STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055497	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Placerville Healthcare Center	1040 Marshall Way Placerville, CA 95667

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to maintain infection control practices for a census of 89 when:The tip of Resident 6's enteral feeding tube (a medical device used to deliver nutrition, fluids, and medications directly to the stomach) was observed hanging from the IV pole without a protective cap;Staff did not follow infection prevention protocols when entering the resident's room; andStaff touched the lunches of Resident 52 and Resident 17 with their bare hands.These failures placed residents at risk for spread of infections, disease outbreaks, increased hospitalization and serious health complications for the residents.Findings: 1.Resident 6 was admitted to the facility in early 2026 with diagnoses that included gastrostomy (a surgical opening fitted with a device that allowed feedings to be administered directly into the stomach, commonly used for people with swallowing problems) and quadriplegia (a condition where a person cannot move both arms and both legs). A review of Resident 6's Order Summary Report (OSR) dated 1/26/26 indicated an order to change the enteral feeding tubing every 24 hours during the evening shift. During an observation on 3/2/26 at 10:28 a.m. in Resident 6's room, the tip of the enteral feeding tube, which was not connected to the resident but remained connected to the formula line, was observed hanging from the pole without a protective cap. During an interview on 3/2/26 at 10:31 a.m. with Licensed Nurse (LN) 1, LN 1 stated that the tip of the enteral feeding tube should have had a protective cover to maintain a closed system for the formula and reduce the risk of infection. During an interview on 3/4/26 at 3:40 p.m. with the Director of Nursing (DON), the DON stated that the tip of the enteral feeding tube should have had a sterile cap when not in use. The DON further stated that if the tip did not have a cover, the enteral feeding tube had to be discarded and replaced entirely because using an uncovered tip could lead to infection. A review of the facility's policy and procedure (P&P) titled Enteral Feedings – Safety Precautions, dated 10/25, indicated, Preventing contamination: 1. Maintain aseptic technique at all times when working with enteral nutrition systems and formulas.c. Use closed enteral nutrition systems. A review of the facility's P&P titled Infection Prevention and Control Program, dated 10/25, the P&P indicated, An infection prevention and control program (ICPC) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055497	A. Building B. Wing	03/05/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview with the Nurse Aide in Training (NAT) on 3/4/26 at 3:47 p.m., the NAT was observed inside a resident's room wearing gloves only and without the required gown while handing snacks to residents, despite posted signage indicated STOP.Contact Plus.Please Report to Nurse Before Entering. The NAT then exited the room, retrieved an item from the snack cart without changing gloves and handed it to another resident. When asked, the NAT stated she had not noticed the signage and acknowledged she should have fully donned a gown and checked with the nurse before entering. The NAT later confirmed with a nurse that a resident in the room is on C. difficile (a bacteria that causes life-threatening diarrhea) precaution and stated it was important to fully follow PPE protocols to prevent transmission when going room to room. During an interview with the Director of Staff Development (DSD) on 3/4/26 at 3:52 p.m., the DSD stated that Contact Plus Precaution were used for residents on heightened levels of precaution such as those with C. difficile. The DSD further stated that staff were required to fully gown and glove before entering a room under Contact Plus and must wash hands with soap and water before entering and after exiting. The DSD further stated that staff were expected to follow all posted signs and warnings to protect themselves and residents and to prevent the spread of infection. During a concurrent observation and interview on 3/5/26 at 9:32 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 was observed entering a resident's room where a sign posted near the door indicated Enhanced Standard Precautions. CNA 7 was observed to be wearing gloves but did not don a gown before entering and proceeded to assist the resident in emptying the urinal. When questioned about the observation, CNA 7 stated that according to their infection prevention training he should have followed