 a.m.April 2026: 4/2 (11 a.m.) 4/4, 4/5, 4/8, 4/9, 4/14, 4/18 (11 a.m.), 4/19, 4/20, 4/21, 4/23, 4/25, 4/30 (all others at 6 a.m. unless indicated)March 2026: 3/5,3/7,3/8,3/18, 3/24,3/26, 3/28,3/30, 3/31The DON and ADON confirmed that Resident 45's insulin doses were held once in May, 14 times in April, and 9 times in March. They stated there were no nursing notes documenting a reason for holding the doses, and there were no notes indicating the physician was notified of the held doses. The ADON stated her expectation is that the prescriber would be notified if the insulin was held 2 to 3 times. The DON confirmed the MARs for March, April, and May 2026 contained no documentation of monitoring for insulin side effects and no assessment for signs or symptoms of hypoglycemia or hyperglycemia.During a review of the facility's policy and procedure titled, Medication Administration-General Guidelines effective date March 2018, indicated Medications are administered as prescribed in accordance with good nursing principles and practices. and further indicated, .2. Medications are administered in accordance with written orders of the attending physician. 3. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated too the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification. or contacts the provider for clarification.During a review of the facility's policies and procedures titled, Prescriber Medication Orders, effective date March 2018, indicated, B. Any dose or order that appears inappropriate considering the residents age, condition, allergies, or diagnosis is verified with the attending physician. C. The prescriber is (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contacted to verify or clarify an order (.there are contraindications to the medication, the directions are confusing.A review of the Prescribing Information for insulin lispro, Revised December 2018, indicated, Hyper-or Hypoglycemia with Changes in Insulin Reimen: Carry out under close medical supervision and increase frequency of blood glucose monitoring further review indicated, Hypoglycemia: Hypoglycemia is the most common adverse reaction associated with insulins, including insulin lispro. Severe hypoglycemia can cause seizures, may be life-threatening, or cause death. Hypoglycemia can impair concentration ability and reaction time; this may place an individual and others at risk in situations where these abilities are important.A review of the American Diabetes Association website, titled, Signs, Symptoms of Hypoglycemia, accessed 5/14/2026, indicated, These signs and symptoms of dropping blood glucose level can develop quickly. Common Signs and Symptoms: Feeling shaking, being anxious, sweating, dizziness, confusion, hunger, blurred/impaired vision seizures and further indicated, it's important to learn the signs and symptoms you have when your blood glucose levels are low.

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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 its medication error rate was below 5 %. The facility had a medication error rate of 13.89% when 5 medication errors occurred out of 36 opportunities observed during the medication administration for 2 out of 5 sampled residents (Residents 81 and 62).Resident 81 received a lower-than-prescribed dose of cholecalciferol (Vitamin D3 supplement), placing the resident at risk for vitamin deficiency and weakened bones. Resident 81 also received a higherˆthanˆprescribed dose of magnesium (electrolyte supplement), creating the potential for diarrhea, nausea, or stomach cramps.Nursing staff crushed Resident 62's delayedˆrelease aspirin, a medication designed to bypass the stomach, creating the potential for stomach upset, nausea, and vomiting. Staff also crushed Resident 62's ferrous sulfate (supplement) tablet, which can cause mouth irritation and stomach discomfort.In addition, nursing staff failed to prime Resident 62's insulin pen before administration, a required manufacturer safety step to ensure accurate insulin delivery. This failure created the potential for incorrect dosing and unstable blood sugar levels.Findings:1. During a medication observation on 5/5/2026 at 9:14 a.m.at the Station 2 Med Cart, Licensed Nurse (LN4) prepared 5 oral medications and 1 topical ointment (6 medications in total) for Resident 81, including 1 tablet of cholecalciferol 25 mcg (microgram, strength) and 1 tablet of magnesium oxide 400 mg (milligram, strength). Resident 81 was observed taking the oral medications with water.A review of Resident's 81's clinical record indicated the following physician orders:-Cholecalciferol Oral Tablet 125 mcg (5,000 international units), give 1 tablet by mouth one time a day, dated 4/25/26, scheduled for 8 a.m.