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	08/30/2024

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43943 Based on observation, interview, and record review, the facility failed to meet the needs of 1 of 22 sampled residents (Resident 12) when the facility did not adequately follow up on the resident's request for a prosthetic (artificial) leg. This failure had the potential to result in loss of independence, dignity, and decreased quality of life. Findings: During a review of Resident 12's clinical record titled, Admission Record (a document that contained the resident's demographic information), indicated Resident 12's diagnosis included Type 2 diabetes (inability to control blood sugar) and the absence of left leg above the knee. During a concurrent observation and interview on 8/27/24, at 10:34 a.m., Resident 12 was observed in her bed with her wheelchair at the bedside. Resident 12 had her left leg amputated (a limb that had been surgically removed). Resident 12 stated she had been waiting for a year for her prosthetic leg. Resident 12 stated she was willing to put in the work with Physical Therapy to get stronger in order to walk. Resident 12 stated she would have liked a prosthetic leg in order to walk to the bathroom and outside without maximum assistance. Resident 12 stated it made her feel sad that she was unable to walk. A review of Resident 12's clinical record titled, Orders, dated 6/29/23, at 7:36 a.m., by the Physician (Phys 1), indicated Resident 12 had an order for a prosthetic evaluation. During an interview on 8/28/24, at 3:02 p.m., with the Medical Director (MD), the MD stated Resident 12 was referred for a prosthetic consultation once but was unsure of the outcome. During an interview on 8/28/24, at 3 p.m., with the Director of Rehab (DR), the DR stated Resident 12 had two referrals for an evaluation for a prosthetic leg. The DR stated the prosthetic evaluation notes were not found in Resident 12's clinical record. During a phone interview on 8/28/24, at 3:14 p.m., with Responsible Party (RP) 1, RP 1 stated the facility had not given her a lot of details as to why Resident 12 had not received a prosthetic leg. RP 1 stated she purchased Resident 12 new shoes because Resident 12 had told her she was getting a prosthetic leg. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24, at 1:22 p.m., with the DR, the DR stated the prosthetic evaluation notes should have been in Resident 12's clinical record. The DR stated without the notes in the clinical record, the physician would not know what the prosthetic evaluation recommendation was for Resident 12. The DR stated Resident 12 was last evaluated for a prosthetic last year. During a concurrent phone interview and record review on 8/29/24, at 2:47 p.m., with the Prosthetic Representative (PR), Resident 12's clinical record titled, Orthopedics Clinical Notes, dated 8/29/24, at 2:22 p. m., by the PR, was reviewed. The document indicated, . patient seems sound of mind and is highly motivated for a prothesis. We had talked about a year ago about the possibility of providing a prosthesis . Recently I had spoken with patient again and again patient is very motivated; she really has the desire to have a prosthesis and get back to standing and possibly walking . there is the argument that with a prosthesis patient has a chance to possibly improve and may have the chance to stand with assistance . The PR stated she assessed Resident 12 a couple times last year for an evaluation for a prosthetic leg. The PR stated Resident 12 was very motivated to have a prosthetic leg. During a follow up phone interview on 8/29/24 at 3:06 p.m., with the PR, the PR stated she wrote Resident 12's clinical note on 8/29/24 (the date requested by the facility), the PR stated she could not find copies of any of the past evaluation notes. The PR stated it was not her practice to provide the facility with a copy of Resident 12's evaluation notes. The PR stated Resident 12, fell through the cracks. During a joint concurrent interview and record review on 8/29/24 at 4:10 p.m., with the Director of Nursing (DON) and the Administrator (ADM), the facility's policy and procedure (P&P) titled, Quality of Life, dated 8/2009 was reviewed. The P&P indicated, .The resident's individual needs and preferences, including the need for adaptive devices . shall be evaluated upon admission and reviewed on an ongoing basis . In order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible. The DON acknowledged the facility did not follow through with the results of the prosthetic leg assessment for Resident 12. The DON and ADM stated the P&P was not followed. A review of the facility's P&P titled, Resident Rights, 12/16, indicated, . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . communication with and access to people and services, both inside and outside the facility .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 43943 Based on interview and record review, the facility failed to ensure preferences for end of life or emergency care would be honored for 3 of 22 sampled residents (Residents 12, 43, 49) when, 1. The facility failed to determine upon admission whether Resident 43 and Resident 49 had an Advance Directive (specific instructions about one's own health care) and, if not, determine whether they wished to formulate an Advance Directive; and, 2. The facility failed to ensure a copy of Resident 12's Advance Directive was available at the facility. These failures could have resulted in the residents' end of life wishes not being honored. Findings: 1a. During a review of Resident 43's clinical record titled, Admission Record (a document that contained the resident's demographic information), the record indicated Resident 43's diagnosis included type 2 diabetes (the body's inability to control blood sugar), and dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). A review of Resident 43's clinical record titled, Preferred Intensity of Care, dated 6/7/24, signed by the Physician and Resident 43, did not indicate if Resident 43 did or did not have an Advanced Directive. A review of Resident 43's clinical record titled, Physician Orders for Life-Sustaining Treatment (POLST - physician's order indicating the resident's request for basic end of life care), dated 6/7/24, did not indicate if Resident 43 had an Advanced Directive, if it was discussed with Resident 43 or the legally recognized decisionmaker, or if Resident 43 had the capacity (understanding) to make decisions. A review of Resident 43's clinical record on 8/29/24, at 9:50 a.m., indicated Resident 43's Electronic Health Record (EHR) and paper chart did not contain a copy of an Advanced Directive on file or indicate if Resident 43 had formulated an Advanced Directive. During a concurrent interview and record review on 8/29/24, at 8:46 a.m., with the Director of Nursing (DON), Resident 43's POLST was reviewed. The DON stated she was not sure if an Advanced Directive portion of the POLST was discussed with the resident during the admission process. The DON stated there was a difference between a POLST and an Advanced Directive with the Advanced Directive giving more details about end-of-life care and wishes. The DON stated the POLST should have been completed in its entirety, verifying if an Advanced Directive was completed (and a copy obtained) or if the resident desired to have one completed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/24, at 9:43 a.m., with Resident 43, Resident 43 stated he remembered signing some type of paper that indicated if he wanted to have compressions if his heart stopped beating or if he stopped breathing. Resident 43 stated the facility did not explain to him the meaning of an Advanced Directive or ask if he wanted to formulate an Advanced Directive. During an interview on 8/29/24, at 10:00 a.m., with Medical Records (MR 2), MR 2 stated Resident 43's Electronic Health Record (EHR) did not indicate if Resident 43 did or did not had an Advanced Directive. MR 2 stated it was the facility's responsibility to obtain a copy of Resident 43's Advanced Directive or ask if Resident 43 wanted to formulate an Advanced Directive to ensure his end-of-life wishes were honored. 1b. During a review of Resident 49's clinical record titled, Admission Record (a document that contained the resident's demographic information), indicated Resident 49's diagnosis included history of a stroke (the brain was deprived of oxygen for a time resulting in brain damage and affecting the resident's mobility and speech). A review of Resident 49's clinical record titled, Physician Orders for Life-Sustaining Treatment (POLST - physician's order indicating the resident's request for basic end of life care), dated 1/20/23, did not indicate if Resident 49 had an Advance Directive and/or if it was discussed with Resident 49 or the legally recognized decisionmaker. During an interview on 08/28/24, at 3:29 p.m., with the Social Services Director (SSD), the SSD stated during the admission process if the resident stated he did not have an Advance Directive, the SSD did not explain what an Advance Directive was or ask the resident if he wanted help formulating and Advanced Directive. During a concurrent interview and record review on 8/29/24, at 8:46 a.m., with the Director of Nursing (DON), Resident 49's POLST was reviewed. The DON stated she was not sure if an Advance Directive portion of the POLST was discussed with the resident during the admission process. The DON stated there was a difference between a POLST and an Advance Directive with the Advanced Directive giving more details about end-of-life care and wishes. The DON stated the POLST should have been filled out in its entirety verifying if an Advance Directive was completed or if the resident desired to have one completed. During an interview on 8/29/24, at 9:46 a.m., with Resident 49, Resident 49 stated he thought he had an Advance Directive, and that the facility had a copy. During an interview on 8/29/24, at 10:00 a.m., with Medical Records (MR 2), MR 2 stated Resident 49's Electronic Health Record (EHR) did not indicate if Resident 49 did or did not have an Advance Directive. MR 2 stated the facility did not have an Advance Directive on file for Resident 49. MR 2 stated it was the facility's responsibility to obtain a copy of Resident 49's Advanced Directive or ask if Resident 49 wanted to formulate an Advanced Directive to ensure his end-of-life wishes were honored. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 12's clinical record titled, Admission Record (a document that contained the resident's demographic information), the record indicated Resident 12's diagnosis included a history of a stroke (the brain was deprived of oxygen for a time resulting in brain damage and affecting the resident's mobility and speech), type 2 diabetes (body's inability to control blood sugar), and epilepsy (intermittent, uncontrolled body movements caused by electrical dysfunction in the brain). A review of Resident 12's clinical record titled, Preferred Intensity of Care, dated 5/18/23, signed by the physician and the surrogate (stand-in) decision maker, indicated Resident 12 had an Advanced Directive and the document further indicated the facility was supposed to attach a copy of the Advanced Directive to the Preferred Intensity of Care form. A review of Resident 12's clinical record titled, Physician Orders for Life-Sustaining Treatment (POLST - physician's order indicating the resident's request for basic end of life care), dated 1/24/24, did not indicate whether or not Resident 12 had an Advanced Directive. During an interview on 8/28/24, at 3:11 p.m., with the Licensed Nurse (LN 4), LN 4 stated during the admission process, the facility should have called Resident 12's family to obtain a copy of Resident 12's Advanced Directive. During an interview on 8/28/24, at 3:29 p.m., with the Social Services Director (SSD), the SSD stated her process was, once she was made aware the resident had an Advanced Directive, she called the resident's family to obtain a copy. During a joint interview on 8/29/24, at 10:55 a.m., with the DON and the Administrator (ADM), the DON and the ADM acknowledged that Social Services should have followed up with Resident 12 regarding obtaining a copy of the Advanced Directive. During an interview on 8/29/24, at 9:59 a.m., with Resident 12's Responsibly Party (RP 1- assisted resident in making decisions), RP 1 stated Resident 12 had an Advanced Directive and she had provided a copy to the facility. During an interview on 8/29/24, at 10:00 a.m., with Medical Records (MR 2), MR 2 stated the Electronic Health Record (EHR) indicated Resident 12 had an Advanced Directive, but the facility did not have a copy on file. MR 2 stated it was the facility's responsibility to obtain a copy of Resident 12's Advanced Directive to ensure her end-of-life wishes were honored. During an interview on 8/29/24, at 10:10 a.m., with Resident 12, Resident 12 stated she had an Advanced Directive, and the facility should have had a copy of it on file. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/29/24, at 11:03 a.m., with the DON and the Administrator (ADM), the facility's Policies and Procedures (P&Ps) titled, Advanced Directive/Individual Health Care Instructions, dated 3/22/18 and Physician Orders for Life Sustaining Treatment (POLST), dated 3/22/18, were reviewed. Advanced Directive/Individual Health Care Instructions, indicated, . Periodically conduct educational programs for facility staff, residents and family members on . How to help people complete an Advance Health Care Directive or an Individual Health Care Instruction if they so choose. The Resident has the right to . Complete advance health care directives or individual health care instructions . Physician Orders for Life Sustaining Treatment (POLST) indicated, . A qualified healthcare provider, preferably a registered nurse or social worker will review the POLST form for completeness .Once reviewed, the POLST should be copied, and the current original form placed in the resident's chart, along with the resident's Advance Directive if he/ she has one . The DON and the ADM acknowledged the POLST should have been completed in its entirety including information about the Advanced Directive. The ADM and the DON stated the admitting nurse should have notified Social Services and Social Services should have followed up with the residents and assisted them with resources to formulate an Advanced Directive if so desired. The DON and the ADM stated the P&Ps were not followed.

