

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Tracy Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, and serve food in accordance with professional standards for food safety when:1. Items past their use by dates and spoiled food items were stored in the dry storage pantry,2. There was no air gap or back flow prevention device installed for the food prep sink or the three compartment sink (a commercial kitchen essential with three basins for washing, rinsing, and sanitizing dishes),3. The dishwasher chlorine level was below the proper level for sanitizing dishes, and4. Dietary staff (DS) 1 and DS 2 did not perform appropriate hand hygiene while working in the kitchen. These failures had the potential to affect the flavor and palatability of the food and to lead to food borne illness (nausea, vomiting, diarrhea) for the 51 residents receiving facility prepared food. Findings: 1. During a concurrent observation and interview on 12/2/25 at 8:36 AM with the Food Service Director (FSD) in the dry storage area of the kitchen, the FSD confirmed the following items were on the shelves and available for use: a) a bottle of Worcestershire sauce with a best by date of 11/20/25, b) a soft, discolored onion, four white potatoes, and two red potatoes that were spongy and sprouted, c) spice containers of Tarragon with a use by date of 10/8/25, ginger powder use by date 11/12/25, pumpkin spice use by date 8/27/25, dill weed use by date 11/18/24, and mustard powder with a use by date of 8/8/25, d) a box of baking soda with a use by date of 10/16/25. The FSD stated the items should not be available for use beyond their use by dates. The FSD further stated use of these items could affect the flavor and diminish the residents' enjoyment of the food. The FSD confirmed spoiled food items should not be kept in the storage area. During an interview on 12/4/25 at 10:48 AM with the Registered Dietitian (RD), the RD stated food items should be labeled to inform staff of when they were received and when they were outdated. The RD further stated the use of outdated food items could affect the flavor and enjoyment of the food. The RD stated the food should be fresh and palatable, and spoiled items should be removed from storage to avoid attracting pests. A review of a facility policy titled STORAGE OF FOOD AND SUPPLIES, dated 2017, indicated, .Food and supplies will be stored properly and in a safe manner. Dry food items which have been opened. will be tightly closed, labeled and dated. These items will be used per times specified in the Dry Food Storage Guidelines. A review of a facility document titled DRY FOOD STORAGE GUIDELINES, dated 2018, indicated, This storage length is to be followed. Baking soda. Opened on shelf 6 months. Sauces-bottled. Opened on shelf 1 year. Spices opened on shelf .1 year. 2. During a joint concurrent observation and interview on 12/4/25 at 8:20 AM with the Maintenance Supervisor (MS) and the Maintenance Consultant (MC), the MS confirmed there was no air gap or backflow prevention device in use for the food prep sink or the three compartment sink. The MC stated the purpose of a backflow prevention system was to prevent contaminated water from backing up into the clean sinks. During an interview on 12/4/25 at 10:48 AM with the Registered Dietitian (RD), the RD stated the lack of an air gap or backflow device under the kitchen sinks had the potential for contamination of food and dishes that could have led to food borne illnesses. A review of 2022 Food Code 5-202.13, indicated, .Backflow Prevention, Air Gap. An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE. shall be at least twice the diameter of the water supply inlet. A review (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of 2022 Food Code 5-202.14, indicated, .Backflow Prevention Device, Design Standard.A backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device.3. During a concurrent observation and interview on 12/4/25 at 12:18 AM with DS 3, DS 3 stated she used the low temperature dishwasher in the morning to wash the dishes. DS 3 demonstrated how she used test strips to check the chlorine level in the dishwasher. The result of the test indicated the chlorine level was 25 ppm (parts per million, unit of concentration).During an interview on 12/4/25 at 12:27 PM with the FSD, FSD stated the chlorine level in the dishwasher should be 100 ppm in order to sanitize the dishes. The FSD indicated that insufficient chlorine levels could lead to un-sanitized dishes and a potential spread of infection to residents.During an interview on 12/5/25 at 8:36 AM with the RD, the RD stated that when the chlorine level in the dishwasher was too low, the dishes would not have been cleaned correctly, and the residents would have been at risk of food borne illness.A review of a facility policy titled DISH WASHING, dated 2018, indicated, .All dishes will be properly sanitized through the dishwasher.Appropriate chemicals will be used to wash, de-stain, and rinse the dishes.The chlorine should read 50-100 ppm on dish surface in final rinse. The proper chlorine level is crucial in