-Magnesium Oral Tablet, give 200 mg by mouth two times a day, dated 5/3/26, scheduled for 8 a.m. and 5 p.m.During an interview and clinical record review on 5/5/26 at 1:21 p.m. at the Station 2 Med Cart, LN 4 confirmed she had administered one 400 mg magnesium tablet to Resident 81. After reviewing the resident's clinical record, LN 4 acknowledged the physician's order was for one 200 mg tablet. She confirmed the error and stated only 400 mg tablets were available in the cart.When asked to identify the bottle she used to obtain Resident 81's vitamin D, LN 4 removed a bottle labeled Vitamin D (cholecalciferol) 25 mcg and confirmed she had administered one tablet to Resident 81 that morning. After reviewing the clinical record, she acknowledged the prescribed dose was one 125 mcg tablet. LN 4 stated the resident would have needed five of the 25 mcg tablets to receive the correct dose. She confirmed that only 25 mcg tablets were stocked in the cart and stated she would clarify the dose with the physician.During an interview on 5/8/2026 at 10:04 a.m. with the DON and ADON, both stated staff are expected to follow provider orders and clarify any unclear orders.During a review of the facility's policy and procedure titled, Medication Administration-General Guidelines, effective date March 2018, indicated, Medications are administered as prescribed in accordance with good nursing principles and practices.2a. During a medication observation on 5/6/26 at 7:59 a.m. Licensed Nurse (LN 5) was observed preparing 13 medications for Resident 62 at the Station 2 Medication cart. LN 5 placed each of the nine oral tablets into separate medication cups, including aspirin delayedˆrelease 81 mg and ferrous sulfate 325 mg.At 8:27 a.m., LN 5 began administering medications to Resident 62. At 8:44 a.m., after the resident began coughing and gurgling while attempting to swallow a liquid medication, LN 5 asked the resident if he wanted his medications crushed. The resident indicated yes. LN 5 then crushed each of the nine oral medications individually and mixed each crushed medication with applesauce before administering them. She verbally identified the aspirin and the ferrous sulfate as she administered them in crushed form.A review of the clinical record showed physician orders dated 6/6/24 for aspirin delayedˆrelease 81 mg and ferrous sulfate 325 mg, both specifying DO NOT CRUSH.During an interview and concurrent clinical record review on 5/6/26 at 1:03 p.m. at the Station 2 Medication Cart, LN 5 acknowledged she had crushed and administered the aspirin and ferrous sulfate when the orders indicated, DO NOT CRUSH. At 1:12 p.m., during a joint review of the physician orders with LN 5 and the Assistant Director of Nursing (ADON), the ADON acknowledged the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications should not have been crushed and that an alternative dosage form should have been obtained.During a review of the facility's policy and procedure titled, Medication Administration-General Guidelines, effective date March 2018, indicated, Medications are administered as prescribed in accordance with good nursing principles and practices. further review indicated, If it is safe to do so, medication tablets may be crushed. when a resident has difficulty swallowing. using the following guidelines: Long-acting or enteric-coated dosage forms should generally not be crushed; an alternative should be sought.2b. On 5/6/2026 at 8:56 a.m.at the Station 2 Med Cart LN 5 was observed preparing Resident 62's Lantus Solostar pen (a preˆfilled pen containing lo insulin glargine-long-acting insulin for blood glucose control). LN 5 donned gloves, attached a new needle, dialed the pen to 23 units, and administered the insulin to the resident's abdomen. During a postˆobservation interview on 5/6/2026 at 9:10 a.m. at the medication cart, LN 5 was asked about priming the insulin pen. LN 5 stated, What do you mean about priming? and stated she was taught that priming was unnecessary because the pen is ready to go.A review of Resident 62 clinical record indicated the following physician order:-Insulin Glargine Solution, inject 23 units once daily for blood sugar control, dated 8/26/2025, scheduled for 8 a.m.During an interview on 5/8/26 at 10:04 a.m. with the DON and ADON, when asked about the expectation for staff to prime insulin pens, the DON stated that staff are expected to follow the manufacturer's guidelines for administration.A review of the drug manufacturer's INSTRUCTIONS FOR USE LANTUS SOLOSTAR, revised May 2025, indicated the following instructions for administering the pen: -Always perform a safety test (see Step 3) . Step 3: Do a safety testAlways do a safety test before each injection to:Check your pen and the needle to make sure they are working properly.Make sure that you get the correct LANTUS dose. 3A. Select 2 units by turning the dose selector until the dose pointer is at the 2 mark.3B. Press the injection button all the way in.When insulin comes out of the needle tip, your pen is working correctly.If no insulin appears:You may need to repeat this step up to 3 times before seeing insulin. Step 4: Select the dose.