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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. 50716 Based on observation, interview, and record review, the facility failed to ensure a homelike environment was provided for 1 of 22 sampled residents (Resident 55), when Resident 55 did not have enough room to store personal belongings. This deficient practice did not ensure a homelike environment that encouraged the use of personal belongings to the extent possible. Findings: Review of Resident 55's admission record indicated Resident 55 had been admitted to the facility in July of 2024. During a concurrent observation and interview on 8/27/24 at 12:16 PM with a family member (FM)1, FM 1 stated he was concerned about space in the room. FM1 showed the narrow closet space dedicated to Resident 55 in bed A. FM1 then stated he felt frustrated due to lack of space for the resident's personal belongings and pointed to the drawers. FM1 indicated he was unable to use the drawers dedicated to bed A, because a previous resident's name was labeled on all of bed A's drawers. FM1 further stated that he did not feel comfortable touching the belongings that were still in the drawers. During a concurrent observation and interview on 8/27/24 at 12:20 PM, Certified Nurse Assistant (CNA) 1 confirmed that another resident's name was listed on the drawers in the room that were supposed to be dedicated to the resident in bed A. CNA 1 stated she was not sure why the drawers were labeled and agreed the name and belongings should have been removed and available for use by Resident 55. During a concurrent observation and interview on 8/28/24 at 9:35 AM, Licensed Nurse (LN) 1 verified that a discharged resident's name was still labeled on the drawers assigned to Resident 55. LN 1 further stated the drawers should have been emptied and the name of the previous resident's label should have been removed. LN 1 confirmed there were still belongings in the drawer that did not belong to Resident 55. LN 1 further stated she understood that it was a problem since Resident 55 was unable to use all the space dedicated to her personal belongings. During an interview on 8/28/24 at 10:08 AM, the Director of Nursing (DON) stated it was not their policy to label resident names on the drawers, it should just have the label of bed A or bed B. The DON stated it was her expectation that all belongings be removed at the time of the discharge. The DON stated that leaving the name and belongings was a problem because the resident could not use all the space dedicated for their personal belongings. The DON further stated this situation is not in line with their policy of a homelike environment. Review of facility policy titled, Quality of Life - Homelike Environment, revised 5/17, indicated, Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible.