sanitizing dishes.4. During a concurrent observation and interview on 12/4/25 at 12:15 PM with DS 2 in the kitchen, DS 2 was observed wiping her nose with a tissue. DS 2 left the kitchen and returned still holding a tissue. DS 2 again wiped her nose, disposed of the tissue in the trash can, and walked over to the steam table. When asked about hand hygiene DS 2 stated she forgot to wash her hands.During an observation on 12/4/25 at 12:34 PM, DS 1 walked out of the kitchen wearing gloves, and entered the food storage closet. DS 1 walked back into the kitchen wearing the gloves, approached a food prep cart and touched the cart. The FSD then instructed DS 1 to perform hand hygiene.During an interview on 12/5/25 at 8:36 AM with the RD, the RD stated it was her expectation that dietary staff would change their gloves and wash their hands after they blew their noses, touched their hair, or did anything else that could contaminate their hands. The RD further stated not washing hands could potentially lead to the spread of infection to the residents.A review of a facility policy titled Hand Hygiene, dated 2/27/24, indicated, .Policy: To maintain the highest standards of infection prevention and control through hand hygiene adherence.Staff shall perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.A review of a facility policy titled, GLOVE USE POLICY, dated 2018, indicated, .The appropriate use of gloves is essential in preventing food borne illness. Gloved hands are considered a food contact surface that can get contaminated or soiled. Disposable gloves are a single use item and should be discarded after each use. Wash hands when changing to a fresh pair, Gloves must never be used in place of hand washing.WHEN GLOVES NEED TO BE CHANGED.Before beginning a different task.After sneezing, coughing, smoking, eating, drinking, using a tissue or going to the toilet.After touching bare skin or hair.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive water safety management program based on nationally accepted standards to minimize the risk of Legionella (bacteria spreads via inhaling contaminated water and can lead to a serious lung infection) and other waterborne pathogens (a microorganism [bacteria] that exists in water sources or plumbing [pipes required for the water supply, heating and sanitation in a building] systems that can cause serious illness in people over [AGE] years of age and those with weakened immune systems) for a census of 52 residents when:a. The facility did not complete and document a facility wide assessment of potential Legionella growth areas to include flow charts;b. The facility did not implement adequate control measures;c. The facility did not establish sufficient monitoring protocols;d. The facility did not create an intervention plan for when control limits are not met. These failures put the residents and at risk of potential Legionella and other opportunistic waterborne pathogen exposure, threatening their health and well-being. Findings: During a concurrent interview and record review on 12/3/25 at 11:06 AM, with the Administrator (ADM), the ADM stated that the facility managed its own water system. The ADM stated the Maintenance Supervisor (MS) checked the water temperatures but acknowledged a gap in their current water management plan, admitting that it lacked a flow chart or diagram that indicated the water distribution throughout the facility. During an interview on 12/4/25 at 8:46 AM, the MS explained that water entered the facility from the main supply line and was distributed throughout the facility building. The MS stated he regularly checked the water temperatures and tested for Legionella annually. The MS stated in 2025, random testing was done in the visitors' restroom in the hallway (near the laundry room) because it received unfiltered water. The MS stated in 2024, testing was water testing was conducted in the kitchen. MS acknowledged he was unable to produce documentation of water testing. The MS admitted that he did not have a flow chart or diagram, lacked knowledge of control limits and measures, and was unaware of other risk areas. The MS was not able to explain the facilities process for decontaminating the building water systems, if necessary, and further stated the facility did not have an external contractor for this purpose. During an interview on 12/4/25 at 12:15 PM with the Infection Preventionist (IP), the IP indicated that she was not highly familiar with the facility's water management; however, the MS was responsible for testing and maintaining the system. The IP mentioned that the MS would inform her if there was a positive result for Legionella, upon which she would address the infection prevention aspect. The IP acknowledged deficiencies in their water management program and noted that she had previously informed the Administrator (ADM) about these issues. Additionally, the IP stated that she was unaware whether a facility risk assessment had been conducted or if any control measures were in place. During a follow-up interview on 9/4/2025 at 3:10 PM with the ADM, the ADM mentioned