STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Oak Nursing and Rehabilitation Center	4635 College Oak Drive Sacramento, CA 95841

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food was stored, prepared and served in a sanitary manner for a census of 112 when:1.Three bags of food were found unsealed in the freezer, and 2.There was a large buildup of black residue on the inside door jam of the walk-in refrigerator .These failures present a potential risk of foodborne illnesses for residents eating facility prepared meals.Findings:1.During a concurrent observation and interview on 4/6/26 at 8:12 a.m. with the Dietary Supervisor (DS) in the facility kitchen, a plastic bag of 216 biscuits, about 1/3/full, a large bag of 144 enchiladas in an open box and a partial bag of 107 sausage patties were found in unsealed plastic bags, open and exposed to the air and contamination in the facility freezer. DS verified the bags were unsealed and available for use.2. During an observation on 4/6/26 at 8:28 a.m. of the walk-in refrigerator in the facility kitchen, a heavy black residue was observed around the door frame inside the walk-in fridge. There was heavier residue toward the bottom and blackish residue on the putty around a pipe containing electrical wiring in the left corner of the refrigerator window.During an interview on 4/6/26 at 8:30 a.m. with Dietary Aid (DA)1 in the facility kitchen, DA 1 stated, I have not noticed black [residue on the door frame] in the walk-in fridge. Two other anonymous kitchen staff were asked and indicated they had not noticed any black residue in the walk in fridge.During an interview on 4/6/26 at 8:32 a.m. with the DS in the facility kitchen, DS said, I was not aware of the black [residue] around the door casing in the walk-in refrigerator.Food should be tightly closed and the [enchilada] box closed as well.During a concurrent observation and interview on 4/6/26 at 8:34 a.m. with the Maintenance Supervisor (MS), MS verified the black colored residue around the door jam and pipes carrying electrical wiring and indicated he had never noticed the black [residue] on the inner door jam or on the putty at the top of the window.During an interview on 4/9/26 at 8:55 a.m. with the Registered Dietician (RD) in her office, the RD said, I do an inspection of the walk-in refrigerator monthly and have never seen black discoloration around the door jam. The RD was asked her expectation for cleaning of the walk-in refrigerator and the sealing of plastic bags of food in the freezer and said, My expectation is to monitor and keep the refrigerator clean. Bags of food should be kept sealed to protect from freezer burn. If not sealed, it could cause freezer burn, change in appearance and flavor.During a review of the facility policy and procedure (P&P) titled PROCEDURE FOR FREEZER STORAGE, dated 2023, the P&P indicated, Store frozen foods in an airtight moisture resistant wrapper such as a plastic bag.to prevent freezer burn.During a review of the facility P&P titled, PROCEDURE FOR REFRIGERATED STORAGE, dated 2023, the P&P indicated, Refrigeration equipment should be routinely cleaned.

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interview and record review, the facility failed to notify a room change and to provide room transfer assessment for two of 112 sampled residents (Resident 32 and Resident 127) when Resident 127 was moved into Resident 32's room.These failures resulted in both Resident 32 and Resident 127 to be inadequately informed regarding the transfer and did not receive complete assessments following the room change.Findings:Resident 127 was admitted to the facility in December of 2025 with diagnoses which included Diabetes Type II with neuropathy (nerve damage) and Asthma (a condition in which your airways narrow and swell and may produce extra mucus)Resident 32 was admitted to the facility in August of 2023 with diagnoses which included Epilepsy (a type of seizure) and Diabetes Type II.A review of Resident 127's Order Summary Report (ORS) indicated, Resident has capacity to understand choices and make health care decisions.A review of Resident 127's Minimum Data Set (a standardized assessment tool used in nursing homes), dated 3/17/26, indicated Resident 127 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition.During an interview with Resident 127 on 4/6/26 at 8:43 a.m. in her room, Resident 127 stated being relocated from her previous room without a clear explanation, other than being informed that the room required cleaning and she would return afterwards. Resident 127 expressed concern that the information provided for the transfer was inaccurate and stated she did not wish to move rooms. She further stated that neither the nursing staff nor the Certified Nurse Assistants (CNA) provided additional information regarding the transfer. Resident 127 stated a staff informed her that the room had been reassigned to provide accommodation for short-term residents.During an interview with the Assistant Director of Nursing (ADON) on 4/6/26 at 10:51 a.m., the ADON explained that facility policy requires obtaining resident consent prior to moving them to a different room. She emphasized that the facility could not relocate a patient solely to accommodate another individual, regardless of whether they were receiving long-term or short-term care. Furthermore, she stated that residents must be informed of