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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. 40911 Based on interview, and record review, the facility failed to develop and implement a resident specific care plan (provides direction on the type of nursing care the resident may need based on their health, medication, behavioral, and psychosocial needs) for 1 of 22 sampled residents (Resident 317) when Resident 317 did not have a care plan developed for catheter care. This failure had the potential for care needs not being met for Resident 317. Findings: A review of Resident 317's ADMISSION RECORD, indicated Resident 317 was admitted to the facility in the middle of 2024 with diagnoses which included urinary tract infection and artificial openings of urinary tract status. During a review of Resident 317's Minimum Data Set, (MDS-an assessment tool) dated 8/27/24, the MDS indicated Resident 317 had an indwelling catheter (a medical device that drains urine from the bladder to a drainage bag). A review of Resident 317's Order Summary Report, indicated, .Catheter Care for Indwelling catheter every shift for catheter care cleanse area every shift monitor for redness, irritation, swelling, s/s (signs and symptoms) UTI [urinary tract infection] . During a concurrent interview and record review on 8/29/24, at 1 p.m. with Licensed Nurse (LN) 8, Resident 317's care plan dated 8/21/24 was reviewed. LN 8 stated there was no care plan created for use of an indwelling catheter. LN 8 further stated there should be a care plan created to monitor care of Resident 317 pertaining to catheter use. During an interview on 8/30/24, at 10:25 a.m. with the Director of Nursing (DON), the DON stated she would have expected a care plan for catheter care was created upon admission. The DON explained the care plan dictated everything that needed to be done for the resident and without a care plan, there was a risk for care not being met. A review of the facility's procedure titled, Catheter Care, Urinary, revised September 2014, indicated, .The purpose of this procedure is to prevent catheter associated urinary tract infections .Review the resident's care plan to assess for any special needs of the resident . A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised December 2016, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 40911 Based on interview, and record review, the facility failed to provide care and services for activities of daily living (ADLs) for 1 of 22 sampled residents (Resident 22) when Resident 22 had no documented evidence a shower was given from 8/6/24 through 8/15/24. This failure had the potential to result in poor hygiene and decreased psychosocial well-being for Resident 22. Findings: A review of Resident 22's ADMISSION RECORD, indicated Resident 22 was admitted to the facility in the middle of 2024 with diagnoses which included presence of left artificial hip joint, diabetes mellitus (too much sugar in the blood), and heart disease. During a phone interview on 8/29/24, at 10:16 a.m. with Resident 22's Family Member (FM) 3, FM 3 stated Resident 22's shower schedule was Tuesdays and Saturdays. FM 3 stated Resident 22 did not receive a shower on a Tuesday. During a concurrent interview and record review on 8/30/24, at 8:09 a.m. with the Director of Staff Development (DSD), Resident 22's Shower Skin Checks Sheets were reviewed. The DSD confirmed Resident 22's shower days were Tuesdays and Saturdays. The DSD explained shower skin checks sheets were to be completed everytime the resident had a shower to indicate the residents had intact skin and these sheets were to be signed by the licensed nurse and then submitted to the DSD for review. The DSD confirmed there were no shower sheets from 8/6/24 through 8/15/24. The DSD stated nine days was too long without a shower. During a concurrent interview and record review on 8/30/24, at 8:51 a.m. with the DSD, Resident 22's Documentation Survey Report for showers was reviewed. The report indicated Resident 22 had missed showers from 8/6/24 through 8/15/24. The DSD confirmed there were shower days that were not documented as given. The DSD confirmed Resident 22 did not receive a shower as scheduled. During a subsequent interview with the DSD, the DSD stated residents would feel dirty, uncomfortable, unhygienic, and embarrassed if showers were not given as scheduled. The DSD further stated a full skin assessment would not be performed if showers were missed, which could lead to unidentified skin issues. During an interview on 8/30/24, at 10:26 a.m. with the Director of Nursing (DON), the DON stated she would have expected the residents to receive their showers as scheduled because it was a basic need. The DON further stated showers would help in preventing infections and would promote a feeling of well-being. The DON also stated it was during showers residents' skin was checked thoroughly for any new skin issues. The DON confirmed showers that were not documented were missed showers. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, revised March 2018, the policy indicated, .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .including appropriate support and assistance with hygiene .bathing . A review of the facility's procedure titled, Bath, Shower/Tub, revised February 2018, indicated, .The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40911 Based on interview, and record review, the facility did not ensure correct medications were administered and correct plan of care was followed for 1 of 22 sampled residents (Resident 22) when Resident 22 was admitted with wrong discharging documents from the acute hospital and the error was not identified for 3 days after admission. This failure placed Resident 22 to not receive the necessary care and services at time of admission and three days thereafter. Findings: The Department received a report from the facility and a complaint regarding Resident 22's interfacility transfer (IFT) documents (IFT-it is a communication tool when transferring a patient to another facility which contains pertinent information regarding the patient's care received from the discharging facility and to continue care at the admitting facility) from the acute hospital indicated a different name and did not reflect the correct information at time of admission. This error caused Resident 22 to receive medications that were not prescribed for her and care that was not intended for her until it was discovered for at least three days after admission. This report and the complaint were investigated during the facility's unannounced annual recertification survey. During a review of Resident 22's ADMISSION RECORD, indicated Resident 22 was admitted to the facility in the middle of 2024 with diagnoses which included presence of left artificial hip joint, diabetes mellitus (too much sugar in the blood), and heart disease. During a review of Resident 22's Care Plan, dated 8/3/24, the care plan indicated, .Medication error: resident was adminitered [sic] wrong medications . During an interview on 8/29/24, at 10:37 a.m. with the Admissions Coordinator (AD), the AD explained she would review all information written on the referral documents of residents considered for admission to the facility who were waiting to be discharged from the acute hospital. The AD further explained she would review the history and physicals, therapy notes, any isolation precautions, any intravenous (IV) antibiotics, and all medications the resident received while in the acute hospital. The AD continued, she would then upload the documents into the facility's point click care (PCC) system (a cloud-based healthcare software) for the nurses to review the information prior to receiving the resident to the facility. The AD stated the IFT documents received at the time of admission were the most current and correct information for the nurses to carry out the plan of care. The AD further stated the IFT report that came with Resident 22 on admission had a sticker with her name on every page. The AD added the documents itself had a different name on every page in a smaller print. During an interview on 8/29/24, at 11:16 a.m. with the Director of Nursing (DON), the DON confirmed the IFT document that came with Resident 22 at the time of admission indicated a different name but the sticker attached on every page of the IFT documents had Resident 22's name. The DON stated the IFT documents had the correct sticker attached but had the wrong name on each page of the document. The DON also confirmed the error was discovered three days after admission when the acute hospital called the facility that the IFT documents did not belong to Resident 22. (continued on next page)