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 10 sampled residents (Resident 45) was free from a significant medication error when Resident 45's insulin lispro (a shortˆacting insulin used to treat diabetes) was not administered according to physician orders, manufacturer guidelines, and the facility's policies. The facility's failure to administer Resident 45's insulin at the correct time increased the potential for severe low blood sugar (hypoglycemia) and other medical complications.Findings:A review of Resident 45's clinical record showed the resident was admitted on [DATE] with multiple diagnoses that included: type 2 diabetes (a chronic disease causing high blood sugar), longˆterm insulin use (ongoing need for insulin injections), type 2 diabetes with circulatory complications (blood vessel damage), polyneuropathy (nerve damage causing numbness or tingling), and other diabetic neurological complications.A review of Resident 45's clinical record indicated the following physician orders: Insulin lispro 3 units inject; three times daily before meals scheduled 6 a.m. 11 a.m. and 4 p.m. (start date 7/13/2025).Fingerstick blood sugar monitoring ordered daily with instructions to notify the physician if blood sugar was <60 or >300, and to treat hypoglycemia per protocol. Scheduled for 6 a.m. (order start date 12/31/2025),During a concurrent interview and record review on 5/8/2026 at 10:04 a.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) reviewed progress notes, MARs from March through May 2026, and physician orders for Resident 45. The ADON stated mealtimes were 7 a.m., noon, and 5 p.m., and confirmed insulin lispro was expected to be administered within 30 minutes of the meal.A review of the Medication Administration Records with the ADON and DON indicated morning insulin dose was routinely administered 1 to 2 hours before the scheduled 7 am breakfast time.May 2026:5/1 at 5:19 a.m.; 5/2 at 5:30 a.m.; 5/3 at 5:43 a.m.; 5/4 at 5:40 a.m.; 5/5 at 5:28 a.m.; 5/6 at 5:29 a.m.; 5/7 -HeldApril 2026:4/1 - 6:10 a.m.; 4/2 at 5:44 a.m.; 4/3 at 5:40 a.m.; 4/6 at 5:40 a.m.; 4/7 at 5:56 a.m.; 4/10 at 5:31 a.m.; 4/11at 5:53 a.m.; 4/12 at 5:40 a.m.; 4/13 at 5:55 a.m.; 4/16 at 6:31 a.m.; 4/17 at 6:35 a.m.; 4/18 at 5:37 a.m.; 4/22 at 5:42 a.m.; 4/24 at 5:42 a.m.; 4/26 at 5:12 a.m.; 4/27 at 5:37 a.m.; 4/28 at 6:30 a.m.; 4/29 at 5:40 a.m.March 2026:3/1 at 6:15 a.m.; 3/2 at 5:57 a.m.; 3/3 at 5:23 a.m.; 3/4 at 5:06 a.m.; 3/9 at 5:48 a.m.; 3/11 at 6:25 a.m.; 3/12 at 6:29 a.m.; 3/13 at 5:32 a.m.; 3/14 at 5:33 a.m.; 3/15 at 5:44 a.m.; 3/16 at 5:28 a.m.; 3/17 at 5:43 a.m.; 3/19 at 5:26 a.m.; 3/20 at 6:08 a.m.; 3/21 at 5:49 a.m.; 3/22 at 6:05 a.m.; 3/23 at 6:07 a.m.; 3/25 at 5:22 a.m.; 3/27 at 6:14 a.m.; 3/29 at 5:48 a.m.The DON and ADON acknowledged these earlyˆmorning insulin administrations occurred before breakfast and in some cases 2 hours before the meal. ADON accessed the manufacturer's website and stated insulin lispro is to be administered within 15 minutes before a meal or immediately after a meal. They acknowledged these administrations did not follow the prescriber's orders, facility medication administration policies, or manufacturer guidelines.The ADON and DON further acknowledged that administering rapidˆacting insulin earlier than mealtime increases the risk of hypoglycemia and side effects. They confirmed this incorrect timing occurred repeatedly throughout March, April, and May 2026.During a review of the facility's policy and procedure titled, Medication Administration Schedule, revised November 2020, indicated, Medications are administered according to the following routine schedule: Before meals: 7:30 a.m. / 11:30 a.m. / 4:30 p.m. The policy and procedure further indicated, Scheduled medication designated as time-critical (medications that may cause harm or sub-therapeutic effect if administered before or after the scheduled time) are administered at the scheduled time (for example, rapid-acting insulin) or within 30 minutes of the scheduled time. And Scheduled medications that must be given around mealtimes may fluctuate based on delivery and consumption of meals.A review of the Prescribing Information for insulin lispro, Revised December 2018, indicated, Indications and usage: Insulin lispro is a rapid acting human insulin analog indicated to improve glycemic control in adults . with diabetes . and Dosage and Administration: .Administer insulin lispro . within 15 minutes before a meal or immediately after a meal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055491	A. Building B. Wing	05/08/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored and maintained according to manufacturer guidelines and facility policies and procedures when:Medications requiring temperature control were not stored at the proper temperature. The medication refrigerator was observed to be out of range for over five hours without followˆup. The refrigerator stored medications for a census of 62 residents.An expired bottle of latanoprost (a medication used to reduce and control eye pressure in glaucoma) labeled for Resident 66, and an opened, undated multidose container of glucose test strips, were observed in the Station 3 medication cart (one out of two medication carts sampled). This created the potential for administering expired or ineffective medication to Resident 66 and the risk of using expired or inaccurate glucose test strips to monitor blood glucose levels.Resident 81's eye drops were observed stored at the resident's bedside.These failures resulted in medications not being stored according to manufacturer guidelines and facility policies and created the potential for residents to receive unsafe, degraded, or ineffective medications.Findings: During