that the facility did not possess a diagram of their water system detailing the flow chart of inlets and outlets as water moved through the building's pipes. The only diagram available was a fire exit plan that listed the boilers but did not include any areas of concern or potential legionella risk. The ADM acknowledged that improper water management could put residents at risk of illness and emphasized the importance of having a proper plan to minimize bacterial growth and infections. A review of the facilities P&P titled, Legionella Water Management Program, revised 7/17, indicated, .c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. g. A diagram of where control measures are applies; . h. A system to monitor control limits and effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective. A review of the CDC's online guide titled Overview of Water Management Programs, published 3/15/24, indicated, .Key Points. Many buildings need a water management program (WMP) for their building water system. WMPs identify hazardous conditions and outline steps to minimize the health impact of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	waterborne pathogens. Developing and maintaining a WMP is a multi-step process that requires continuous review. Seven steps of a Legionella WMP are to: 1. Establish a WMP team 2. Describe the building water systems 3. Identify areas where Legionella could grow and spread 4. Decide where to apply and how to monitor control measures 5. Establish interventions when control limits aren't met 6. Ensure the program runs as designed and is effective 7. Document and communicate all activities. the principle of effective water management include: Ensuring adequate disinfection. Maintaining devices to prevent. Sediment, Scale, Corrosion, Biofilm. Maintaining water temperatures to limit Legionella growth, preventing water stagnation. Once established, WMPs require regular monitoring of key areas for potentially hazardous conditions. The programs use predetermined responses to respond when control measures aren't met. Each program has to be tailored for each building at a particular point in time. In some settings, the entire building needs a WMP: Hospitals and long-term care facilities. https://www.cdc.gov/control-legionella/php/wmp/index.html		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to ensure four (4) of 20 sampled residents' (Resident 3, Resident 9, Resident 42, and Resident 53) basic grooming needs were met when:Resident 3's fingernails nails were long, jagged, and unclean;Resident 9's fingernails nails were long, jagged, and unclean;Resident 42's fingernails nails were long, jagged, unclean and Resident 42 had an odor coming from her clenched right hand;Resident 53's fingernails nails were long, jagged, and unclean. These failures had the potential for Resident 3, Resident 9, Resident 42, and Resident 53 to sustain injury and/or acquire an infection.Findings:1. During a review of Resident 3's admission RECORD, the record indicated Resident 3 was admitted to the facility in 2019, with a diagnosis which included Alzheimer's disease (a progressive disease that affects the parts of the brain that control thought, memory, and language).During a concurrent observation and interview on 12/2/25 at 9:45 AM with Resident 3 in Resident 3's room, Resident 3's fingernails were observed to be long with brown material underneath the nails. Resident 3 stated she preferred her fingernails to be clean and short. Resident 3 stated she no longer had nail clippers and relied on staff to trim her nails. During a concurrent observation and interview on 12/2/25 at 9:47 AM with the Certified Nurse Assistant (CNA) 1 in the room shared by Resident 3 and 53, Certified Nurse Assistant (CNA) 1 confirmed Resident 3's nails needed to be cleaned and trimmed. CNA 1 stated Resident 3's nails should not be soiled and should have been cared for when the resident received a shower or bed bath.2. A review of Resident 9's admission RECORD, the record indicated Resident 9 was admitted to the facility in 2024 with a diagnosis which included hemiplegia and hemiparesis (paralysis/weakness or inability to move one side of the body) affecting the left side.During a concurrent observation and interview on 12/3/25 at 8:20 AM with Resident 9 in Resident 9's room, Resident 9 was observed with long, jagged fingernails, with a dark brown substance underneath. Resident 9 stated he did not know when his fingernails were last cleaned and trimmed. 