protocol and worn a gown prior to entering the room and emptying the urinal. During a concurrent observation and interview with the Assistant Director of Nursing (ADON) on 3/5/26 at 9:35 a.m. outside the aboveˆmentioned resident room, the ADON and the Department observed CNA 7 inside the room assisting a resident with emptying a urinal. The ADON confirmed the observation and stated that staff were expected to fully comply with precautionary signage posted at the entrance of rooms and to follow all required protective measures when assisting residents. A review of the facility P&P, titled Infection Prevention and Control revised 6/22 indicated, .prevent the development and transmission of communicable diseases and infections.Prevention of Infection.education staff and ensuring that they adhere to proper techniques and procedures.preventing the spread to other residents. 3. Resident 52 was admitted to the facility in late 2023 with diagnosis which included a decline in memory, and difficulty swallowing. During a review of Resident 52's Order Summary Report [OSR], order date 1/16/26, the OSR indicated Resident 52 required assistance with eating meals. Resident 17 was admitted to the facility in late 2024 with diagnosis which included progressive brain disorder that causes problems with movement and muscle control, communication deficit, and difficulty swallowing. During a review of Resident 17's OSR, order date 1/16/26, the OSR indicated Resident 17 required assistance with eating meals. During a concurrent observation and interview on 3/2/26 at 12:26 p.m. of Resident 52's lunch (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(hamburger and French fries) with Certified Nursing Assistant (CNA 3) in the dining room, CNA 3 touched both the burger and fries with her bare hands while she assisted Resident 52 to eat her meal. CNA 3 confirmed she touched the food items with her hands. During a concurrent observation and interview on 3/2/26 at 12:27 p.m. of Resident 17's lunch (hamburger and French fries) with Rehab Aide (RA 1) in the dining room, RA 1 touched both the burger and fries with her bare hands while she assisted Resident 17 to eat his meal. RA 1 confirmed she touched the food items with her hands. During an interview on 3/2/26 at 1:51 p.m. with the Director of Staff Development (DSD), the DSD stated staff should not touch resident food with bare hands for infection control reasons, They could get sick from that. The DSD further stated she would expect staff to use some type of barrier or a fork to pick up the food. During a review of the facility's policy and procedures (P&P) titled, Infection Prevention and Control Program, dated 10/25, the P&P indicated, An infection prevention and control program (ICPC) are established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. During a review of the facility's P&P titled, Assistance with Meals/Mealtime Policy, undated, the P&P indicated, .All employees who provide resident assistance with meals will comply with infection control practices.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident needs were accommodated for two of 21 sampled residents (Resident 25 and Resident 54) when:1. Resident 25's breakfast tray left within reach without staff present; and2. Resident 54's call light was not within reach.These deficiencies had the potential to place Resident 25 at risk for aspiration and resulted in delayed staff response for Resident 54's needs. Findings: 1. A review of Resident 25's admission records indicated the resident was admitted in late 2025 with diagnoses including dysphagia (difficulty swallowing) and pneumonitis (swelling of lung tissue) due to the inhalation of food and vomit. A review of Resident 25's Minimum Data Set (MDS) dated [DATE] indicated the Brief Interview for Mental Status (BIMS) could not be conducted and the resident was rarely/never understood. Section C of the MDS further indicated that Resident 25's cognitive skills for daily decisionˆmaking score was 2 (moderately impaired—decisions poor; cues/supervision required). A review of Resident 25's Order Summary Report (OSR) dated 3/2/26, the OSR indicated, .Pureed texture .Mildly Thick consistency, Feed assist for breakfast . During an observation on 3/3/26 at 8:16 a.m., Resident 25's breakfast tray was noted uncovered and within reach without staff present. During an interview on 3/3/26 at 8:24 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated that Resident 25 could eat independently with supervision, but she had left the Resident 25 to assist another resident. During an interview on 3/3/26 at 8:45 a.m. with Licensed Nurse (LN) 1, LN1 stated Resident 25 required both supervision