an inspection of the medication storage room on 5/5/26 at 10:17 a.m. with the Assistant Director of Nursing (ADON), the medication refrigerator temperature was observed to be 54 degrees F (Fahrenheit, unit of temperature). The ADON acknowledged the temperature was outside the required range of 36–46 degrees F and stated it might be due to the door being opened repeatedly. She stated staff check the temperature twice per day. Temperature logs for April and May 2026 were present. ADON stated she would obtain the requested January through March 2026 logs from Medical Records. A followˆup inspection of the same refrigerator was conducted on 5/5/26 at 2:52 p.m. with the ADON. At that time, the thermometer was observed in the red spoilage zone, reading 64 degrees F. The temperature control dial inside the unit was observed in the off position. The ADON stated, It appears the refrigerator was turned off this morning, and acknowledged staff had not rechecked the temperature since it was noted out of range earlier that day. She also acknowledged the medications' efficacy could be compromised and stated she would contact the pharmacist immediately. The following medications were observed stored in the refrigerator at the time of the temperature excursion: Two emergency kits containing: -Lorazepam (sedative medication) vial for injection– Insulin vials (regular, longˆacting, and shortˆacting formulations, manage blood glucose) One vial of Tuberculin (injectable solution used to aid in diagnosing tuberculosis infection) One bottle of lorazepam oral solution Two Mounjaro medication pens (medication to regulate blood sugar and aid in weight control) and Several Bisacodyl suppositories (treatment of constipation) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow^up interview on 5/5/26 at 3:30 p.m. with the ADON and Licensed Nurse (LN 6), the ADON stated the refrigerator had been out of range from approximately 9:00 a.m. (approximately six hours). She confirmed the pharmacy would replace the medications in accordance with manufacturer storage requirements. On 5/6/26 at 10:38 a.m., during another inspection with the ADON, the medication refrigerator temperature measured 32 degrees F. The ADON adjusted the temperature setting and stated she would consult the pharmacist regarding medication safety. She confirmed replacement medications had been received. She also stated that only April and May 2026 temperature logs were available and confirmed that earlier logs were not retained. During a phone interview on 5/7/26 at 3:57 p.m., the Consultant Pharmacist (CP) stated that staff should recheck an out^of^range temperature at a reasonable time frame, within 1–2 hours and acknowledged that medication degradation could occur when stored at incorrect temperatures. During an interview on 5/8/26 at 10:04 a.m., the Director of Nursing (DON) and ADON stated their expectation is for the staff to re-check an out-of-range medication refrigerator within 30 minutes. They acknowledged the refrigerator remained unchecked for over five hours on 5/5/26 and acknowledged the medication effectiveness may be compromised. During a review of the facility's policy and procedure titled, Medication Storage in the Facility, effective date March 2018, indicated, In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls. and further indicated, Drugs requiring refrigeration shall be stored in a refrigerator between 36F and 46 F. 2. During an inspection of the Station 3 Med cart on 5/5/26 at 10 a.m. the following were identified, observed and confirmed Licensed Nurse (LN 3): a. One opened, not dated bottled of glucose test strips. LN 3 read the manufacturer's label on the glucose test strips which indicated, use within 6 months after first opening. LN 3 confirmed the open bottle was not dated. b. One bottle of latanoprost eye drops for Resident 66, the prescription label, indicated expired [EXP] 4/30/26. LN 3 confirmed the medication expired 4/30/26 (5 days ago) and stated he would remove it from stock and order a new bottle. During a review of the facility's policy and procedure titled, Medication Storage in the Facility, effective date, March 2018, indicated, Outdated, contaminated, or deteriorated medications . are immediately removed from stock.and Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use. 3.During a review of Resident 81's admission Record (AR) indicated, Resident 81 was admitted [DATE] with diagnosis including Fracture (broken bone) of Left Femur (large bone in the upper leg that helps you stand.) During a review of Minimum Data Set (MDS- a federally mandated resident assessment tool) indicated, Resident 81 has moderate cognitive impairment. During an observation on 5/6/26 at 8:52 a.m. in Resident 81's room, a bottle of eye drops was found (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055491	A. Building B. Wing	05/08/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on top of Resident 81's bedside table. Resident 81 stated, she uses eye drops for her dry eyes. During a concurrent observation and interview on 5/6/26 at 10 a.m. with Assistant Director of Nursing (ADON) at Resident's 81's room, the ADON confirmed that there was a bottle of eye drops on top of