3. A review of Resident 42's admission RECORD, the record indicated she was admitted to the facility in early 2021 with a diagnosis which included hemiplegia and hemiparesis affecting the left side.During an observation on 12/2/25 at 1:37 PM in Resident 42's room, Resident 42 was observed to have long, jagged fingernails with dark material underneath. During a telephone interview on 12/2/25 at 3:45 PM with Resident 42's Responsible Party (RP) 2, RP 2 stated he trimmed Resident 42's fingernails when he visited and noticed they were long and dirty. RP 2 further stated he was not aware the facility staff trimmed fingernails.During a concurrent observation and interview on 12/4/25 at 10:03 AM with the DSD in Residents 42's room, the DSD confirmed Resident 42 had long, soiled fingernails. The DSD further confirmed an odor was present from Resident 42's clenched right hand. The DSD stated Resident 42's hands should be washed and dried daily to prevent infection. The DSD confirmed staff were not following the facility's policy for ADL care.4. A review of Resident 53's admission RECORD, the record indicated Resident 53 was admitted to the facility in 2023 with a diagnosis which included hemiplegia and hemiparesis affecting the right dominant side of the body. During a concurrent observation and interview on 12/2/25 at 9:40 AM with Resident 53 in Resident 53's room, Resident 53 stated she asked staff to trim her fingernails, and they did not. Resident 53's fingernails were observed to be long, jagged, with a dark brown material underneath the nails. Resident 53 stated she preferred her nails to be short and clean. Resident 53 further stated it was unsanitary to have long, dirty fingernails. During a concurrent observation and interview on 12/2/25, at 9:47 AM with the Certified Nurse Assistant (CNA) 1 in the room shared by Resident 3 and 53, CNA 1 confirmed Resident 53 needed nails cleaned and trimmed. CNA 1 stated the resident's nails should not have been soiled and should have been cared for when the resident received a shower or bed bath.During an interview on 12/4/25 at 8:46 AM with the Director of Staff Development (DSD), the DSD stated every CNA should have been able to trim the residents' fingernails. The DSD further stated if a resident was diabetic and at a higher risk of infection, the licensed nurse should have trimmed their fingernails. The DSD stated residents' fingernails should have been trimmed whenever (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they appeared soiled. The DSD stated it was her expectation that long nails would be trimmed and cleaned to prevent residents scratching themselves and causing an open area which could lead to infection. The DSD stated eating with soiled fingernails could also lead to infection. During an interview on 12/5/25 at 9:05 AM with the Director of Nurses (DON), the DON stated it was her expectation that nail care would be performed by the appropriate staff when residents received their showers. The DON further stated there was a risk to the residents of infection and unintentional skin issues if their nails were not trimmed and cleaned. A review of a facility policy titled, Supporting Activities of Daily Living (ADLs) Policy, dated 10/25, indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.A review of a facility policy titled, Fingernails/Toenails, Care of, dated 2/18, indicated, .The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .Nail care includes daily cleaning and regular trimming .Proper nail care can aid in the prevention of skin problems around the nail bed .Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review the facility failed to ensure one of twenty sampled residents (Resident 9) was free from unnecessary drugs when Resident 9 was prescribed psychotropic medications (medication that affects behavior, mood, thoughts, or perceptions) and diagnosed with schizophrenia (a serious mental illness that affects how a person thinks, feels and behaves) after admission to the facility. This failure placed Resident 9 at risk of unnecessary psychotropic medication use which could lead to medication side effects, decreased mobility, skin breakdown, and decreased ability to perform self-care tasks. Findings: A review of Resident 9's admission RECORD, indicated, he was originally admitted to the facility in mid-2017. A review of Resident 9's clinical document titled, Brief Interview for Mental Status (BIMS), (a tool used to screen for cognitive impairment, the assessment uses a point system that ranges from 0 to 15 points: a score of 13 to 15 points suggests that cognition is intact) dated 11/10/25, indicated, a score of 14. During an interview, in Resident 9's room, on 12/5/25, at 7:47 AM, Resident 9 stated he did not have any mental illness diagnoses and was not prescribed any psychotropic medications. During a telephone interview on 12/5/25, at 8:28 AM, with Resident 9's Responsible Party (RP) 3, RP 3 stated he did not know where Resident 9's schizophrenia diagnosis came from. RP 3 further stated he became aware of the diagnosis when he read Resident 9's paperwork after a hospital visit. RP 3 stated he was not sure if Resident 9's hallucinations were related to dehydration or some other medical condition. A review of Resident 9's Minimum Data Set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) Section I, titled, .Active Diagnoses, dated 2/8/21, indicated, .Psychiatric/Mood Disorder. Anxiety Disorder. Depression. Psychotic Disorder (other than schizophrenia). A review of Resident 9's clinical document titled, Psychiatry Follow Up Note, dated 6/3/21, indicated, .HISTORY OF PRESENT ILLNESS. Patient admitted to facility for s/p [status post] CVA [cerebrovascular accident, stroke, when