and assistance during meals due to the risk of aspiration and was undergoing a feeding trial. During a concurrent interview and record review on 3/4/26 at 9:46 a.m. with the Speech Language Pathologist (SLP), the SLP stated staff were required to supervise Resident 25 during meals. The SLP further stated the resident's diet was downgraded recently from minced and moist to pureed and that she had educated staff, including Restorative Nursing Assistants (RNAs) and CNAs, regarding diet and swallow precautions. A review of the facility's undated policy titled Assistance with Meals/Mealtime Policy indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. A review of the facility's policy titled Accommodation of Needs, dated 10/25, indicated, .staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. 2. Resident 54 was admitted to the facility in Spring of 2025 with diagnoses which included cerebral infraction (stroke, due to a blockage in the blood vessels supplying blood to the brain) and aphasia (a language disorder that affects how you communicate). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 54's Order Summary Report (ORS) indicated, Resident capable of making own decisions A review of Resident 54's Care Plan (CP), dated 1/12/26, indicated **PAIN** [Resident 54's name] is at risk for pain related to.CVA/Post Stroke Syndrome. A review of Resident 54's CP, dated 1/12/26, indicated **FALL CARE PLAN** [Resident 54's name].Approach: Keep call light within reach. A review of Resident 54's Weekly Summary Notes (WSN) dated 2/25/26, indicated Resident 54 was dependent on basic activities of daily living (ADL's) and mobility. During an initial tour of the facility on 3/2/26 at 9:47 a.m., Resident 54 was observed lying on bed crying and grimacing. The Department asked Resident 54 if she needed help, and the resident nodded. When asked whether she had attempted to use the call light to request help, Resident 54 attempted to reach for the callˆlight cord, which was observed to be looped around the bed rails. The resident tried to pull the callˆlight cord but she was unable to. When asked if it was stuck, Resident 54 nodded. The Department confirmed that the callˆlight button was lodged between the mattress and the bed frame, making the callˆlight system inaccessible to the resident. During a concurrent observation and interview with Certified Nurse Assistant (CNA) 4 on 3/2/26 at 10 a.m., in the Resident 54's room, CNA 4 confirmed the findings above and stated that the call light was difficult for Resident 54 to reach because it was stuck between the mattress and the bed frame, and that it should have been positioned closer to the resident. CNA 4 further stated, I could check more often. During a concurrent observation and interview with Licensed Nurse (LN) 2 on 3/2/26 at 11:13 a.m., LN 2 stated that call lights should not be wrapped around bed rails and should instead be clipped or placed across the resident's lap or otherwise within reach. LN 2 further stated that if residents were unable to use their call light to request staff assistance, staff would not be able to assess or respond to the resident's needs. LN 2 added that it was especially important for Resident 54 to have the call light within reach because the resident was choking risk. During an interview with the Assistant Director of Nursing (ADON) on 3/5/26 at 9:32 a.m., the ADON stated that staff should check on residents in their rooms as much as possible, inquire about any specific needs, and scan the rooms for potential hazards. The ADON confirmed that staff receive training on proper callˆlight placement and were expected to ensure call lights were within the resident's reach before leaving the room. The ADON further stated that if call lights were not positioned properly, residents would be unable to call for help or request medications. A review of the facility's Policy and Procedures (P&P) titled, Answering Call Light revised 9/2025, the P&P indicated Residents, when in their rooms.will have the ability to call for assistance.When the resident is in bed.be sure the call light is within easy reach of the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interviews, and record review the facility failed to ensure that the physical environment was maintained in a clean, safe, and homelike condition. One of five corridors containing15 resident rooms, a hole was observed in the ceiling. The ceiling around the hole showed visible water damage including staining and deterioration consistent with a leak from a pipe above the celling. This failure to maintain the building structure in good repair has the potential to lead to mold growth, further structural