the reason for any transfer. The ADON stated that she was unaware of the reason for Resident 127's room change.During a concurrent interview and records review with the Social Services Director (SSD) on 4/6/26 at 11:11 a.m., the SSD explained that residents must be notified of any room changes and must provide consent. The SSD stated that requiring a short-term room was not an appropriate justification for initiating room changes. Additionally, the SSD stated that once a room change was initiated, a room change assessment must be completed. It was confirmed that Resident 127 was relocated on 4/4/26; however, the room change assessment section was not completed. Furthermore, there was no documentation regarding the reason for the transfer or evidence of Resident 127's consent to the move. The SSD acknowledged that all transfers should be documented in resident records, The SSD was unable to identify who initiated the transfer of Resident 127.During an interview with Resident 32 on 4/9/26 at 9:15 a.m., outside the dining hall, Resident 32 stated that she remembered her roommate, Resident 127, moving into her room. She further stated that she was not informed by staff regarding the move.During a concurrent interview and records review with SSD on 4/9/26 at 9:55 a.m., SSD verified that documentation was not available to indicate that Resident 32's responsible party (RP) was notified of the transfer. Additionally, the SSD stated there was no record indicating that Resident 32 was informed of the transfer. Furthermore, she confirmed that the transfer form had not been initiated. The SSD stated that there should have been documentation in Resident 32's records.During an interview conducted with the Administrator (ADM) on 4/9/26 at 10:06 a.m., the ADM verified that Resident 127 had been transferred to another room on 4/4/26. However, the ADM was unable to provide information regarding who authorized the transfer or the reason for its occurrence.A review of the facility policy and procedure (P&P) titled, Room Change/Roommate Assignment revised 03/21 indicated, .Resident preferences are taken into account when such changes are considered.Prior to changing a room or (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	roommate assignment all parties involved in the change/assignment (e.g., residents and their representatives are given written notice of such change.Resident have the right to refuse to move to another room in the facility if the purpose of the move is:.from skilled nursing within the facility to one that is not a skilled nursing unit.from a nursing unit within the facility to one that is skilled nursing unit.solely for the convenience of staff.Documentation of a room change is recorded in the resident's medical record.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interviews, observations, and record review the facility failed to manage pain for two of 24 sampled residents (Resident 3 and Resident 136), when Resident 3 and Resident 136 reported significant pain to staff and did not receive their ordered pain medication when requested. This failure led to prolonged pain for Resident 3 and Resident136.Findings:Resident 3 was admitted to the facility in March of 2026 with diagnoses that included epididymitis (inflammation in the sperm-carrying tube at the back of the testicle causing pain and swelling).A review of Resident 3's Minimum Data Set (MDS, an assessment tool used in skilled nursing facilities), dated 3/25/26, indicated Resident 3's Brief Interview for Mental Status (BIMS, an assessment to test cognitive function) was 15, indicating that Resident 3 had no cognitive deficits.A review of Resident 3's, Order Details, dated 3/30/26, indicated, oxyCODONE [medication used to treat moderate to severe pain] HCL [hydrochloride] Oral tablet 10 MG [milligrams, a unit of measurement] Give 1 tablet by mouth every 6 hours as needed for pain.A review of Resident 3's, Medication Administration Record, dated 4/2026, indicated that Resident 3 had received his last dose of oxycodone on 4/6/26 at 5:22 a.m. and was due for another dose by 11:22 a.m.During an interview on 4/6/26 at 2:57 p.m. with Resident 3, Resident 3 indicated that he had requested his oxycodone pain medication before lunch but did not receive it until two to three hours later at 1:59 p.m. Resident 3 had described his pain as, It feels like someone is hitting me with a hammer on my testicle. He further indicated that the pain had made it very difficult for him to move around limiting his mobility and independence.During an interview on 4/7/26 at 9:14 a.m. with Licensed Nurse 3 (LN 3), LN 3 indicated that he had been running behind during his shift on 4/6/26 and it had caused him to administer Resident 3's pain medication late.Resident 136 was admitted to the facility in March of 2026 with diagnoses that included breast cancer.A review of Resident 136's, Order Details, dated 3/31/26, indicated, Hydrocodone-Acetaminophen [medication used to treat significant pain] Tablet 5-325 MG *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for pain management Hold if RR [respiration rate] is less than 12.A review of Resident 136's, Medication Administration Record, dated 4/2026, indicated that Resident 136 had received her last dose of hydrocodone-acetaminophen on 4/5/26 at 1:44 a.m.During an interview on 4/6/26 at 12:13 p.m. with Resident 136, Resident 136 indicated that she had