blood flow to the brain is suddenly interrupted causing brain cells to die from lack of oxygen and nutrients] and metabolic encephalopathy [brain dysfunction caused by a chemical imbalance from an underlying illness]. Today patient reports c/o [complaints of] depression, anxiety and visual hallucinations. Diagnosis. Schizophrenia, unspecified. A review of Resident 9's MDS Section I, titled, .Active Diagnoses, dated 11/24/21, indicated, .Psychiatric/Mood Disorder. Anxiety Disorder. Depression. Schizophrenia. A review of Resident 9's Medication Administration Record (MAR) dated 11/1/25 through 11/30/25, indicated, .Quetiapine Fumarate (atypical antipsychotic medication used to treat schizophrenia) 100 mg (milligram) two times per day. and .Monitor for episodes of (Visual hallucinations), and document number of episodes every shift. The MAR indicated 1 episode of hallucinations documented on 11/22/25, there were no other episodes of hallucinations documented for the month of November. During a telephone interview on 12/5/25, at 10:07 AM, with the current Mental Health Nurse Practitioner (MHNP), the MHNP stated she had visited Resident 9 twice, and during the last visit he was asleep. The MHNP further stated she did not know Resident 9 well enough to determine if he met the criteria for a schizophrenia diagnosis. The MHNP stated the criteria for a schizophrenia diagnosis was very broad and included behaviors of visual hallucinations, disorganized thoughts, and agitation. The MHNP stated disorganized thought processes was the most frequent behavior. The MHNP further stated schizophrenia took a lot of time to diagnose and it was not something that could be done on one visit. The MHNP stated that, based on Resident 9 being alert and oriented, she would need to reassess him to rule out other issues that could lead to psychosis. The MHNP further stated it would be important to determine if Resident 9 continued to need his psychotropic medications or if they could be causing him to be sedated. During an interview on 12/5/25, at 10:56 AM, with the Director of Nurses (DON), the DON stated she was unable to find documentation in Resident 9's health record to indicate the reason for the schizophrenia diagnosis. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accurately complete a Pre-admission Screening and Resident Review (PASRR, a required assessment for individuals with mental illness, intellectual or developmental disabilities, or related conditions, so that a determination of need, appropriate setting, and a set of recommendations for services to be included in the individual's plan of care is provided) for 1 of 20 sampled residents (Resident 8) when, Resident 8's level I PASRR did not reflect her diagnosis of bipolar disorder (a mental disorder characterized by periods of extreme mood swings, and causes shifts in mood, energy, activity levels, and concentration), anxiety disorder [a group of mental health conditions that cause fear, dread, and worry), major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities), and schizophrenia (a serious, chronic brain disorder causing abnormal thinking, perception, and behavior, where people struggle to tell what's real from imagination).This failure resulted in a level II PASRR (a mental health screening for additional services) never being completed with the potential to affect the provision of appropriate treatment and specialized services for Resident 8 and increased her risk of having unmet behavioral health needs.Findings:Review of Resident 8's admission RECORD, indicated Resident 8 was originally admitted to the facility in spring of 2025, with a diagnosis including but not limited to, bipolar disorder, major depressive disorder, and anxiety disorder.Review of Resident 8' s [name redacted, Discharging Hospital A] History and Physical, dated 3/4/25, indicated, .History obtained from patient and previous documentation. As per record patient admitted to [Hospital name redacted] from January 18 till 21st [2025] during that admission she was managed for altered mental status.Past medical history.seizure disorder [abnormal electrical activity in the brain].bipolar disorder.seizure disorder.schizophrenia, cerebral palsy [a group of neurological disorders affecting movement, balance, and posture, caused by damage or abnormal development in the brain, often before birth or in early childhood].Nursing home medications.omeprazole [medication to reduce stomach acid] 40 mg [unit of measurement] daily.Eliquis [blood thinner medication] 5 mg.depokote [medication to treat seizures and mood disorders].Emergency Documentation- MD.ED Physician Notes.XXX[AGE] year-old female with cerebral palsy and extensive medical history.bipolar.seizure disorder.presenting from her board and care of altered mental status.Review of Resident 8's undated and untitled hospice document, indicated, . [name redacted, Resident 8] is a 65 yr [year] old female with admitting diagnosis of Acute Kidney Failure unspecified [loss of kidney function]. She was approved by hospice by [name redacted, hospice MD 2] .Past medical history pt [patient] has