damage and safety hazards for residents.Findings:During an observation on 3/4/26 at 10:03 a.m., in the resident corridor, the Department observed a hole in the ceiling surrounded by black and white substance, with visible water marks and waterˆdamage consistent with moisture intrusion.During a concurrent observation and interview with Licensed Nurse (LN 7) in the resident corridor on 3/4/26 at 10:19 a.m., LN 7 confirmed the findings described above and acknowledged that the ceiling hole had water marks and was surrounded by black and white substance. LN 7 further stated that the condition should have been reported to the maintenance department and that such issues should not be present as they may pose potential health concerns for residents.During a concurrent interview and record review with LN 7 on 3/4/26 at 10:24 a.m., LN 7 confirmed that the aboveˆnoted findings had not been reported in the facility's maintenance log.During a concurrent observation and interview with the Director of Plant Operations (DPO) on 3/4/26 at 10:38 a.m., the DPO stated that the finding had not been reported. The DPO confirmed that the hole was surrounded by black and white substance and stated that the damage was caused by water intrusion. The DPO indicated that the facility had recently experienced roof leaks and stated that he was responsible for ensuring the facility remained in good repair and condition. The DPO acknowledged the environment should be maintained in a homelike manner for the residents.During a concurrent observation and interview with the DPO on 3/4/26 at 4:07 p.m., the DPO confirmed that there had been a leaking water pipe in the ceiling and that it had caused water damage to a portion of the ceiling.During a concurrent interview with the facility Administrator (ADM), on 3/4/26 at 12:55 p.m., the ADM confirmed the findings described above and stated that the facility should be maintained in good repair and condition. The ADM further stated that the facility should provide a homelike, comfortable, and safe environment for the residents. The ADM added that staff should have reported the findings promptly so the issue could have been addressed and corrected sooner.A review of the facility's Policy and Procedures (P&P) titled, Homelike Environment, revised10/26, the P&P indicated, Residents are provided with a safe, comfortable, and homelike environment.A review for the facility's P&P titled, Maintenance Service, revised 10/25, The P&P indicated, The maintenance Department is responsible for maintaining the buildings.safe and operable manner.Maintaining the building in good repair.plumbing fixtures.

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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 services provided met professional standards of quality for a census of 89 when:1. Staff did not assess for and treat Resident 12's shortness of breath;2. Staff administered the wrong dose of morphine sulfate for Resident 60; and3. Staff did not accurately complete the weekly summary for Resident 92.These findings had the potential to delay care for Resident 12 and Resident 92, cause inadequate pain control for Resident 60, lead to adverse reactions from medications for Resident 60, and compromise resident safety for Resident 92. Findings: 1. Resident 12 was admitted to the facility in February of 2024 with diagnoses that included asthma (a chronic condition that inflames and narrows the airways in the lungs) and chronic obstructive pulmonary disease (COPD) (a progressive, irreversible lung disease). A review of Resident 12's Physician Orders (PO), dated 2/10/26, indicated, Morphine Sulfate (Concentrate) [a medication used to treat pain and alleviate shortness of breath] Oral Solution 100MG [milligrams, a unit of measurement]/5ML [milliliter, a unit of measurement] (Morphine Sulfate) *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for Mild Pain (1-3) or Shortness of Breath A review of Resident 12's Care Plan (CP), dated 2/12/26, indicated, HOSPICE/PALLIATIVE [comfort and symptom management for serious illnesses] CARE PLAN.Administer medication as ordered. A review of Resident 12's CP, dated 2/29/26, indicated, PSYCHOSOCIAL/WELL BEING CARE PLAN.Observe for clinical changes: pain, respiratory distress, GI [gastrointestinal] distress, edema, change in LOC [level of consciousness]. During an observation on 3/4/26 at 8:23 a.m., Resident 12 was observed to have a respiration rate of about 36 breaths per minute. Resident 12 also displayed signs of shortness of breath such as accessory muscle use and opening her mouth to breath. During an observation on 3/4/26 at 9:19 a.