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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555080	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tracy Nursing and Rehabilitation Center	545 West Beverly Place Tracy, CA 95376

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify the resident's representative or responsible party (RP-a person designated to act on behalf of the resident) of significant changes in the resident's condition for one of three sampled residents (Resident 1) when Resident 1 experienced significant weight loss and was non-compliant with treatment and care conference (a meeting to discuss the resident's plan of care) participation.This failure resulted in the resident's representative not being able to participate in care planning, which placed Resident 1 at risk for worsening of underlying conditions, overall health decline, and preventable complications. Findings: A review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility with a diagnosis that included chronic kidney disease stage 3 B (kidneys are moderately to severely damaged and are not working well to filter waste from the blood) and type 2 diabetes mellitus (high blood sugar where the body still has the hormone that controls blood sugar but cannot keep blood sugar at a normal level). A review of Resident 1's care plan (a document that indicates the resident's specific problems, goals, and interventions), initiated on 11/26/25, in the section titled Focus, indicated, . [Resident 1] Prefers own routine and activities.Have his family involved in discussion about your [sic] care.A review of Resident 1's Physical Therapy PT Evaluation & Plan of Treatment, dated 11/25/25, in the section Assessment Summary.Reason for Skilled Services, the record indicated, . Pt [Patient] refusing any skilled service [medical care that requires a licensed healthcare professional].Risk Factors: Due to the document physical impairments and associated functional deficits, the patient is at risk for falls.During a concurrent interview and record review on 1/20/26 at 12:39 PM with Licensed Nurse (LN) 1, Resident 1's Progress Notes, dated 11/25/25 through 12/20/25 and the admission Record, in the section titled CONTACTS, were reviewed. The Progress Notes indicated Resident 1 refused morning medications from 11/25 through 12/20/25, requested not to be disturbed on 11/26/25, refused a blood draw on 12/1/25, refused to attend a care conference on 12/2/25, and had significant weight loss discussed by the IDT (Interdisciplinary Team, a team of health professionals with different roles that work interdependently to create a plan of care for the resident) on 12/15/25. The admission Record indicated a family member was assigned as the RP and care conference contact person. LN 1 stated the RP was not notified of Resident 1's refusal of prescribed morning medications, refusal of a blood draw, request not to be disturbed for care, refusal to participate in a care conference, or of the significant weight loss, and was not invited to participate in the care conference. LN 1 further stated that because the RP was not notified, the RP was not given the opportunity to encourage Resident 1 to accept care and treatment, which placed Resident 1 at risk for potential health decline.During an interview on 1/20/26 at 1:36 PM with the Director of Nursing (DON), the DON stated that RP had the right to be informed of changes in Resident 1's condition, such as significant weight loss or refusal of care or treatment. The DON stated that if the RP was notified, the RP could have intervened and encouraged Resident 1 to accept (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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NAME OF PROVIDER OR SUPPLIER Tracy Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 545 West Beverly Place Tracy, CA 95376	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. The DON further stated that without notification, the RP was not given the opportunity to participate in care planning and decision-making, which placed Resident 1 at risk for health decline due to continued refusals of care and treatment. The DON further stated that because the RP was not notified, the RP was not able to participate in care planning and decision making. A review of facility's policy and procedure (P&P) titled, Requesting: Refusing and/or Discontinuing Care or Treatment, revised on 5/17, the P&P indicated, .The resident/representative will be informed of.refuse and/or discontinue treatment.A review of facility's P&P titled, Nutrition & Weight Management Policy, revised on 10/25, the P&P indicated, .Notify physician and Responsible Party of: Significant changes in weight.A review of facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised on 12/16, the P&P indicated, .The Interdisciplinary Team (IDT) [staff from different departments who work together to plan a resident's care], in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.

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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 develop and implement a comprehensive care plan (written plan that guides staff on daily care and safety based on the resident's needs) for one of three sampled residents (Resident 1) to address Resident 1's refusals of care, treatment, and participation in a care conference (a meeting to discuss the resident's plan of care), which prevented Resident 1 from receiving appropriate care, treatment, and care planning. This failure placed Resident 1 at risk for worsening of underlying conditions, overall health decline, and preventable complications. Findings: A review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility with a diagnosis that included chronic kidney disease stage 3 B (kidneys are moderately to severely damaged and are not working well to filter waste from the blood), asthma (long-term breathing condition that makes it hard to breathe due to narrowed airways), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness or paralysis on the right side of the body caused by a stroke, affecting the side normally used for the most for daily activities) , essential hypertension (high blood pressure with no single known cause), post-traumatic stress disorder (mental health condition caused by a traumatic event that leads to ongoing fear, anxiety, and emotional distress), type 2 diabetes mellitus (high blood sugar where the body still has the hormone that controls blood sugar but cannot keep blood sugar at a normal level).Review of Resident 1's Physical Therapy PT Evaluation & Plan of Treatment, dated 11/25/25, in the section, Assessment Summary.Reason for Skilled Services, the record indicated, . Pt [Patient] refusing any skilled service [medical care that requires a licensed healthcare professional].Risk Factors: Due to the document physical impairments and associated functional deficits, the patient is at risk for falls.During a concurrent interview