been hospitalized at [hospital A] .4 times since December. She has had encephalopathy [disturbance of brain function], seizure, Altered mental status.seizure disorder.schizophrenia, Bipolar disorder.Review of Resident 8's Care Plan, initiated on 3/14/25, indicated, .Altered mood pattern related to anxiety manifested by Inability to relax.Interventions. Assess resident's needs.evaluate food, thirst, toileting needs, comfort level.Notification of primary care physician and/or consulting psychiatrist regarding the escalation of inability to relax.Review of Resident 8's Care Plan, initiated on 3/14/25, indicated, .Altercation in mood and behavior pattern R/T [related to] Depression M/B [manifested by] verbalized sadness.Will have no adverse consequences through the next review date.Administer prescribed medication.Monitor black box warning signs and symptoms.Increased risk of suicidal thinking and behavior in individuals with Major Depressive Disorder and other psychiatric disorders.Monitor for signs of suicidal thinking or unusual changes in behavior .Report the MD in the event that resident exhibit black box warning signs and symptoms.Review of Resident 8's Care Plan, initiated on 3/14/25, indicated, .Alteration in behavior patter R/T DX [diagnosis] of Bipolar Disorder M/B [manifested by] mood lability.Resident will have no episode of mood lability through the next review date.Interventions.Administer prescribed anti-psychotic.Seroquel & Aripiprazole.Notification of the primary care physician and /or consulting psychiatrist regarding the escalation of mood (continued on next page)		

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	liability. Review of Resident 8's Care Plan, initiated on 11/17/25, indicated, .The resident has a psychosocial well-being problem (actual or potential) r/t Alleged Abuse. The resident will have no indications of psychosocial well being problem by/through review date. Consult with Pastoral care, Social services, Psych services. Monitor/document residents feeling relative to (Specify.). Provide opportunities for the resident and family to participate in care. During a concurrent interview and record review on 12/5/25, at 10:34 a.m., with the Minimum Data Set (MDS, an assessment tool) Coordinator (MDS) 1, Resident 8's quarterly MDS, dated [DATE] was reviewed. The MDS 1 stated that a PASSR was needed upon admission and wherever the resident was discharged from such as an acute care hospital; they would send the PASSR file. The MDS 1 stated the quarterly MDS should have captured all active diagnoses and be accurate. The MDS further confirmed Resident 8's schizophrenia diagnosis was not captured. During a concurrent interview and record review on 12/5/25, 12:11 p.m., with the Director of Nursing (DON), Resident 8's PASSR was reviewed. The DON confirmed Resident 8's PASSR was wrong, the Interdisciplinary team (IDT, a group of professionals from different fields who work together and communicate closely to create one unified, holistic care plan for a patient, focusing on all their needs (physical, emotional, social) should have reviewed it, noticed it was incorrect, and resubmitted the PASSR. The DON stated it was important for the PASSR to be correct be it guided treatment and could have recommendations to address mental health conditions. The DON further stated there was a risk for the resident's mental health not being adequately addressed. Review of the facility Policy & Procedure (P&P) titled, ADMISSION, TRANSFER, DISCHARGE, AND BED-HOLDS, dated 2016, indicated, .PURPOSE .To provide uniform guidelines for admission .in compliance with state and federal guidelines. To promote equal access to quality care and facilitate continuity with care transitions .The facility .requires individuals diagnosed with major mental illness .or developmental disabilities to be screened prior to admission and throughout stay in accordance with PASRR requirements .Review of the facility P&P titled, Behavioral Health Services, dated 2025, indicated, .It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being .The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy[independence], privacy, socialization, independence, choice, and safety .Staff will .Complete PASARR screening .The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrist [doctor specializing in mental health], or neurologists [brain doctor] .Review of the facility Policy and Procedure (P & P) titled, Preadmission SCREENING & RESIDENT REVIEW (PASSR), dated 11/30/23, indicated, .Facility will. Coordinate assessments with he pre-admission screening and resident review (PASSR) program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort to include. Incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into the resident's assessment, care planning, transitions of care. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change of in status assessment. Notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who ahs mental illness or intellectual disability for resident review. for resident review.		