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 entered Resident 12's room to prepare Resident 12 for a bed bath. After completing the bed bath and leaving the room, CNA 2 failed to report Resident 12's increased respiratory rate and shortness of breath to her supervising licensed nurse (LN). During a concurrent observation and interview on 3/4/26 at 9:48 a.m. with LN 2, LN 2 entered Resident 12's room to change her scopolamine patch (a medication used in hospice care to manage excessive secretions or nausea). After replacing the scopolamine patch, LN 2 left the room without assessing Resident 12's respiratory rate or shortness of breath. Resident 12's PO for morphine sulfate were then reviewed with LN 2, who confirmed that the last dose was given on 3/2/26 and indicated that morphine sulfate should currently be administered for Resident 12's respiratory symptoms. During an interview on 3/5/26 at 9:33 a.m. with the Director of Nursing (DON), the DON indicated that shortness of breath should be managed if it was outlined in the CP or PO. The DON further indicated that she expected staff to correctly assess residents' vital signs [blood pressure, temperature, heart (continued on next page)

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	055497	A. Building B. Wing	03/05/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rate, respiratory rate, and pain level] and report any changes or irregularities to the interdisciplinary team. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, revised 7/17, the P&P indicated, In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These include.Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care. 2.Resident 60 was admitted to the facility in December of 2023 with diagnoses which included dementia (a condition characterized by persistent loss of intellectual functioning) and type 2 diabetes mellitus (a condition when the body cannot use insulin correctly and sugar builds up in the blood). A review of Resident 60's Order Summary Report (ORS), indicated, Morphine Sulfate Oral Solution 10mg [milligrams, a unit of measurement]/5ml [milliliters, a unit of measurement].Give 2.5 ml by mouth every 6 hours as needed for moderate (4-7) to severe (8-10) pain Hold for RR [respiratory rate] < 12. A review of Resident 60's Care Plan (CP), dated 12/18/25, indicated **COGNITIVE CARE PLAN** [Resident 60's name] has altered Cognition R/T [related to]: Dementia M/B [manifested by] Changes in skills for daily decision making.Administered meds as ordered A Review of Resident 60's CP, dated 12/18/25, indicated PAIN [Resident 60's name] Resident at risk for pain .will remain adequate level of comfort .Administer pain medication as ordered. A review of Resident 60's electronic medication administration record (EMAR) indicated that 2.5 ml of Morphine Sulfate Oral Solution was administered on 2/26/26 at 10:37 a.m. for a reported pain level of 5/10, indicating moderate pain. A review of the Resident 60's EMAR – Medication Administration Note dated 2/26/26 at 10:37 a.m., indicated, .1 ml given. During a concurrent interview and record review with Licensed Nurse (LN) 7 on 3/4/26 at 10:55 a.m., regarding the medication administration from 2/26/26 during the morning medication pass, LN 7 stated that the resident was experiencing pain and had a documented pain score of 5/10, indicating moderate pain. LN 7 confirmed that Resident 60 had an active order for Morphine Sulfate Oral Solution, 2.5 ml every six hours as needed. After reviewing the progress note, LN 7 acknowledged that the documentation reflected administration of only 1 ml and stated that she administered 1 ml instead of the ordered 2.5 ml. LN 7 confirmed this constituted a medication error and stated that no medication error report had been completed. LN 7 further stated that the physician should have been notified of the error. During an interview with the Director of Nursing (DON) on 3/4/26 at 11:45 a.m., the DON stated that licensed nurses were required to follow physician orders and confirmed that a medication error occurred when only 1 ml of Morphine Sulfate was administered by LN 7 instead of the ordered 2.5 ml. The DON further stated that no medication error report had been submitted at the time the variance occurred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055497	A. Building B. Wing	03/05/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policies and procedures (P&P) titled, Physician Order, revised 10/25 indicated, Prescribed medications and treatment orders will be carried out in accordance with the physician/nurse practitioner's order.The licensed staff shall carry out physicians/nurse practitioner's orders as prescribed. A review of the facility's P&P titled, Medication Error, revised 10/25, indicated, The safety of the residents is the goal of care during medication passes.Whenever a medication error occurs, the nurse responsible for the error or the staff who caught the medication error will:.Inform the DNS [DON].the nurse will immediately contact the physician.The nurse involved will be involved with filling out the Medication Error Report. 