STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056243	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Slope Health Center	3280 Washington Street 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety when:1. There were food debris on shelves with clean and ready-to-use sheet pans,2. A container in the clean and ready-to-use storage area was stacked wet,3. Two small cups of yogurt were stored in the refrigerator uncovered and,4. The microwave for residents' food was not clean.These failures had potential to cause food-borne illnesses in a highly susceptible population of 91 out of 91 residents who received food from the kitchen.Findings: 1. During a concurrent observation and interview on 3/3/26 at 8:11 a.m. with Dietary Supervisor (DS) at the kitchen's initial tour, food debris were observed on the shelves that stored clean and ready-to-use sheet pans. DS confirmed there were food debris on the shelves and acknowledged the area should have been kept clean and free from food debris. During an interview on 3/5/26 at 11:05 a.m. with Registered Dietician (RD), RD acknowledged the risk for foodborne illness when food debris were found on the shelves. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, .all.shelves.shall be kept clean. 2. During a concurrent observation and interview on 3/3/26 at 8:13 a.m. with DS at the kitchen's initial tour, a half-gallon plastic container was stacked wet in the clean and ready-to-use storage area. DS confirmed the container was wet. DS stated containers should be completely dry before being stored. During an interview on 3/5/26 at 11:05 a.m. with RD, RD acknowledged the risk for foodborne illness when the container was stored wet. During a review of the facility's policy and procedure (P&P) titled, Dishwashing, undated, the P&P indicated, .dishes are to be air dried in racks before stacking and storing. 3. During a concurrent observation and interview on 3/3/26 at 8:15 a.m. with DS at the kitchen's initial tour, two small containers of yogurt were stored uncovered in the refrigerator. DS confirmed the two containers of yogurt were uncovered. DS stated the yogurt should have been covered. During an interview on 3/5/26 at 11:05 a.m., RD acknowledged the risk for foodborne illness when the yogurt was stored uncovered in the refrigerator. During a review of the facility's P&P titled, Labeling and Dating of Food, dated 2023, the P&P (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	indicated, .all prepared foods need to be covered. 4. During a concurrent observation and interview on 3/4/26 at 2:34 p.m. with Activities Director (AD), the interior part of the microwave for residents' food had splashes of dry food. AD confirmed the microwave was dirty and needed to be cleaned. During an interview on 3/5/26 at 11:05 a.m., RD acknowledged the risk for foodborne illness when the residents' microwave was dirty. During a review of the facility's P&P titled, Sanitation dated 2023, it indicated, .all.equipment shall be kept clean.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure nonpharmacological interventions were implemented for two residents (Resident 3 and Resident 4) of 24 sampled residents, when target behavior and side effect monitoring were not performed for Resident 3's and Resident 4's psychotropic medications. These failures had the potential to result in unnecessary medication for Residents 3 and 4 and an increased risk and exposure to side effects associated with psychotropic medications such as sedation, memory loss, falls, abnormal involuntary movements, and death.Findings: Resident 3 was admitted to the facility in January 2026 with diagnoses with included post-traumatic stress disorder (PTSD, symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event). A review of Resident 3's medical record (MR) indicated a physician's order for the following: - Quetiapine (a psychotropic medication, drugs that affect brain activities associated with mental processes and behavior) 100 milligrams (mg, a unit of measurement), give 1 tablet at bedtime for PTSD AEB (as evidenced by) paranoid delusions, dated 2/11/23. - Lorazepam (medication to treat anxiety) 0.5 mg: Give 1 tablet by mouth every 8 hours as needed for anxiety/agitation for 14 days, dated 2/18/26. A review of Resident 3's MR indicated the facility was not monitoring the target behavior and side effects related to lorazepam and non-pharmacological interventions were not implemented along with the use of lorazepam and quetiapine. During a concurrent interview and record review on 3/5/26 at 10:32 a.m., with Licensed Nurse (LN) 2, Resident 3's MR was reviewed. LN2 stated he did not see non-pharmacological interventions were implemented with the use of psychotropic medications for Resident 3. LN2 stated he would expect a resident to be monitored for target behaviors and side effects related to the use of lorazepam and confirmed he did not see it documented as completed in the MR. During a concurrent interview and record review on 3/5/26 at 11 a.m. with Director of Nursing (DON), Resident 3's MR was reviewed. DON confirmed residents with psychotropic medication orders were to be monitored for side effects and target behaviors and non-pharmacological interventions were to be implemented. DON confirmed Resident 3 did not have non-pharmacological interventions implemented was not monitored for target behaviors and side effects related to lorazepam. Resident 4 was admitted to the facility in February 2026 with a diagnosis with included Delirium due to known psychological conditions, and unspecified dementia with unspecified severity with behavioral disturbances. A review of Resident 4's medical records (MR) indicated