Resident 81's bedside table. ADON stated, the goal is to get medications from home, have them reviewed and secured in the locked medication cart. ADON further stated, there is potential misuse and potential contamination of the over-the-counter medications if not secured and stored properly. During a review of the facility's policy and procedure titled, Medication Storage in the facility, dated, March 2018, indicated, Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendation. the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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	055491	A. Building B. Wing	05/08/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper infection control practices were implemented when:1. Clean gauze was not used to dry the wound after cleansing for Resident 76.2. Glucometer not sanitized properly between residents, and;3. Insulin pen hub not sanitized before the needle was attached.These failures had the potential to compromise resident's health and safety and potentially lead to infection and the spread of communicable diseases.Findings: 1. During a review of Resident 76's admission Record (AR), AR indicated Resident 76 was admitted on [DATE] with diagnoses that included pressure ulcer of sacral (large triangular area at the base of spine) region stage 2 (partial-thickness loss of skin, presenting as a shallow open sore or wound); pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) right buttock unstageable and pressure ulcer left buttock unstageable. During a review of Resident 76's Order Summary Report (OSR), the OSR indicated Resident 76 had an order for Tx (treatment): Pressure ulcer to left gluteus (buttocks), cleanse with NS (normal saline) and apply Medi honey then cover with dry dressing daily and prn (as needed) loose or soiled until resolved. During a concurrent observation and interview on 5/7/26 at 9:59 a.m. in Resident 76's room, during wound treatment observation, the Wound Treatment Nurse (WTN) removed the old dressing from the wound, took the prepared stack of gauze, poured normal saline over the stack of gauze, and cleaned the wound with the gauze. WTN then folded the same stack of gauze in half and stated she folded it to dry the wound. WTN proceeded to dry the wound using the same stack of gauze. During an interview on 5/7/26 at 10:20 a.m. with Infection Preventionist (IP), IP stated a clean gauze should be used to dry a wound because used gauze, even if folded, was considered contaminated. IP stated using clean gauze was important for infection control purposes and cleanliness. During an interview on 5/7/26 at 10:27 a.m. with Director of Nursing (DON), DON stated used gauze should not be used to dry a wound. The DON stated staff should use clean gauze to clean the wound with NS and a separate clean gauze to dry the wound. During a review of the facility's policy and procedure (P&P) titled, Dressings, Dry/Clean, revised 9/2013, the P&P indicated, .15. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleaning stroke. 16. Use dry gauze to pat the wound dry. 2. On 5/6/26 at 8:36 a.m., during a medication pass observation at Station 2 Medication Cart 2 with Licensed Nurse (LN 5), LN 5 prepared Resident 62's morning medications. Resident 62 was seated in his wheelchair near the entrance of his room. LN 5 stated that she needed to check the resident's blood sugar. She performed hand hygiene, donned gloves, and brought the glucometer, alcohol pads, and a test strip into the room. After pulling the privacy curtain, LN 5 swabbed the resident's finger with an alcohol pad, performed the fingerstick, applied the blood to the test strip, and placed the glucometer back into the medication cart. LN 5 performed hand hygiene and continued medication preparation. During a follow^up interview with LN 5 on 5/6/26 at 1:03 p.m., when asked when she cleaned the glucometer, LN 5 stated she cleaned it with an alcohol pad before performing the resident's (continued on next page)

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	055491	A. Building B. Wing	05/08/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fingerstick and waited a few seconds for it to dry. LN 5 stated she used the same type of alcohol pad that was used to clean the resident's finger. During an interview on 5/7/26 at 10:30 a.m. at the Station 4 Medication Cart, Licensed Nurse (LN 3) stated the glucometer should be cleaned before and after using it on residents. He stated it is cleaned with a MicroKill bleach wipe, allowing the surface to remain visibly wet for three minutes. During an interview on 5/8/26 starting at 10:04 a.m. with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the ADON stated that staff are expected to use MicroKill bleach wipes to clean the glucometer between residents, maintaining a wet contact time of three minutes to ensure effective disinfection against bacteria and viruses. The DON and ADON both confirmed that alcohol pads should not be used to clean the glucometer. During a review of the facility's policy and procedure titled, Obtaining a Fingerstick Glucose Level, revised October 2011, indicated, Clean and disinfect reusable equipment between uses according to manufacturer's instructions and current infection control standards of practice. During a review of the Center for Disease Control (CDC) Injection Safety Website titled, Considers for Blood Glucose Monitoring and Insulin Administration, dated August 7, 2024, indicated, If healthcare providers use blood glucose testing .on more than one patient, equipment and supplies may become contaminated. Unsafe practices during assisted monitoring of blood glucose and insulin administration contribute to the spread of hepatitis B virus, hepatitis C virus, HIV and other infections. Unsafe practices include: .Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses. During a review of the EVENCARE G3 Blood Glucose Monitoring System, User's Guide, titled, Cleaning and Disinfecting Procedures for the Meter, accessed 5/12/26, indicated, The EVENCARE G3 Meter should be cleaned and disinfected between each patient.The following products have been approved for cleaning and disinfecting. the Meter: Dispatch Hospital Cleaner Disinfectant Towels with Bleach Medline Micro-Kill+™ Disinfecting, Deodorizing, Cleaning Wipes with Alcohol Clorox Healthcare Bleach Germicidal and Disinfectant Wipes Medline Micro-Kill™ Bleach Germicidal Bleach Wipes 3. During the same medication observation on 5/6/26 at 8:56 a.m., LN 5 removed Resident 62's Lantus Solostar pen (a preˆfilled insulin pen containing insulin glargine) from the medication cart. She donned gloves, removed the insulin pen cap, and attached a new needle without first wiping the rubber seal of the insulin pen with an alcohol swab before needle attachment. She then dialed the pen to the prescribed dose of 23 units. LN 5 changed gloves, asked the resident about his preferred injection site, drew the privacy curtain, cleansed the lower abdomen with an alcohol pad, and administered the insulin. (continued on next page)

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	055491	A. Building B. Wing	05/08/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LN 5 on 5/6/26 at 9:10 a.m. at Medication Cart 2, LN 5 confirmed she did not swab the rubber seal on the pen with an alcohol swab prior to attaching a new needle. During an interview with DON and ADON on 5/8/26 starting at 10:04 a.m. they confirmed staff need to follow the manufacturer guidelines when preparing insulin. During a review of Prescribing information for Lantus Solostar titled, Instructions for Use Lantus Solostar, revised May 2025, indicated: 1B Pull the pen cap. 1C Check that the Insulin is clear. 1D Wipe the rubber seal with an alcohol swab. Step 2: Attach a new needle

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	055491	A. Building B. Wing	05/08/2026

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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 respect one out of eighteen sampled residents (Resident 26) right to privacy, and respect for personal property when staff searched and took Resident 26's belongings without consent. This deficient practice resulted in psychosocial distress for Resident 26 who was observed visibly upset, expressing anger, pacing in his room and verbalizing that the staff opened and took something from his belongings while he was not in his room and without his permission. Findings:During a review of Resident 26's admission Record (AR), Resident 26 was admitted , 8/25 with diagnosis including Fracture of Second Cervical Vertebra (a broken bone in the upper neck), and frequent falls.A review of Resident 26's Minimum Data Set (MDS- a federally mandated resident assessment tool)- dated, 3/5/26 indicated, Resident 26 has intact cognition.During an observation on 5/6/26, at 10:47 a.m., Resident 26 was observed pacing inside his room, appearing visibly upset, angry and frustrated. Resident 26 stated he was very upset, he did not like the facility and wanted to leave. Resident 26 stated that the staff opened and checked his personal belongings without his permission while he was not present in his room. During a review of progress notes dated, 5/4/26 at 1:10 p.m. indicated, .Resident had a statement about reaching out to narcotics while he was on LOA (Leave of Absence) vacation.by permission of Director of Nursing (DON), checked residents room and belongings for possible Medications or beverages.a [brand name-alcoholic beverage] bottle was found in his bag.placed in the med room . No documented evidence found that the resident's consent was obtained prior to opening or searching for Resident 26's personal belongings. No specific documentation or evidence were written that Resident 26 was intoxicated, under the influence of drugs or alcohol, or exhibiting behavioral changes indicating an immediate safety concern at the time staff searched the resident belongings while he was not in his room. During an interview on 5/7/26, at 2 p.m. with DON, stated and confirmed, she authorized her staff to check Resident 26 belongings without his consent.During a review of the facility's policy and procedure titled, Resident Rights, dated, February 2021, indicated, Federal and state law guarantees certain basic rights to all residents of this facility. These rights include a resident right to a. dignified existence.b. to be treated with respect, kindness and dignity.