3. Resident 92 was admitted to the facility in late 2022 with diagnosis which included stroke with right side weakness, inability to urinate, urinary retention and urinary tract infections. During a review of resident 92, Order Summary Report, [OSR] order date 4/10/25, the OSR indicated Resident 92 had an order for an indwelling catheter (a thin flexible tube inserted into the bladder to drain urine). During a review of Resident 92's Care Plan Report [CP], date initiated 4/10/25, the CP indicated, INDWELLING URINARY CATH CARE PLAN [Resident 92] requires an indwelling urinary catheter R/T [related to].At risk for Chronic UTIs [urinary tract infections].Monitor urine for sediments, cloudy, odor, blood.Monitor I&O [intake and output, record of fluid that enter the body and fluid that leaves the body] as indicated. During a review of Resident 92's Weekly Summary Notes [WSN], dated 1/15/26 and 1/22/26, the WSN indicated, Is Resident on I&O? No.Average 24-hour Intake: [question not answered], Average 24-hour Output: [question not answered], Urine Color: [question not answered], Consistency: [question not answered], Urine Color: [question not answered], Urine Odor: [question not answered], Clarity: [question not answered], Skin Turgor: [question not answered], Edema: [question not answered], Mucous Membrane: [question not answered]. During a review of Resident 92's hospital records dated 1/28/26, the hospital records indicated Urinary tract infection associated with indwelling catheter. During a concurrent interview and record review on 3/5/26 at 9:30 a.m. with the Director of Nursing (DON), the DON stated all residents were on I&O monitoring and the question in the WSN, Is Resident on I&O? should have been marked Yes. The DON confirmed Resident 92's WSN dated 1/15/26 and 1/22/26 indicated an answer of No for I&O monitoring. The DON confirmed the WSN was not accurate which created a missed opportunity to assess the urine for Resident 92 and stated the documentation should have been accurate for a resident who had an indwelling catheter and was at risk for urinary tract infections. During a review of the facility's policy and procedure (P&P) titled, Weekly Summary Documentation, dated 10/25, the P&P indicated, It is the policy of this facility to provide a weekly summary documentation.The assigned nurse shall complete a weekly summary. During a review of the facility's P&P titled, Intake and Output Measuring and Recording, dated 10/25, the P&P indicated, .Intake and output monitoring is indicated for residents with.Indwelling catheter. (continued on next page)

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	055497	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Placerville Healthcare Center	1040 Marshall Way Placerville, CA 95667

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Catheter Care, Urinary, dated 10/25, the P&P indicated, .The following information should be recorded into the resident's medical record.Character of urine such as color.clarity.and odor.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility did not ensure the medication error rate did not exceed 5% for a census of 89 when: Resident 95's pantoprazole (a medication used to treat heartburn) was crushed;Resident 95's liquid fluconazole (a medication used to treat fungal diseases) was not shaken prior to administration; andResident 60 did not receive the ordered dose of her liquid morphine. These failures resulted in a medication error rate of 10.34% with three medication errors observed out of 29 medication administration opportunities. Findings: 1. Resident 95 was admitted to the facility in February of 2026 with diagnoses that included candidal esophagitis (a fungal infection of the esophagus) and gastroesophageal reflux disease (GERD, a chronic condition where stomach acid frequently flows back into the esophagus, causing symptoms like heartburn, regurgitation, chest pain, and difficulty swallowing). A review of Resident 95's fluconazole pharmacy label indicated, Give 10ml [milliliters, a unit measurement for liquids] via G-Tube [a tube inserted into the stomach to administer nutrition] one time a day for ESOPHAGEAL CONDIDIASIS [a type of fungal infection] UNTIL 3/04/26.SHAKE WELL. During a concurrent observation and interview on 3/2/26 at 8:38 a.m. with Licensed Nurse 3 (LN 3), LN 3 prepared and administered 10ml of fluconazole to Resident 95 without shaking the medication bottle and ensuring the contents of the bottle were adequately mixed. After the medication administration, LN 3 confirmed that fluconazole should be shaken prior to being administered. 