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	08/30/2024

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 22's Inter-Facility Transfer Report, dated 8/3/24 with the DON, indicated a list of medications Resident 22 received which was not prescribed for her. The list of medications were as follows: ampicillin-an antibiotic enoxaparin-an anticoagulant melatonin-a supplement for sleep amlodipine-lower high blood pressure linaclotide-relieve chronic constipation memantine-treat memory loss in dementia metoprolol-lower high blood pressure ranolazine-treat chronic chest pain rivastigmine-treat Alzheimer's disease rosuvastatin-lower high cholestrol The DON confirmed the list of medications that were not prescribed for Resident 22. During a record review of Resident 22's Inter-Facility Transfer Report, dated 8/6/24 with the DON, indicated a list of medications prescribed for Resident 22 and should have been receiving at the time of admission. The list of medications were as follows: oxycodone-relieve pain rivaroxaban-prevent blood clots dapagliflozin-lower blood sugar fludrocortisone-lower potassium in the blood gabapentin-used to decrease nerve pain insulin glargine-lower high blood sugar midodrine-lower blood pressure insulin aspart-lower blood sugar semaglutide-lower blood sugar (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sertraline-antidepressant The DON confirmed the list of medications Resident 22 should have been receiving. The DON stated she would have expected the nursing staff to check the IFT documents thoroughly and should have been checked by everyone including the pharmacy that verified the medications. The DON further stated the nurses would call the facility's medical director (MD) to verify the orders and for the MD to visit the same day of admission or the following day of admission. During an interview on 8/29/24, at 11:43 a.m. with Licensed Nurse (LN) 3, LN 3 confirmed she would call the MD and to let him know regarding a new admission and would ask the MD if the facility could follow the orders. LN 3 stated the MD would agree and would visit the same day of the resident's admission or the following day. LN 3 explained the acute hospital called her on the third day of Resident 22's admission to check the IFT documents if it had Resident 22's name on it. LN 3 stated usually the nurses would check the stickers attached to the IFT documents because the sticker stood out but did not check the name on the document. LN 3 further stated the facility usually received IFT documents with same name on the sticker and the name on the documents. LN 3 confirmed the IFT documents should have been checked both the stickers attached and the document itself to make sure the names matched to prevent errors in delivering wrong treatment or care that could possibly cause injury or harm to the resident. During an interview on 8/30/24, at 1:11 p.m. with LN 7, LN 7 stated he picked up resident from the acute hospital with the IFT documents. LN 7 explained he contacted the MD to continue the orders received from the acute hospital and stated he got the consent from the MD. LN 7 stated he checked the IFT documents thoroughly but did not catch the name on the sticker did not match the name on the documents. LN 7 stated that it was missed. During a review of the facility's procedure titled, Admission assessment and Follow Up: Role of the Nurse, revised September 2012, indicated, .Reconcile the list of medications from the medication history, admitting orders, the previous MAR (medication administration record), and the discharging summary from the previous institution .Contact the Attending Physician to communicate and review the findings .and obtain admission orders based on these findings .

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	555080	A. Building B. Wing	08/30/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49823 Based on interview and record review, the facility failed to ensure adequate supervision was provided to prevent accidents and hazards for 1 of 22 sampled residents (Resident 62) when the facility did not implement Resident 62's care planned intervention of a wheelchair alarm, and staff did not complete bed alarm checks during the night shift on 7/3/24. This failure could have been a factor in staff not being aware of Resident 62's fall outside, and had the potential increased wandering behavior would not be identified. Findings: A review of Resident 62's Admission Record indicated Resident 62 was admitted to the facility in Spring of 2024 with diagnoses including benign prostatic hyperplasia (a condition in men in which the prostate gland [a gland in the male reproductive system] is enlarged), surgical aftercare following surgery on the prostate, history of falling, anxiety disorder (a nervous condition characterized by a state of excessive uneasiness, apprehension, and panic attacks that interfere with activities of daily living), major depressive disorder (a persistent feeling of sadness and loss of interest that can interfere with activities of daily living), and disorientation (a state of mental confusion). During a review of Resident 62's SBAR Progress Note (SBAR-Situation, Background, Assessment, and Recommendation- a facility nursing note reporting a change in a resident's condition), the SBAR Progress Note indicated Resident 62 was found on his knees in the facility's front parking lot on 7/4/24 at 12:30 p.m. by facility staff. The SBAR Progress Note indicated Resident 62 refused to be touched by facility staff, so Resident 62 was sent to the acute care emergency department for further evaluation. During a phone interview on 8/30/24 at 11:11 a.m. with Resident 62 and his Responsible Party (FM 3), Resident 62 stated that after the acute care emergency department cleared him to be discharged , he decided to go home with FM 3 instead of going back to the facility. FM 3 stated that she felt that the facility was not supervising Resident 62 appropriately. FM 3 stated that she was concerned for Resident 62's safety while he was at the facility. Resident 62 stated he felt safer at home. During an interview with Licensed Nurse (LN) 7 on 8/30/24 at 1:06 p.m., LN 7 stated FM 3 would sit with Resident 62. LN 7 stated Resident 62 would try and get up on his own. LN 7 stated Resident 62 hallucinated (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there) and had memory issues. LN 7 stated Resident 62 was at risk for falling because his gait (the way he walked) was unsteady. LN 7 stated Resident 62 had an alarm on his bed to alert staff if he tried to get up on his own, but she didn't recall if he had an alarm on his wheelchair. LN 7 stated Resident 62 did not have a Wander Guard (a monitoring device used to alert staff a resident was leaving the premises). LN 7 stated that Resident 62 was found outside in the parking lot on 7/4/24. (continued on next page)