a physician's order for the following: - Olanzapine (used to treat schizophrenia and bipolar disorder by balancing brain chemicals to reduce hallucinations, mania, and agitation) 5 milligrams by mouth at bedtime for Behavioral and Psychological Symptoms of Dementia (BSPD) as evidence by (AEB) auditory hallucinations (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavioral/psychological symptoms of dementia, dated 2/13/26. A review of Resident 4's MR indicated the facility was not implementing and documenting non-pharmacological intervention before administration of Olanzapine at bedtime. During a concurrent interview and record review on 3/5/26 at 10:35 a.m. with LN2, Resident 4's MR was reviewed. LN2 stated he did not see non-pharmacological interventions were implemented before the use of psychotropic medications for Resident 4. During a concurrent interview and record review on 3/5/26 at 11:15 a.m. with Director of Nursing (DON), Resident 4's MR was reviewed. DON confirmed residents with psychotropic medication orders were to be monitored for side effects and target behaviors and non-pharmacological interventions were to be implemented. DON confirmed Resident 4 did not have non-pharmacological interventions implemented or documented. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, revised October 2025, the P&P indicated, 8. Non-pharmacological interventions will be considered as applicable 9. The staff will observe, document, and report to the Physician/Nurse Practitioner for information regarding the effectiveness of any interventions, including psychotropic medications. 10. Nursing staff shall monitor for and report any side effects and adverse consequences of psychotropic medications to the Attending Physician/Nurse Practitioner.

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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 accurate accountability and effective documentation of controlled medications (those with high potential for abuse or addiction), when:Random controlled medication audits for two out of four residents (Resident 5, and Resident 19) were not reconciled. The medications were documented in the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medications) but were not documented accurately on the Medication Administration Record (MAR) to indicate they were given to the residents; and,Resident 12's controlled medication was observed as given but was not reconciled in CDR at the time of medication administration.These failures resulted in the facility not having accurate accountability of controlled medications and potential for abuse or misuse of these medications, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions.Findings: 1. Resident 5 had a physician's order dated 2/28/26 for Oxycodone HCL (hydrochloride) (medication used to relieve moderate to serve pain) 15 mg (milligram, unit of measurement), 1 tablet every 6 hours as needed for moderate to severe pain (4-10 on a pain scale of 1-10 where 1 is lowest and 10 is highest). The CDR indicated 1 tablet was signed out on 2/22/26 at 10:48 p.m. and on 2/25/25 at 6:30 p.m. The MAR did not indicate Oxycodone was administered to Resident 5 on either of those dates and times. Resident 19 had a physician's order dated 10/1/25 for Tramadol (a strong painkiller used to treat moderate to severe pain) 50 milligram, 1 tablet every 6 hours as needed for moderate pain of 4-6. The CDR indicated 1 tablet was signed out on 2/12/26 at 9:30 a.m. The MAR did not indicate Tramadol was administered to Resident 19 on these dates or times. During a concurrent interview and record review on 3/4/26 at 11:30 a.m. with Director of Nursing (DON), DON confirmed the CDRs and MARs for Resident 19 (Tramadol) and Resident 5 (Oxycodone) were not accurate and missed documentation in MAR. DON stated nursing staff were expected to document in both the CDR and MAR any time a controlled medication was removed from the cart and administered. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 10/2025, the P&P indicated, 15. The individual administering the medication documents in the resident's eMAR. 2. During a medication administration observation on 3/3/26 at 8:36 a.m. with Licensed Nurse (LN) 1, LN 1 was observed preparing medication for Resident 12 including two oxycodone (a controlled medication to treat pain) 5 mg tablets. LN 1 removed the medication from the bubble pack (a unit dose medication packaging system) and administered the medication to Resident 12 without documenting the dose on the CDR at the time of administration. During a concurrent interview and record review on 3/3/26 at 12:06 p.m. with LN 1, Resident 12's oxycodone 5 mg MAR and CDR were reviewed. LN 1 confirmed she had not signed out the tablets in the CDR at time of administration. She acknowledged to document in both required areas immediately to reduce the risk of error or miss count. During a concurrent interview and record review on 3/4/26 at 11:30 a.m. with Director of Nursing (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(DON), DON stated nursing staff were expected to document in both the CDR and MAR any time a controlled medication was removed from the cart and administered. DON's expectation was for documentation to be completed right away. During a review of the facility's policy and procedure (P&P) titled, Controlled Substance, dated 10/2025, the P&P indicated, Dispensing and Reconciling Controlled Substances, 1. Controlled substance inventory is .reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The system of reconciling the . dispensing and disposition .includes the following .b. Medication administration records and c. Declining inventory records .