2. A review of Resident 95's Physician Orders (PO) for pantoprazole, dated 2/21/26, indicated, Pantoprazole Sodium Oral Tablet Delayed Release 40 MG [milligrams, a unit of measurement] (Pantoprazole Sodium) Give 1 tablet by mouth two times a day for GI [gastrointestinal] bleeding Do Not Crush. During a concurrent observation and interview on 3/2/26 at 3:24 p.m. with LN 4 and LN 5, LN 5 was observed crushing Resident 95's pantoprazole tablet prior to being administered. LN 5 then administered the crushed tablet to Resident 95. After the medication was administered, Resident 95's PO for pantoprazole were reviewed with LN 4 and LN 5, and both LN 4 and LN 5 confirmed pantoprazole should not be crushed prior to administration. During an interview on 3/5/26 at 9:33 a.m. with the Director of Nursing (DON), the DON indicated that staff should administer medications to residents according to the PO. The DON further indicated that staff should call pharmacy and double check if medications can be crushed prior to doing so. During a review of the facility Policy and Procedure (P&P) titled, Crushing Medications, revised 10/25, the P&P indicated, Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders.When such a medication is administered, the facility staff will observe the resident for pertinent adverse effects. During a review of the facility PNP titled, Physician Orders, revised 8/24, the P&P indicated, Prescribed medication and treatment orders will be carried out in accordance with the physician/nurse practitioner order. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.Resident 60 was admitted to the facility in December of 2023 with diagnoses which included dementia (a condition characterized by persistent loss of intellectual functioning) and type 2 diabetes mellitus (a condition when the body cannot use insulin correctly and sugar builds up in the blood). A review of Resident 60's Order Summary Report (ORS), indicated, Morphine Sulfate Oral Solution 10mg [milligrams, a unit of measurement]/5ml [milliliters, a unit of measurement].Give 2.5 ml by mouth every 6 hours as needed for moderate (4-7) to severe (8-10) pain Hold for RR [respiratory rate] < 12. A review of Resident 60's Care Plan (CP), dated 12/18/25, indicated **COGNITIVE CARE PLAN** [Resident 60's name] has altered Cognition R/T [related to]: Dementia M/B [manifested by] Changes in skills for daily decision making.Administered meds as ordered A Review of Resident 60's CP, dated 12/18/25, indicated PAIN [Resident 60's name] Resident at risk for pain .will remain adequate level of comfort .Administer pain medication as ordered. A review of Resident 60's electronic medication administration record (EMAR) indicated that 2.5 ml of Morphine Sulfate Oral Solution was administered on 2/26/26 at 10:37 a.m. for a reported pain level of 5/10, indicating moderate pain. A review of the Resident 60's EMAR – Medication Administration Note dated 2/26/26 at 10:37 a.m., indicated, .1 ml given. During a concurrent interview and record review with Licensed Nurse (LN) 7 on 3/4/26 at 10:55 a.m., regarding the medication administration from 2/26/26 during the morning medication pass, LN 7 stated that the resident was experiencing pain and had a documented pain score of 5/10, indicating moderate pain. LN 7 confirmed that Resident 60 had an active order for Morphine Sulfate Oral Solution, 2.5 ml every six hours as needed. After reviewing the progress note, LN 7 acknowledged that the documentation reflected administration of only 1 ml and stated that she administered 1 ml instead of the ordered 2.5 ml. LN 7confirmed this constituted a medication error and stated that no medication error report had been completed. LN 7 further stated that the physician should have been notified of the error. During an interview with the Director of Nursing (DON) on 3/4/26 at 11:45 a.m., the DON stated that licensed nurses were required to follow physician orders and confirmed that a medication error occurred when only 1 ml of Morphine Sulfate was administered by LN 7 instead of the ordered 2.5 ml. The DON further stated that no medication error report had been submitted at the time the variance occurred. A review of the facility's policies and procedures (P&P) titled, Physician Order, revised 10/25 indicated, Prescribed medications and treatment orders will be carried out in accordance with the physician/nurse practitioner's order.The licensed staff shall carry out physicians/nurse practitioner's orders as prescribed. A review of the facility's P&P titled, Medication Error, revised 10/25, indicated, The safety of the residents is the goal of care during medication passes.Whenever a medication error occurs, the nurse responsible for the error or the staff who caught the medication error will:.Inform the DNS [DON].the nurse will immediately contact the physician.The nurse involved will be involved with filling out the Medication Error Report.