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	555080	A. Building B. Wing	08/30/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/24 at 1:17 p.m. with the Director of Nursing (DON) and the Administrator (ADM) in the Administrator's office, the ADM and the DON stated that Resident 62 was found in the front parking lot. and was unsure how long he had been there. The DON stated that she was one of the people who brought Resident 62 back into the facility. The DON stated Resident 62 was refusing all assessments, so Resident 62 was sent to the hospital emergency room for evaluation. The ADM and DON stated Resident 62 was at risk for falling due to psychiatric diagnoses, he walked late at night, he took the mattress off the bed, and his legs were not strong. The DON stated Resident 62 only had a bed alarm. During an interview and concurrent record review on 8/30/24 at 1:17 p.m. with the DON of Resident 62's Physician Orders, the Physician's Orders indicated there was no order for a wheelchair alarm, and there was an order for a bed alarm. The DON confirmed there was no order in Resident 62's medical record for a wheelchair alarm. During an interview and concurrent review of Resident 62's clinical record with the DON on 8/30/24 at 1:17 p. m., Resident 62's Care Plan, .High risk for falls and injury related to limitation of mobility .date initiated 6/26/24 .Goal: Resident will be able to adjust to a change in the usual environment and routine to prevent falls and injury .Interventions .use of self-release belt with alarm/tab alarm/sensor pad alarm while up in wheelchair to alert staff when resident is attempting to get up unassisted .use of sensor pad alarm or tab alarm when in bed to alert the staff when resident is attempting to get out of bed unattended . The DON confirmed the Care Plan indicated Resident 62 should have had a wheelchair alarm. During an interview and concurrent record review of Resident 62's Medication Administration Record (MAR) with the DON on 8/30/24 at 1:17 p.m., the MAR indicated the bed alarm was checked on 7/3/24 by the AM, and PM shift nurses, but was not documented as checked by the Night shift nurse. The DON stated she expected bed alarm checks to be completed each shift and documented. The DON stated she was worried about the missing documentation of bed alarm checks in Resident 62's MAR. The DON stated that if increased wandering behavior was noted, interventions could have been put in place, such as a Wander Guard, so that Resident 62 would have been more closely monitored. During an interview and concurrent record review with the DON on 8/30/24 at 1:43 p.m., the facility policy and procedure (P&P) titled, Safety and Supervision Procedures, revised 7/201, indicated, Facility-oriented approach to safety .4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents . Individualized, resident-centered approach to safety .1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents .3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices . The DON stated that Resident 62 should have had closer supervision due to his behaviors of wandering and his diagnoses, and would have benefited from a Wander Guard.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 49823 Based on observation, interview and record review, the facility failed to ensure one of two residents (Resident 35) who received parenteral (delivery of medication through a vein) medication was provided services consistent with professional standards of practice when: 1. Resident 35's peripheral IV saline lock (a thin flexible tube placed in a vein in the hand or arm used to give medication and fluids) dressing was not dated; 2. Resident 35 did not have a care plan developed for the IV saline lock; 3. IV site care and flushing for Resident 35's IV saline lock was not documented in the medical record; and, 4. Resident 35's IV saline lock was left in place for eight days. These failures had the potential to increase the risk of infection for Resident 35 and further compromise her health and well-being. Findings: A review of Resident 35's Admission Record indicated Resident 35 was admitted to the facility in Spring 2024. Resident 35's Admission Record indicated Resident 35's admitting diagnoses included wedge compression fracture of second lumbar vertebra (a broken bone in the lower back), low back pain, and osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down). During an observation of Resident 35 on 8/27/24 at 11:05 a.m., Resident 35 was sleeping with her left hand resting on the outside of her blanket. An IV saline lock in Resident 35's left hand was covered with a clear transparent dressing (covering to protect the IV site from germs) and had no insertion date or nurses' initials on it. During a concurrent observation, interview, and record review on 8/27/24 at 11:35 a.m. with Licensed Nurse (LN) 8, LN 8 stated that there was no date on the transparent dressing, and stated it should have been dated. LN 8 checked Resident 35's medical record and stated the IV saline lock was inserted on 8/19/24, eight days ago. LN 8 stated the device should not be in place more than seven days, in order to prevent possible infection. LN 8 stated Resident 35 also had a Peripherally Inserted Central Catheter (PICC, a tube inserted into a vein and guided into a large vein above the heart, used to administer intravenous medication) in her right upper arm, and did not need the IV saline lock. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 8/27/24 at 3:40 p.m. with the Director of Staff Development (DSD), Resident 35's Treatment Administration Record (TAR, documented care procedures provided in the facility) was reviewd. The TAR indicated the IV saline lock was inserted 8/19/24 into Resident 35's left hand vein and was used to give a dose of IV antibiotic (medication to fight an infection) prescribed by resident's physician on 8/19/24. The DSD confirmed there was no documentation of site care or flushing of the IV saline lock in Resident 35's left hand. The DSD confirmed that site care and flushing of IVs needed to be documented in the resident's medical record. During an interview and concurrent review of a facility policy and procedure (P&P) titled, IV 203, dated 3/2023, with the DSD on 8/27/24 at 3:40 p.m., the P&P indicated, .Transparent dressings are changed with each site rotation and/or at least every 7 days, or if the integrity [condition] of the dressing is compromised [wet, loose, or soiled] . Condition of site will be documented at least every shift .Label dressing with date, time, and nurse's initials .Documentation in the medical record includes but is not limited to: 1. Date and time 2. Site assessment 3. Resident response to procedure 4. Resident teaching . The DSD confirmed that IV site care should be documented in the resident's medical record and stated the IV transparent dressing should have been labeled with the date of insertion and the inserting nurse's initials per policy. The DSD confirmed according to the insertion date documented in Resident 35's TAR, the IV saline lock had been in place for eight days. The DSD confirmed that the IV saline lock in Resident 35's left hand should not be in place for more than seven days to prevent complications such as infection. During an interview and concurrent review of a facility P&P titled, IV 104, dated 3/2023, with the DSD on 8/27/24 at 3:40 p.m., the P&P indicated, .Adhere to the specific IV therapy policy and procedure for site changes, tubing changes, and dressing changes . The DSD confirmed that the facility policy was not followed. During an interview on 8/29/24 at 4:47 p.m. with the Director of Nursing (DON), the DON stated that her expectation was that the policy be followed for insertion, IV site dressings be labeled with date of insertion and inserting nurses' initials, IV site assessments, care and flushing of IVs be documented, and that IV saline locks be removed once a midline catheter (a catheter inserted into a vein in the upper arm with the tip located just below the armpit) or a PICC line was in place.

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	555080	A. Building B. Wing	08/30/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43943 Based on observation, interview, and record review, the facility failed to ensure the controlled medications (highly addictive and regulated medications) for 1 of 22 sampled residents (deceased Resident 58) were removed from the medication cart and the nurses did not count Resident 58's controlled medications at shift change. These failures could have resulted in medication being given to the wrong resident and/or drug diversion (the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber) of controlled medications. Findings: A review of Resident 58's Electronic Health Record (EHR) indicated Resident 58 died on [DATE]. During a concurrent observation and interview on [DATE], at 3:17 p.m., with Licensed Nurse (LN) 1 and LN 6, the LNs counted the controlled medications for medication Cart # A (day shift)/Cart # C (PM shift). LN 1 and LN 6 acknowelged they forgot to count the controlled medications for Resident 58. LN 1 verified she should have counted Resident 58's controlled medications with LN 6. LN 6 stated it was important to count all the controlled medications with the off-going nurse (LN 1) because if there would have been missing medications, she would have been held responsible. The medications that were not counted were: -hydrocodone (narcotic pain medication) ,d+[DATE] mg (milligrams-unit of measurement) - 56 tablets on a medication card -hydrocodone ,d+[DATE] mg - 14 tablets on a medication card -lorazepam 0.5 mg - 30 tablets on a medication card (anti-anxiety medication) -lorazepam 0.5 mg - 6 tablets left on medication card -morphine 24 milliliters (unit of volume - ml) left in the medication bottle (narcotic pain medication) -lorazepam 27.5 ml left in the medication bottle. During a follow up interview on [DATE], at 3:25 p.m., with LN 6, LN 6 stated the controlled medications should have been counted and stored in the locked medication cart until the medications were given to the Director of Nursing to destroy. During an interview on [DATE], at 3:34 p.m., with LN 3, LN 3 stated LN 1 and LN 6 were supposed to count Resident 58's controlled medications to ensure there were not any missing medications. (continued on next page)

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	555080	A. Building B. Wing	08/30/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE], at 8:45 a.m., with the Director of Nursing (DON), the facility's Policies and Procedures (P&Ps) titled, Medication Storage in the Facility: Controlled Medication Storage, dated ,d+[DATE], and Disposal of Medications and Medication-Related Supplies: Discontinued Medications, dated ,d+[DATE], were reviewed. The facility's P&P tiled Medication Storage in the Facility Controlled Medication Storage, indicated, . At each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licenses nurses and is documented on the controlled medication accountability record . The P&P titled, Disposal of Medications and Medication-Related Supplies: Discontinued Medications, indicated, . If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified and shall be stored in a separate location designated soley for this purpose . Medications awaiting disposal are stored in a locked secure area designated for that purpose until destroyed . medications are removed from the medications cart . The DON stated after Resident 58 died , the licensed nurses were supposed to give the controlled medications to the DON to destroy with the pharmacist. The DON stated the on-going and off-going nurses were supposed to count the controlled medications until the medications were picked up by the hospice nurse or destroyed by the DON and pharmacist. The DON acknowledged the P&Ps were not followed.