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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:Resident 58's nebulizer mask (neb mask-a face mask that fits over the nose and mouth to deliver medication into the lungs) and CPAP mask (continuous positive airway pressure-a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) and Resident 64's nebulizer mask were not stored in antimicrobial bag and Resident 64's oxygen tubing was on the floor.Meal trays, with uncovered salad, were transported to residents' rooms. Resident 12's foley catheter (a device that drains urine from the bladder) drainage bag was touching the floor. Enhanced Barrier Precautions (EBP - healthcare workers wear gloves and a gown during certain care activities to stop germs from spreading between residents) not followed during wound care for Resident 1. These failures had the potential to compromise resident's health and safety, and potentially lead to the spread of communicable illnesses. 1.During a review of Resident 58's admission Record (AR), the AR indicated, Resident 58 was admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with exacerbation and obstructive sleep apnea (OSA- sleep disorder that occurs when the airway becomes blocked while sleeping). During a review of Resident 58's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated March 2026, the MAR indicated, Resident 58 had an order for CPAP to be used continuously while sleeping, and Resident 58 last received a dose of ipratropium-albuterol inhalation solution (inhaled medication to treat chronic, ongoing breathing problems given via nebulizer machine) 0.5-2.5mg/3mL (milligram-unit of measurement; milliliters-unit of measurement) on 3/2/26 at 3:40 a.m. During a concurrent observation and interview on 3/3/26 at 9:20 a.m. with Licensed Nurse (LN) 4 in Resident 58's room, Resident 58's neb mask was observed on top of the bedside table, and the CPAP mask was hanging on the bedside rail, both not stored in an antimicrobial bag. LN 1 confirmed the nebulizer mask and CPAP mask were not stored in an antimicrobial bag. LN 1 stated the night shift may have administered a nebulizer treatment and stated that when masks were not in use, they should be stored in an antimicrobial bag due to the potential for bacterial contamination. During a review of Resident 64's AR, the AR indicated, Resident 64 was re-admitted on [DATE] with diagnoses which included hypoxemia (condition where body tissues and organs do not receive enough oxygen), OSA, shortness of breath and dependence on supplemental oxygen. During a review of Resident 64's MAR, dated March 2026, the MAR indicated Resident 64 had an order for ipratropium-albuterol inhalation solution 0.5-2.5mg/3mL via nebulizer as needed and oxygen at 4 liters per minute via nasal cannula continuously. During an observation on 3/3/26 at 11:07 a.m. in Resident 64's room, Resident 64's nebulizer mask was on top of the nebulizer machine without a bag. Resident 64 was receiving oxygen via nasal cannula, and the oxygen tubing was on the floor, dragging from Resident 64's bed under the roommate's bed and extending into the restroom. The oxygen concentrator was stored in the restroom, and the oxygen tubing was also touching the restroom floor. During an interview on 3/3/26 at 11:36 a.m. with Infection Preventionist (IP), IP stated the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectation was for nebulizer masks and CPAP masks to be stored in an antimicrobial bag when not in use due to the risk of bacterial contamination and infection. IP also stated oxygen tubing should not touch the floor due to the risk of exposure to infectious material. During a review of the facility's policy and procedure (P&P) titled, Respiratory Therapy-Prevention of Infection, revised 10/25, the P&P indicated, .Infection Control Considerations Related to Oxygen Administration: 3. Change the oxygen cannula every seven (7) days or as needed. Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 9. Take care not to contaminate internal nebulizer tubes.11. Store the circuit in a marked antimicrobial bag. A P&P for the storage of CPAP mask and oxygen tubing touching the floor was requested; however, the facility did not provide one. 2.During a concurrent observation and interview on 3/4/26 at 12:31 p.m. in Hallway 1 with Certified Nursing Assistant 1(CNA 1), meal trays with uncovered salad were transported from the dining cart through the hall into rooms 112-116. CNA 1 confirmed the dining cart was parked in the middle of the hall and trays were transported through the hall with uncovered salad. During an interview on 3/5/26 at 11:05 a.m. with Registered Dietician (RD), RD stated if meal trays were being transported from the dining cart to a resident's room, the cart should be parked outside the room to avoid uncovered food from being contaminated. RD acknowledged the risk of foodborne illness when uncovered food was being transported through the hall. During a review of facility's P&P titled, Covering Food During Transport, dated 2023, the P&P indicated, .Carts may be parked outside of each resident's door as their tray is delivered; minimizing transport of food through a common area (hall) to protect it from contamination. 