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to implement their medication storage policy for a census of 89 when expired medications were not disposed of.These failures had the potential for residents to receive medications with unsafe and reduced potency from being used past their discard date.Findings:A review of the fluticasone propionate/salmeterol (drugs to aide in breathing) 250mcg/50mcg (micrograms, a unit of measurement) inhaler manufacturer box indicated to discard the product one month after opening.During a concurrent observation and interview on 3/2/26 at 1:35 p.m. with Licensed Nurse 2 (LN 2), medication cart two contained an expired propionate/salmeterol 250mcg/50mcg inhaler with an open date of 1/4/26. The inhaler was being stored with other inhaled medications. LN 2 confirmed the inhaler was expired and indicated that using an inhaler past its expiration date could lead to a loss of effectiveness.During a concurrent observation and interview on 3/3/26 at 9 a.m. with Licensed Nurse 6 (LN 6), the following medications were found to be expired and available for use in the wound treatment cart: two diclofenac sodium 1% gel (a medication used to treat pain and other symptoms of arthritis of the joints) tubes, a triamcinolone 0.1% cream (a medication used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions), and a bottle of ketoconazole 2% shampoo (a medication used to treat infections caused by a fungus). LN 6 confirmed the medications were expired and being stored in the cart. LN 6 then indicated that expired medications should be disposed of.During an interview on 3/5/26 at 9:33 a.m. with the Director of Nursing (DON), the DON indicated that nursing staff should not store expired medications in the medication carts and expects nursing staff to dispose of expired medications.During a review of the facility's policy and procedure (P&P) titled, Medication Labeling, revised 8/24, the P&P indicated, Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.Follow the manufacturer's expiration date for inhalers.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to ensure 9 resident rooms (Rooms 3, 4, 5, 6, 7, 8, 9,15, and 16) met the required 80 square feet (sq. ft.) per resident when rooms 3, 4, 5, 6, 7, 8, 9, 15, and 16 were measured as 228.55 sq. ft. for a three residents occupancy or 76.2 sq. ft. per resident. This failure had the potential to result in inadequate space for the provision of health care and services for 27 residents residing in these rooms for a census of 89 residents.Findings:The observations were made throughout the survey in rooms 3, 4, 5, 6, 7, 8, 9, 15 and 16. The rooms had enough space to store assistive devices, like wheelchairs and walkers, and staff were able to provide care.During an interview on 3/2/26 at 1:04 p.m. with Licensed Nurse (LN) 1, LN 1 stated they were able to give resident care in the rooms without any problems.During a concurrent observation and interview on 3/3/26 at 11:30 a.m. Certified Nursing Assistant (CNA) 1, CNA 1 was seen using a sitˆtoˆstand device to move Resident 16 from the resident's room to the shower room. CNA 1 stated she did not need to move any items in the room to use the device safely.During an interview on 3/3/26 at 1:15 p.m. with the Director of Plant Operations (DPO), the DPO stated no changes had been made to the size or layout of any of the resident rooms.During an observation on 3/4/26 at 10:51 in Resident 7's room, Resident 7 walked from the bed to the closet, took out clothing, and prepared for a shower without any difficulty.Interviews conducted during the survey process with available residents living in the affected rooms showed that the residents felt they had sufficient space to receive care.During a concurrent interview and record review on 3/5/26 at 1 p.m. with the Administrator (ADM), the rooms' dimension were reviewed. the ADM confirmed that Rooms 3, 4, 5, 6, 7, 8, 9, 15, and 16 measured 228.55 square feet for three residents. The ADM confirmed that each resident should have 80 square feet.The Department recommends continuation of the waiver for the above-mentioned rooms.