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	555080	A. Building B. Wing	08/30/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 40911 Based on interview, and record review, the facility did not ensure correct medications were administered for 1 of 22 sampled residents (Resident 22) when Resident 22 was admitted with the wrong discharging documents from the acute hospital and the error was not identified for three days after admission. This failure placed Resident 22 at risk for complications related to medications received which were not intended for her. and complications related to medications she should have received, but did not for three days. Findings: The Department received a report from the facility and a complaint regarding Resident 22's interfacility transfer (IFT) documents (IFT- a communication tool when transferring a patient to another facility which contains pertinent information regarding the patient's care received from the discharging facility and to continue care at the admitting facility) from the acute hospital indicated a different name and did not reflect the correct information at time of admission. This error caused Resident 22 to receive medications that were not prescribed for her until it was discovered for at least three days after admission. This report and the complaint were investigated during the facility's unannounced annual recertification survey. During a review of Resident 22's ADMISSION RECORD, indicated Resident 22 was admitted to the facility in the middle of 2024 with diagnoses which included presence of left artificial hip joint, diabetes mellitus (too much sugar in the blood), and heart disease. During a review of Resident 22's Care Plan, dated 8/3/24, the care plan indicated, .Medication error: resident was adminitered [sic] wrong medications . During an interview on 8/29/24, at 10:37 a.m. with the Admissions Coordinator (AD), the AD explained she would review all information written on the referral documents of residents considered for admission to the facility who were waiting to be discharged from the acute hospital. The AD further explained she would review the history and physicals, therapy notes, any isolation precautions, any intravenous (IV) antibiotics, and all medications the resident received while in the acute hospital. The AD continued, she would then upload the documents into the facility's point click care (PCC) system (a cloud-based healthcare software) for the nurses to review the information prior to receiving the resident to the facility. The AD stated the IFT documents received at the time of admission were the most current and correct information for the nurses to carry out the plan of care. The AD further stated the IFT report that came with Resident 22 on admission had a sticker with her name on every page. The AD added the documents itself had a different name on every page in a smaller print. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/24, at 11:16 a.m. with the Director of Nursing (DON), the DON confirmed the IFT document that came with Resident 22 at the time of admission indicated a different name but the sticker attached on every page of the IFT documents had Resident 22's name. The DON stated the IFT documents had the correct sticker attached but had the wrong name on each page of the document. The DON also confirmed the error was discovered three days after admission when the acute hospital called the facility that the IFT documents did not belong to Resident 22. During a record review of Resident 22's Inter-Facility Transfer Report, dated 8/3/24 with the DON, indicated a list of medications Resident 22 received which was not prescribed for her. The list of medications were as follows: ampicillin-an antibiotic enoxaparin-an anticoagulant melatonin-a supplement for sleep amlodipine-lower high blood pressure linaclotide-relieve chronic constipation memantine-treat memory loss in dementia metoprolol-lower high blood pressure ranolazine-treat chronic chest pain rivastigmine-treat Alzheimer's disease rosuvastatin-lower high cholestrol The DON confirmed the list of medications that were not prescribed for Resident 22. During a record review of Resident 22's Inter-Facility Transfer Report, dated 8/6/24 with the DON, indicated a list of medications prescribed for Resident 22 which she should have been receiving at the time of admission. The list of medications were as follows: oxycodone-relieve pain rivaroxaban-prevent blood clots dapagliflozin-lower blood sugar fludrocortisone-lower potassium in the blood gabapentin-used to decrease nerve pain insulin glargine-lower high blood sugar (continued on next page)

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Tracy Nursing and Rehabilitation Center	545 West Beverly Place Tracy, CA 95376

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	midodrine-to raise blood pressure insulin aspart-lower blood sugar semaglutide-lower blood sugar sertraline-antidepressant The DON confirmed the list of medications Resident 22 should have been receiving. The DON stated she would have expected the nursing staff to check the IFT documents thoroughly and should have been checked by everyone including the pharmacy that verified the medications. The DON further stated the nurses would call the facility's medical director (MD) to verify the orders and for the MD to visit the same day of admission or the following day of admission. During an interview on 8/29/24, at 11:43 a.m. with Licensed Nurse (LN) 3, LN 3 confirmed she would call the MD and let him know regarding a new admission, and would ask the MD if the facility could follow the orders. LN 3 stated the MD would agree and would visit the same day of the resident's admission or the following day. LN 3 explained the acute hospital called her on the third day of Resident 22's admission to check the IFT documents if it had Resident 22's name on it. LN 3 stated usually the nurses would check the stickers attached to the IFT documents because the sticker stood out but did not check the name on the document. LN 3 further stated the facility usually received IFT documents with same name on the sticker and the name on the documents. LN 3 confirmed the IFT documents should have been checked for both the stickers attached and the document itself to make sure the names matched to prevent errors in delivering wrong treatment or care that could possibly cause injury or harm to the resident. During an interview on 8/30/24, at 1:11 p.m. with LN 7, LN 7 stated he picked up resident from the acute hospital with the IFT documents. LN 7 explained he contacted the MD to continue the orders received from the acute hospital and stated he got the consent from the MD. LN 7 stated he checked the IFT documents thoroughly but did not catch the name on the sticker did not match the name on the documents. LN 7 stated that it was missed. During a review of the facility's procedure titled, Admission assessment and Follow Up: Role of the Nurse, revised September 2012, indicated, .Reconcile the list of medications from the medication history, admitting orders, the previous MAR (medication administration record), and the discharging summary from the previous institution .Contact the Attending Physician to communicate and review the findings .and obtain admission orders based on these findings .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 50716 Based on observation, interview, and record review, the facility failed to ensure 1 of 22 sampled residents (Resident 30) received recommended dental services when Resident 30 was not provided the dental treatment recommendation of a full mouth x-ray (a set of pictures that provides images of teeth, gums, and jaw bones) for a broken tooth which was identified on 4/22/24. This failure had the potential to result in health complications for Resident 30 including increased discomfort, infection, problems chewing food, and weight loss. Findings: During a concurrent observation and interview on 8/27/24 at 10:01 AM, Resident 30 stated she needed dental care. Resident 30 reported she had dental pain in her teeth for about two months and no one had come to look at her teeth. Resident 30 stated she had told multiple staff members but did not remember which staff members. Resident 30 opened her mouth and pointed inward to her upper and lower teeth, stating she had pain. During a second interview on 8/28/24 at 2:53 PM, Resident 30 stated, I feel frustrated like I am not being heard and that they don't care. During a concurrent interview and record review on 8/28/24 at 3:14 PM, with the Social Services Director (SSD), Resident 30's paper medical chart was reviewed. When asked about Resident 30's complaint of tooth pain, the SSD stated she did not have any referrals or notices for service for Resident 30 from the nurses. The SSD advised that all the residents were seen at least annually and that the documentation or notes of their visit should be in the resident's paper chart. The SSD retrieved Resident 30's chart and produced a record from an outside healthcare agency titled, Dental Notes, dated 4/22/24. The notes under Tx [Treatment] Recommendation, indicated, #3 [tooth number] broken. The SSD advised that the dental office was responsible to follow up on treatment recommendations and it could take a while. The SSD stated that there was no follow-up done by their facility that she was aware of. The SSD further stated that the facility needed a follow up process on treatment recommendations, so the residents would know what was happening. During a concurrent interview and record review, on 8/29/24 at 8:57 AM, with the Director of Nursing (DON), Resident 30's dental notes from the visit date of 4/22/24 were reviewed. The DON confirmed the notes under treatment recommendation showed a broken tooth and further indicated in the section under Tx (treatment) in progress indicated, Fmx [full mouth x-rays]. The DON further stated that usually they write orders for follow up and this form did not have any orders listed. The DON stated the form gets filed into the resident's chart if there were no orders, and there was no additional follow up by the facility. The DON stated that they should have a system in place for a nurse to work with the SSD when the dental notes were received to ensure follow up with the outside dental service responds to the recommended treatment. The DON stated that four months was too long of a time frame for follow up. The DON stated that no follow up was a risk to Resident 30 because a broken tooth left untreated could lead to further disease or complications like increased pain, the inability to eat, infection, and weight loss. The DON further stated that the resident had the right to have the plan communicated and followed up per the dental services policy. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Dental Services, revised 12/16, indicated, .Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care .Selected dentists must be available to provide follow up care .