and record review on 1/20/26 at 12:39 PM with Licensed Nurse (LN)1, Resident 1's Progress Notes, dated 11/25/25 through 12/20/25 were reviewed. The progress notes indicated that from 11/25/25 to 12/20/25, Resident 1 refused his morning medications. The progress notes on 11/26/25 at 2:59 AM, indicated Resident 1 requested not to be disturbed. The progress notes on 12/1/25 at 5:04 AM indicated Resident 1 refused a blood draw. The progress notes on 12/2/25 at 3:53 PM indicated Resident 1 refused to participate in a care conference. LN 1 stated that Resident 1's refusal of care, treatment and participation in a care conference required a care plan with effective interventions to encourage Resident 1 to accept care, treatment, and participation in a care conference. During a concurrent interview and record review on 1/20/26 at 12:45 PM with LN 1, Resident 1's care plans were reviewed. LN 1 stated that Resident 1 did not have a care plan to address refusals of care, treatment, and participation in a care conference. LN 1 further stated that without a care plan to address Resident 1's refusals of care, treatment and participation in care conference, Resident 1 was at risk for health decline.During an interview on 1/20/26 at 1:36 PM with the Director of Nursing (DON), the DON stated that when a resident refused care and treatment, nursing staff were expected to assess the resident and initiate a care plan to address the refusals and implement appropriate interventions to prevent potential health decline. A review of facility's policy and procedure (P&P) titled, Requesting: Refusing and/or Discontinuing Care or Treatment, revised on 5/17, the P&P indicated, .The interdisciplinary team [staff from different departments who work together to plan a resident's care] will assess the resident's needs and offer the resident alternative treatments, if available and pertinent, while continuing to provide other services outlined in the care plan.Review facility's P&P, titled Care Plans, Comprehensive Person-Centered revised on December 2016, the P&P indicated, .A comprehensive, person -centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functional needs is developed and implemented for each resident.The Interdisciplinary Team (IDT)[staff from different departments who work together to plan a resident's care], in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .The comprehensive, person-centered care plan will.incorporate identified problem areas; . Aid in preventing or reducing decline in the resident's functional status and /or functional levels.A review of facility's P&P titled, Using Care Plan, revised on 8/06, the P&P indicated, .The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for one of three sampled residents (Resident 2) when two staff members did not perform hand hygiene (cleaning hands with soap and water or alcohol-based hand sanitizer to remove germs and prevent the spread of infection) before and after entering and exiting Resident 2's room to perform care tasks for Resident 2, who was under Enhanced Barrier Precautions (EBP-an infection-control strategy used in nursing homes to help stop the spread of hard-to-treat infection by requiring extra safety steps, such as wearing gowns and gloves during close care).This failure had the potential to spread infection and cause health problems for the residents in the facility. Findings: A review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility with diagnoses that included urinary tract infection (infection of the bladder or urinary system), unspecified Escherichia Coli as the cause of diseases (type of bacteria that can cause infection), cellulitis of buttock (bacterial skin infection causing redness swelling, and pain), local infection of the skin and subcutaneous tissue (infection involving the skin and tissue under the skin), resistance to multiple antimicrobial drugs (infection that does not respond well to several antibiotics), pressure ulcer of right buttock stage 4 (severe open wound that extends deep into tissue and muscle, Clostridium Perfringes as the cause of diseases (bacteria that can cause serious tissue and wound infections). During a concurrent observation and interview on 1/20/26 at 10:39 AM with the Director of Staff Development (DSD) by the door of Resident 2's room, an EBP sign was posted on the outside of Resident 2's room. The DSD entered Resident 2's room to respond to an activated resident's call light without performing hand hygiene, turned off the call light, and exited Resident 2's room without performing hand hygiene. The DSD stated she had not performed hand hygiene upon exiting Resident 2's room under EBP and the DSD stated hand hygiene was supposed to be performed to prevent the spread of infections in the facility.During a concurrent observation and interview on 1/20/26 at 11:55 AM with Certified Nurse Assistant (CNA)1 in the hallway by the door of Resident 2's room, an EBP sign was posted outside Resident 2's room. CNA 1 picked up a meal tray from the meal cart in the hallway and entered Resident 2's room and delivered the meal tray. CNA 1 placed the meal tray on Resident 2's over-bed table and assisted Resident 2 with meal preparation. CNA 1 then exited Resident 2's room and had not performed hand hygiene and approached the meal cart in the hallway. CNA 1 stated she forgot to perform hand hygiene after she exited the room and before she handled another resident's meal tray. CNA 1 further stated that when she did not perform hand hygiene before food handling and after contact with Resident 2's environment under EBP, other residents were placed at risk for infection. During interview on 1/20/26 at 12:12 PM with the Infection Prevention Nurse (IP), the IP stated that staff were required to perform hand hygiene before they entered and after they exited a resident's room and before and after they performed any task for residents. The IP further stated failure to perform hand hygiene placed other residents at risk for infection.During interview on 1/20/26 at 1:36 PM with the Director of Nursing (DON), the DON stated that staff were required to perform hand hygiene as part of standard precautions (basic infection prevention steps to stop the spread of germs) to break the infection cycle and prevent the spread of infection. A review of facility's policy and procedure (P&P), titled Enhanced Barrier Precaution, revised on 6/20/24, the P&P indicated .To maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Facility staff shall post a visual alert by the resident's door indicating the high contact resident care.Residents with the following criteria.that placed them at higher risk.Wounds.A review of facility's P&P, titled, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Infection Control Guidelines for All Nursing Procedures, revised on 8/12, the P&P indicated .hand hygiene.for all the following situations.After contact with objects.in the immediate vicinity of the resident.