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	055491	A. Building B. Wing	05/08/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to ensure smoking safety interventions per care plan were implemented and adequate supervision was provided to prevent smoking related accidents for one out of 18 sampled residents (Resident 26). This failure to implement smoking safety intervention per care plan despite the facility's non-smoking status, had the potential to place Resident 26 at risk for foreseeable smoking-related accidents and injuries. Findings:During a review of Resident 26's admission Record (AR), Resident 26 was admitted , 8/25 with diagnosis including, Fracture of Second Cervical Vertebra (a broken bone in the upper neck), Repeated Falls, Nicotine (addictive chemical in cigarettes) Dependence.A review of Resident 26's Minimum Data Set (MDS- a federally mandated resident assessment tool)- dated, 3/5/26 indicated, Resident 26 has intact cognition.During a review of Resident 26 care plan, revised 5/5/26, the care plan indicated, Focus- Potential for injury related to noncompliance as evidenced by refusal of.non-compliant with not smoking on campus.with Interventions including- Cigarettes are to be held in nurses' cart. Patient not to have cigarette in room or on self. During an observation on 5/5/26, at 10:47 a.m., Resident 26 was observed pacing inside his room, appearing visibly upset, angry and frustrated. Resident 26 stated he was very upset, he did not like the facility and wanted to leave. Resident 26 observed to be holding a pack of cigarettes in his room.During a concurrent observation and interview on 5/6/26, at 9:30 a.m. with Resident 26 in his room, Resident 26 was holding a pack of cigarettes. Certified Nurse Assistant (CNA) 3 confirmed Resident 26 goes out by himself to smoke outside. CNA 3 confirmed the observation that he was holding a pack of cigarettes while he was in his room. Resident 26 stated, he always has his cigarettes in his possession. Resident 26 further stated and confirmed, he goes out to smoke few times a day.During a concurrent interview and record review on 5/7/26 at 2 p.m. with Assisted Director of Nursing (ADON), Resident 26 care plan was reviewed. ADON acknowledged the resident's care plan intervention, . instructed staff to keep the resident's cigarette in the nurses' cart and the resident was not to have cigarettes in his room or on self. However, when informed that the resident had been observed with cigarettes in his possession on two separate occasions, the ADON stated, .he did it again. ADON further stated that the facility did not have a safety assessment specific to smoking practices. ADON further stated, there was no smoking assessment process interventions done because the facility is a non-smoking facility. No updated care plan and care plan not implemented despite repeated observations of the resident possessing cigarettes.During a review of the facility's policy and procedure titled, Safety and Supervision of Residents, revised July 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.Monitoring the effectiveness of interventions shall include.c. Modifying or replacing interventions as needed and.d. Evaluating the effectiveness of new or revised interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055491	A. Building B. Wing	05/08/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one out of two residents observed for wound treatment (Resident 53) received necessary treatment and services to promote healing and prevent infection when the wound dressing was not changed as needed.This failure had the potential to delay wound healing and increase the risk of wound infection.Findings:During a review of Resident 53's admission Record (AR), AR indicated Resident 53 was admitted on [DATE] with diagnoses that included sepsis (a life-threatening blood infection), Fournier gangrene (rare but serious fast-spreading infection that destroys skin and tissue around the genital and buttock area) and pressure ulcer of unspecified buttock stage 2 (Partial-thickness loss of skin, presenting as a shallow open sore or wound). During a review of Resident 53's Order Summary Report (OSR), the OSR indicated Resident 53 had an order for Tx (treatment): coccyx (bottom of spine near the buttocks) pressure ulcer: cleanse with normal saline. Apply Santyl and cover with dry dressing daily and prn (as needed) loose or soiled.During a review of Resident 53's Treatment Administration Record (TAR-chart used to document and track treatments provided to a resident), dated 5/1/26 to 5/31/26, there was no documentation on the TAR that the coccyx dressing was changed PRN.During a concurrent observation and interview on 5/7/26 at 8:42 a.m. in Resident 53's room, during wound treatment observation, Wound