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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. 43943 Based on interview, and record review, the facility failed to ensure copies of evaluations were in the resident's medical records for 1 of 22 sampled residents (Resident 12), when the facility did not have access to copies of Resident 12's evaluations for a prosthetic (artificial) leg. This failure had the potential for medical providers not to have reviewed the recommendations regarding acquiring a prosthetic leg for Resident 12. Findings: During a review of Resident 12's clinical record titled, Admission Record (a document that contained the resident's demographic information), the record indicated Resident 12's diagnosis included Type 2 diabetes (inability to control blood sugar) and absence of left leg above the knee. During a concurrent observation and interview on 8/27/24, at 10:34 a.m., Resident 12 was observed in her bed with her wheelchair at the bedside. Resident 12 had her left leg amputated. Resident 12 stated she had been waiting for a year for her prosthetic leg. Resident 12 stated she was willing to put in the work with Physical Therapy to get stronger and walk. Resident 12 stated she would like to have a prosthetic leg so she could walk to the bathroom and outside without maximum assistance. Resident 12 stated it made her feel sad that she was unable to walk. A review of Resident 12's clinical record titled, Orders, dated 6/29/23, at 7:36 a.m., by the Physician (Phys 1), indicated Resident 12 had an order for a prosthetic evaluation. During an interview on 8/28/24, at 3:02 p.m., with the Medical Director (MD), the MD stated Resident 12 was referred for a prosthetic consultation once but was unsure of the outcome. During an interview on 8/28/24, at 3 p.m., with the Director of Rehab (DR), DR stated Resident 12 had had two referrals for an evaluation for a prosthetic leg. The DR stated the prosthetic evaluation notes were not found in Resident 12's clinical record. During a phone interview on 8/28/24, at 3:14 p.m., with RP 1, RP 1 stated the facility had not given her a lot of details as to why Resident 12 had not received a prosthetic leg. RP 1 stated she purchased Resident 12 new shoes because Resident 12 had told her she was getting a prosthetic leg. During an interview on 8/28/24, at 4:00 p.m., with the Licensed Nurse (LN 1), LN 1 stated, she had contacted the prosthetic company and was waiting for them to fax over Resident 12's evaluation notes. LN 1 stated the evaluation notes were not in Resident 12's clinical record. During an interview on 8/29/24, at 9:00 a.m., with LN 1, LN 1 stated she still had not received Resident 12's evaluation notes from the prosthetic company. During an interview on 8/29/24, at 1:02 p.m., with LN 1, LN 1 stated she still had not received Resident 12's evaluation notes from the prosthetic company. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24, at 1:22 p.m., with the Director of Rehab (DR), the DR stated the prosthetic evaluation notes should have been in Resident 12's clinical record. The DR stated without the notes in the clinical record, the physician would not know what the prosthetic evaluation recommendation was for Resident 12. The DR stated Resident 12 was last evaluated for a prosthetic last year. A concurrent phone interview and record review on 8/29/24, at 2:47 p.m., with the Prosthetic Representative (PR), Resident 12's clinical record titled, Orthopedics Clinical Notes, dated 8/29/24, at 2:22 p.m., by the Prosthetic Representative (PR), was reviewed. The document indicated, . patient seems sound of mind an is highly motivated for a prosthesis. We had talked about a year ago about the possibility of providing a prosthesis . Recently I had spoken with patient again and again patient is very motivated; she really has the desire to have a prosthesis and get back to standing and possibly walking . there is the argument that with a prosthesis patient has a change to possibly [sic] improve and may have the chance to stand with assistance . The PR stated she assessed Resident 12 a couple times last year for an evaluation for a prosthetic leg and Resident 12 was very motivated to have a prosthetic leg and walk. During a follow up interview on 8/29/24 at 3:06 p.m., with the PR, the PR stated she wrote Resident 12's clinical note on 8/29/24 (the date of request), the PR stated she did not have a copy of any of the past evaluation notes. The PR stated it was not her practice to provide the facility with a copy of Resident 12's evaluation notes. The PR stated Resident 12 fell through the cracks. During a joint concurrent interview and record review on 8/29/24 at 4:10 p.m., with the Director of Nursing (DON) and the Administrator (ADM), the facility's policy and procedure titled, Charting and Documentation, dated 7/17, indicated, . Documentation in the medical record may be electronic, manual or a combination . The following information is to be documented in the resident medical record: . treatments or services performed .Documentation . will include care-specific details, including: a. The date and time the procedure/treatment was provided, b. The name and title of the individual(s) who provided the care, c. The assessment data .notification of family, physician or other staff . d. The signature and title of the individual documenting . The DON and the ADM stated the P&P was not followed.