3.During a review of Resident 12's AR, the AR indicated Resident 12 was admitted to the facility February 2025 with multiple diagnosis including obstructive uropathy (a blockage in the urinary tract). During a review of Resident 12's Physician's Orders, the Physician's Orders indicated Resident 12 had a foley catheter. During a concurrent observation and interview on 3/3/26 at 10:40 a.m. in Resident 12's room with CNA 2, Resident 12's foley catheter drainage bag was hanging from the bottom of his wheelchair and touching the floor. CNA 2 confirmed the drainage bag was touching the floor. During an interview on 3/4/26 at 3:22 p.m. with IP, IP stated the foley catheter drainage bag should be kept off the floor. IP further stated there was a risk for infection and damage to the drainage bag when the drainage bag was not secured high enough to prevent it from touching the floor. During a review of the facility's P&P titled, Indwelling Catheters, dated September 2025, the P&P indicated, .Be sure the catheter tubing and drainage bag are kept off the floor. 4.During a review of Resident 1's AR, AR indicated, Resident 1 was admitted on [DATE] with diagnoses including Pressure Ulcer Stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible) of sacral region (lower back right above the buttocks). During an observation of wound care on 3/5/26 at 10:15 a.m. in Resident 1's room, LN 5 and LN 6 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were preparing for the wound treatment for Resident 1's sacral pressure ulcer. Resident 1's room did not have an Enhanced Barrier Precautions (EBP - infection control measures in nursing homes requiring staff to wear gloves and gowns during high contact care to stop the spread of dangerous germs) sign posted at the door or in her room. LN 5 and LN 6 performed hand hygiene, donned gloves, but did not wear a gown while providing direct wound care involving contact with the resident's sacral area and surrounding linens. During a review of Resident 1's active Order Summary Report (OSR – a list that shows all the medical orders a doctor has given for a resident) printed on 3/5/26 at 11:46 a.m. Resident 1's OSR confirmed EBP order remained active at the time of observation on 3/5/26. OSR indicated, Enhanced Barrier Precautions related to chronic sacrum wound every shift for Proper Personal Protective Equipment. During a review of care plan (CP) on 3/5/26 at 11:46 a.m., initiated 2/9/26, the CP indicated, .Resident requires enhanced barrier precautions during high contact resident care activities due to the presence of chronic wound to lower sacrum. During an interview on 3/5/26 at 3 p.m. with Infection Prevention (IP) nurse, the IP nurse stated, EBP Precautions must be followed as ordered. IP nurse confirmed that during the wound care observation with the treatment nurses LN 5 and LN 6, the EBP precaution order, EBP care plan were in place, and the EBP precautions were not followed as ordered. During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, dated 2001, indicated,.Enhanced Barrier precautions refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms during high contact resident care activities.examples of high contact resident care activities requiring the use of gown and gloves for EBP include.j. wound care (any skin opening requiring a dressing) .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary assistance with nail care and hand hygiene for one out of 24 sampled residents (Resident 11).This failure to maintain clean and trimmed fingernails may increase the risk of infection.Findings:During a review of Resident 11's admission Record (AR), the AR indicated, Resident 11 was admitted on [DATE] with diagnoses including Acute and Chronic Respiratory Failure (the lungs cannot do their job well enough to keep the body alive and functioning properly) with hypoxia (body or brain is not getting enough oxygen); Morbid Obesity (a person has so much extra body weight that it seriously affects their health and increases the risk of life-threatening medical problems).A review of Resident 11's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/22/26, indicated, Resident 11 needs maximal assistance (Helper does more than half the effort) for personal hygiene.During an observation on 3/3/26 at 9 a.m. in Resident 11's room, Resident 11's fingernails were long and had brownish black sediments underneath each fingernail. Resident 11 was asked if nail care was offered, Resident 11 stated, No. They were too busy.During an observation on 3/4/26 at 10 a.m. in Resident 11's room, Resident 11's fingernails were long and had brownish black sediments underneath the fingernails. Resident 11 stated, No one asked me and no one offered to clean my nails.During an observation on 3/5/26 at 1:30 p.m. in Resident 11's room, Resident 11's fingernails were long and had brownish black sediments underneath the fingernails.During a concurrent observation and interview with the Director of Staff Development (DSD), on 3/5/26 at 1:52 p.m. at Resident 11's room hallway, DSD stated, the expectation was for the Certified Nurse Assistant (CNA) to do the nail care. The DSD and Nurse surveyor entered Resident 11's room. DSD held Resident 11's hand, confirmed it was long and had brownish black sediments underneath each nails. The DSD asked Resident 11 if they could clean her fingernails. Resident 11 agreed to the nail care. During a review of Resident 11's care plan initiated on 10/9/25, there was no evidence of a person-centered care plan related to ADLs (Activities of Daily Living) including nail care.During a review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), Supporting, revised 10/2025, indicated, .Residents will be provided ADL care to ensure that their activities of daily living (ADLs) are met .care and services will be provided for residents who are unable to carry out ADL independently.