requested her pain medication last night but was not given the pain medication because staff told her, It is not available. Resident 136 further indicated that she had not slept well and was in pain during the night due to the missed dose of pain medication.During an interview on 4/6/26 at 12:57 p.m. with LN 2, LN 2 confirmed that Resident 136 had not received a dose of her pain medication last night even though the pain medication was due and was available to obtain from an e-kit [emergency kit, a container with medications that are used during emergencies or shortages]. LN 2 indicated that nursing staff should have ensured pain medications did not run out and that nursing staff should have called pharmacy prior to running out of medications to ensure there was adequate pain management for residents.During an interview on 4/8/26 at 1:56 p.m. with the Director of Nursing (DON), the DON explained that if a resident had reported pain, staff should have assessed the resident and administered pain medications as ordered by the physician. The DON indicated that a resident should not wait hours to receive pain medication if it was due. The DON further indicated that if pain medication was not available in the medication cart, staff should have obtained it from the e-kit and requested a refill from the pharmacy.During a review of the facility's policy and procedures (P&P) titled, Pain Assessment and Management, revised 10/22, the PNP indicated, The medication regimen is implemented as ordered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored in accordance with the accepted professional principles and current standard of practice for a census of 112 when an over the counter medication was found stored out of its original package. These failures had the potential for residents to receive medications that were expired and with unsafe or reduced potency.Findings: During a concurrent observation and interview on [DATE] at 1:52 p.m., with Licensed Nurse (LN) 5 on south medication cart, seven cough drops were found in a clear plastic cup and not in their original packaging. LN 5 confirmed the observation. LN 5 stated there were no expiration dates on the cough drops and they should have been in their original packaging. During an interview on [DATE] at 2:04 p.m., with LN 4, LN 4 stated over the counter cough drops needed to be stored in their original package. LN 4 further stated if not stored in the original package, the cough drops could potentially be expired and not safe for residents. During an interview on [DATE] at 8:39 a.m., with the Director of Nursing (DON), the DON stated the expectation was for nursing staff to store all medications, including over the counter medications, in their original packaging. DON further stated medications not stored in their original packaging and without expiration dates, could potentially be expired and have reduced potency. During a review of the facility's Policy and Procedure (P&P) titled, Medication Labeling and Storage, revised 2/23, the P&P indicated, Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers.The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.For over the counter (OTC) medications in bulk containers (if permitted by state law) the label contains: a. medication name; b. strength; c. quantity; d. accessary instructions; e. lot number; and f. expiration date (if applicable).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to maintain accurate medical records for one out of 13 sampled residents when Resident 12's Medication Administration Record (MAR, a legal document that list administered drugs) was inaccurate and inconsistent with the Controlled Drug Record (CDR- a paper log of controlled drug removal for administration to resident).This failure placed Resident 12 at risk for medication errors, adverse drug reactions and ineffective drug therapy. Findings: A review of Resident 12's clinical record indicated Resident 12 was admitted March of 2026 with multiple diagnoses which included anxiety disorder and bipolar disorder (mental illness that causes extreme mood swings). A review of Resident 12's active physician's order, dated 4/7/26, indicated, Valium [medication to treat anxiety] Oral Tablet 5 MG [milligrams- unit of measurement] (Diazepam) Give 1 tablet by mouth every 6 hours as needed for Anxiety.A random audit of Resident 12's MAR and the CDR for valium (Diazepam), for March and April 2026, indicated nursing staff did not document valium administration on the MAR when signed out from CDR on 4/1/26 at 1730 [5:30 p.m.]. During a concurrent interview and record review on 4/7/26 at 3:25 p.m. with the Director of Nursing (DON), Resident 12's CDR and MAR were reviewed. The DON confirmed Resident 12's valium use was not accurately documented on the MAR. During an interview on 4/7/26 at 3:56 p.m. with the Nursing Supervisor (NS), the NS confirmed the expectation was for nursing staff to document in both the CDR and MAR when a controlled drug medication was administered. The NS stated inaccurate documenting could potentially result in residents not getting accurate dosage of medication per physician's order. A review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 7/2017, indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .complete, and accurate.A review of the facility's P&P titled, Controlled Medications, dated 3/2018, 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.