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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. 49823 Based on observation, interviews and record reviews, the facility failed to maintain infection control measures when: 1. Certified Nurse Assistant (CNA) 10 entered the room of a resident on Contact Isolation Precautions (a type of transmission based precautions intended to prevent the spread of multi-drug resistant organisms [MDRO, germs that are resistant to three or more drugs that kill infection] and other germs that cause infections that are spread by direct or indirect contact with the resident or the resident's environment) without the appropriate personal protective equipment (PPE, gowns, gloves, eye protection, face masks or respirators used to prevent the spread of germs), then exited the room without performing hand hygiene (washing hands with soap and water or using alcohol-based rubs [hand sanitizers] to keep hands clean); 2. CNA 7 distributed clean water pitchers to residents on a cart with dirty water pitchers, a dirty cup, and a resident food tray with partially eaten food; and 3. Resident 46's urinary catheter bag (a bag that collects urine from a tube inserted into the bladder to drain urine) was found resting on the floor beneath the bed. These failures had the potential to increase the risk of infection for residents, staff, and visitors. Findings: 1. During an observation and concurrent interview on 8/27/24 at 11:03 a.m., it was noted that the residents in Room X were on Contact Isolation Precautions. CNA 10 entered the room without gloves or gown. CNA 10 stated that she was not sure whether Room X was a Contact Isolation Precautions room. CNA 10 stated that she needed to get information from the licensed nurses. CNA 10 stated that sometimes there were isolation signs on the door, but the resident was not on isolation. CNA 10 left the room without performing hand hygiene and went down the hall to nurses' station. When asked about not wearing needed PPE in room X, CNA 10 stated that she did not know the residents in room X were on Contact Isolation Precautions. Licensed Nurse (LN) (1) informed CNA 10 that residents in room X were on Contact Isolation Precautions, and PPE was needed before entering the room. CNA 10 apologized for not wearing PPE in room X. CNA 10 stated that not wearing the appropriate PPE in room X, and leaving the room without performing hand hygiene could spread infection (germs). During an interview on 8/27/24 at 11:15 a.m. with the Director of Staff Development (DSD) at the nurses' station, the DSD stated that gown, gloves, and mask were needed for Contact Isolation Precautions. The DSD stated that risk of not wearing PPE in a Contact Isolation Precautions room was infection (germs) and cross contamination (spread of infection/germs to other areas of the facility). The DSD stated that policy was to wear PPE as indicated on the sign outside the Contact Isolation Precautions room, and to perform hand hygiene as indicated on the sign outside the Contact Isolation Precautions room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with the Director of Nursing (DON) in the DON's office on 8/29/24 at 4:46 p.m., the DON stated that the expectation was that the staff wore the appropriate PPE when entering the isolation room and perform hand hygiene when leaving the room as indicated on the isolation sign outside the door. Review of a facility policy and procedure (P&P) titled, Isolation - Categories of Transmission-Based Precautions, revised 10/2018, indicated, .Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents . 2. Transmission-Based Precautions are additional measures that protect staff, visitors, and other residents from becoming infected . 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution . a. The signage informs the staff of the type of CDC (Centers for Disease Control and Prevention) precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room .Contact Precautions may be implemented for residents known or suspected to be infected with microorgansms (germs) that can be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident-care items in the resident's environment . The DON confirmed that the policy was not followed. 2. During an observation and concurrent interview with CNA 7 in the hallway near the nurses' station on 8/27/24 at 3:45 p.m., CNA 7 distributed clean water pitchers from a cart with a dirty cup, a resident tray with partially eaten food, and dirty water pitchers. CNA 7 stated that the risk for placing clean and dirty water pitchers on the same cart, was cross contamination. During an interview with the DSD in the DSD's office on 8/27/24 at 4:10 p.m., the DSD stated that the risk was cross contamination when distributing clean water pitchers on a cart with dirty water pitchers, dirty cup, and a resident food tray with partially consumed meal on it. The DSD stated that staff education was needed regarding the risk of cross contamination. During an interview with the DON in the DON's office on 8/29/24 at 4:46 p.m., the DON stated that the expectation was that the staff performed hand hygiene between residents and kept clean and dirty items separated when distributing clean water pitchers to the residents. The DON stated that the risk for mixing clean water pitchers with dirty water pitchers was infection. The DON acknowledged that the procedure for distributing clean water pitchers to residents was not followed. A review of an online document published by the United States Department of Agriculture (USDA) titled, Keep Food Safe! Food Safety Basics, last review dated 1/5/ 2024, indicated, . guidelines to keep food safe: clean - wash hands and surfaces often, separate - don't cross-contaminate . 50778 3. During a review of Resident 46's ADMISSION RECORD (contains demographic and medical information), the record indicated Resident 46 was admitted to the facility with diagnoses including but not limited to urinary tract infection (infection of the kidneys or bladder) and retention of urine (condition in which urine is partially or fully unable to leave the bladder). During an observation on 8/27/24 at 9:13 AM, Resident 46 was observed to be laying on the bed, dressed, and well-groomed with both the catheter bag and a privacy cover (a covering used over the catheter bag to preserve resident dignity) hanging under the bed, resting on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/27/24 at 9:52 AM, Certified Nursing Assistant (CNA 4) confirmed Resident 46's catheter bag and dignity bag were on the floor. CNA 4 further stated the catheter bag was supposed to be below the level of bladder and off the floor. CNA 4 reported the biggest risk with the catheter bag on the floor was that someone could step on it, but stated it was not an infection control issue. During a concurrent observation and interview on 8/27/24, at 10:05 AM, Licensed Nurse (LN 6) confirmed Resident 46's catheter bag was hanging under the bed and not on the side of the bed and was touching the floor and should not be. LN 6 stated the expectation was the catheter bag should be hung on the side of the bed frame, not under the bed, and always be covered with a dignity cover. LN 6 stated the risk of the urinary catheter bag on the floor was definitely infection control as the bag can be contaminated (by germs) on the floor. During an interview on 8/29/24 at 2:29 PM, the Infection Preventionist (IP) stated the expectation was to maintain a clean technique when handling catheter tubing and making sure the catheter tubing and bag were kept off the floor. The IP stated the risk of a catheter bag on the floor was infection from cross-contamination. During an interview on 8/29/24 at 4:45 PM, the Director of Nursing (DON) stated a catheter bag should be placed at a location that it must not touch the floor but be below the level of the resident so that it was draining to gravity. The DON confirmed the risk of the catheter bag on the floor was infection. During a review of the facility's policy and procedure titled, Urinary Catheter Care, dated 3/2021, the P&P indicated, .Be sure the catheter tubing and drainage bag are kept off the floor .

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43943 Based on observation and interview the facility failed to ensure resident bedrooms measured at least 80 square feet per resident in seven shared rooms. This failure had the potential to limit the personal belongings of each resident and compromise their ability to move freely in their rooms. Findings: During an interview on 8/27/24, at 11:00 a.m., with the Administrator (ADM), the following rooms did not meet the minimum space requirement for each resident: Room: Occupancy Room Size 1 3 243.5 x 136.5 (231 square feet (ft 2) 3 3 244.5 x 135 (229 ft 2) 5 3 243.5 x 134 (230 ft 2) 6 3 244.3 x 136.5 (232 ft2) 8 3 244 x 136.5 (231 ft 2) 10 3 243.5 x 140.5 (238 ft2) 11 3 243.5 x 135.5 (229 ft2) During an interview on 8/28/24, at 8:51 a.m., with the Licensed Nurse (LN 1), LN 1 stated she had enough room to do her job safely in rooms [ROOM NUMBERS]. LN 1 stated she has not had a resident complain to her about the room size. During a concurrent observation and interview on 8/28/24, at 8:53 a.m., with Resident 47, Resident 47 stated she had enough space in her room for her personal belongings. Resident 47 stated if she had more space, she would fill the space with things she didn't need. Resident 47 was observed to be in her bed with her personal items within reach and her wheelchair at her bedside. During a concurrent observation and interview on 8/28/24, at 8:56 a.m., with Resident 43, Resident 43 stated he had enough space in his room for his personal items but stated it would have been nicer to only share the room with one other resident instead of two residents. Resident 43 was observed in a wheelchair next to his bed with his personal items within reach. During an observation on 8/28/24, at 8:58 a.m., with the Maintenance Director (M-DIR), room [ROOM NUMBER] and room [ROOM NUMBER] were measured. room [ROOM NUMBER] -243.5 x 136.5 inches - 231 sq ft (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room [ROOM NUMBER] - 244.25 x 136.5 inches - 232 sq feet. During a concurrent observation and interview on 8/28/24, at 9:03 a.m., with Resident 49, Resident 49 stated his room was tight, but he was able to be comfortable in the room. Resident 49 was observed in his wheelchair at his bedside. Personal items were on the side table and within reach. During an interview on 8/28/24, at 9:11 a.m., with LN 2, LN 2 stated he had enough room to do his job safety and stated the staff ensured the rooms were free from clutter. LN 2 stated he had not received any complaints from the residents about the rooms being too small to meet their needs. During an interview on 8/29/24, at 8:50 a.m., with the Director of Nursing (DON), the DON stated she could not recall a resident ever complaining about a small room size or that staff could not do their job safely in the rooms. Based on the findings during the Recertification survey, the Department recommends the continuation of the room size waiver for rooms 1, 3, 5, 6, 8, 10 and 11 housing three residents.