Treatment Nurse (WTN) lifted the blanket to begin wound treatment to the coccyx pressure ulcer, and there was no dry dressing covering the wound. WTN confirmed there was no dry dressing on the wound and stated that if the wound was not covered, contaminants could come into contact with the wound. WTN stated that if the dressing became soiled or was removed, a nurse could change the dressing.During an interview on 5/7/26 at 8:50 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated that she provided Resident 53's incontinence care at approximately 7:00 a.m. because he had bowel movement. CNA 1 stated that when she began care, the dressing was no longer on Resident 53's coccyx wound.During an interview on 5/7/26 at 8:53 a.m. with WTN, WTN stated that if a dressing was not changed as needed, the wound could fail to heal and or could deteriorate.During an interview on 5/7/26 at 10:27 a.m. with Director of Nursing (DON), DON stated that when a dressing was soiled or dislodged, it should be changed right away. DON stated that routine treatment was completed by the treatment nurse, and any licensed nurse could change the dressing as needed when it was soiled or dislodged to prevent infection.During a concurrent observation and interview on 5/8/26 at 9:20 a.m. with Licensed Nurse (LN) 4 in Resident 53's room, Resident 53's coccyx wound was observed. LN 4 confirmed that there was no dry dressing on the coccyx wound.During an interview on 5/8/26 at 9:25 a.m. with CNA 2, CNA 2 stated that she first provided incontinence care at approximately 6:35 a.m. and observed that there was no dry dressing on Resident 53's coccyx wound at that time. CNA 2 stated that she provided Resident 53 with a bed bath at approximately 8:45 a.m. and observed that there was still no dry dressing on the coccyx wound when she began the care.During a review of the facility's policy and procedure (P&P) titled, Wound Care, revised 10/2010, the P&P indicated, .verify that there is a physician's order for this procedure.following information should be recorded in the resident's medical record.1. type of wound care given 2. The date and time the wound care was given. 7. The signature and title of the person recording the data.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055491	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Healthcare Center	310 Oak Ridge Drive Roseville, CA 95661

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review the facility failed to ensure a substitute meal was offered when food intake was 50% or less for one of eighteen sampled Residents (Resident 53).This failure had the potential to cause weight loss, malnutrition, poor wound healing and a decline in overall health status.Findings: Review of Resident 53's admission Record (AR) indicated, Resident 53 was admitted in April 2026 with several diagnosis including Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Pressure Ulcer stage 2 (Partial-thickness loss of skin, presenting as shallow open sore or wound), Unspecified fracture of shaft of humerus (break in the upper arm bone) and anemia (a condition where the body does not make enough healthy red blood cells).Review of Resident 53's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 4/21/26, the MDS indicated that Resident 53 had moderate cognitive impairment.Review of Resident 53's Weights and Vitals Summary (WVS), dated 5/7/26, the WVS indicated that on 4/16/26 Resident 53 weighed 139 lbs. (lbs.-pounds a unit of measurement) and on 5/4/26 Resident 53 weighed 129 lbs. This comparison equals a loss of 10 lbs. and a 7.2 % decrease in three weeks.Review of Resident 53's Care plan (CP), dated 4/16/26, the CP indicated an intervention that included, Honor resident food preferences within diet parameters. Offer substitute if meal taken 50%.Review of Resident 53's Task Sheet-Nutrition, indicated that for the dates 4/15-5/7/26, Resident 53 had meals where 50% or less was eaten. There was no documentation that a substitute meal was offered.During an interview on 5/7/26 at 8:48 a.m. with Certified Nursing Assistant (CNA)1, CNA 1 stated that Resident 53 eats less than 50% for most meals and that CNA 1 does not offer a substitute meal.During a concurrent interview and record review on 5/7/26 at 11:10 am with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 53's record and confirmed there was no documentation of a substitute meal offered to Resident 53.During an interview on 5/7/26 at 12:40 p.m. with the Registered Dietician (RD), the RD stated that factors that put Resident 53 at a nutritional risk included diabetes and wound healing. RD stated she would expect that Resident 53 be offered a substitute meal if his intake was 50% or less and that the facility needed to ensure he gets enough calories for wound healing.