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on interview and record review, the facility failed to ensure 1 of 20 sampled residents (Resident 9) Preadmission Screening and Resident Review (PASRR, a federally mandated screening of all potential nursing home residents, for mental illness and intellectual disability, to help ensure that individuals are not inappropriately placed in a nursing home, and to ensure they receive any specialized services that are required), form was updated after a significant change in mental illness diagnosis. This failure had the potential for Resident 9 to not receive the necessary care and services required to improve Resident 9's mental health condition and quality of life. Finding: A review of Resident 9's admission RECORD, indicated, he was originally admitted to the facility in mid-2017. A review of Resident 9's Minimum Data Set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) Section I, titled, .Active Diagnoses, dated 2/8/21, indicated, .Psychiatric/Mood Disorder.Anxiety Disorder.Depression.Psychotic Disorder (other than schizophrenia).A review of Resident 9's clinical document titled, Preadmission Screening and Resident Review (PASRR) Level I Screening Document, dated 5/3/21, indicated, .Level I -Negative.Case Status: Closed.Reason Code-No- MI [mental illness].A review of Resident 9's clinical document titled, Psychiatry Follow Up Note, dated 6/3/21, indicated, .HISTORY OF PRESENT ILLNESS. Patient admitted to facility for s/p [status post] CVA [cerebrovascular accident, stroke, when blood flow to the brain is suddenly interrupted causing brain cells to die from lack of oxygen and nutrients] and metabolic encephalopathy [brain dysfunction caused by a chemical imbalance from an underlying illness]. Today patient reports c/o [complaints of] depression, anxiety and visual hallucinations.Diagnosis.Schizophrenia, unspecified.A review of Resident 9's MDS Section I, titled, .Active Diagnoses, dated 11/24/21, indicated, .Psychiatric/Mood Disorder.Anxiety Disorder.Depression.Schizophrenia.During an interview on 12/5/25, at 11:50 AM, with the Director of Nurses (DON), the DON stated Resident 9's PASRR should have been updated when he received the schizophrenia diagnosis. The DON further stated the purpose for updating the PASRR was to ensure Residents were evaluated for the appropriate care and services.A review of a facility policy titled, Resident Assessment- Coordination with PASRR Program, revised 10/25, indicated, .This facility coordinates assessments in accordance with the preadmission screening and Resident review (PASRR) program requirements.to ensure that individuals with a mental disorder, intellectual disability, or related condition receives care and services in the most integrated setting appropriate to their needs.Any resident who exhibits newly evident or possible serious mental disorder.will be referred promptly to the state mental health or intellectual disability authority for a level II Resident review upon a significant change in status assessment. Examples include.A Resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a new mental disorder.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review the facility failed to provide services which met professional standards of quality care for one of 20 sampled residents (Resident 3) when Resident 3 expressed suicidal ideation (thinking about, considering, or planning to end one's life) and no interventions were put in place to monitor her psychosocial needs. This failure had the potential for Resident 3 to make a suicide attempt (try and end one's life) and to negatively affect her psychosocial wellbeing. A review of Resident 3's admission RECORD, indicated Resident 3 was admitted to the facility in 2019 with diagnoses which included Alzheimer's Disease (a progressive disease that affects the parts of the brain that control thought, memory, and language), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), vascular dementia, (a decline in cognitive abilities due to reduced blood flow to the brain) and delusional disorders (mental health condition in which a person has false beliefs based on an inaccurate interpretation of reality). A review of Resident 3's clinical document titled, [Company Name] Behavioral Health, dated 6/12/25, indicated, .List of symptoms/problems in patient's own words. Patient reported visual hallucinations, describing she saw her grandson being shot. She also expressed suicidal ideation with a specific plan, stating she intended to stab herself and jump off a bridge. However, due to her physical immobility, the imminent risk is limited. Nonetheless, the facility has initiate [sic] a safety plan, including increased monitoring and environmental precautions. Plan for Medication. Increase . [PSYCHIATRIC MEDICATION NAME] .A review of Resident 3's clinical document titled, Progress Notes, dated 6/13/25, signed by Resident 3's MD, indicated, .Psych [MENTAL HEALTH PRACTITIONER NAME] seen the patient with recommendation to increased [sic] [PSYCHIATRIC MEDICATION NAME] for dementia. Visit Diagnoses. Severe episode of recurrent major depressive disorder. A review of a Resident 3's clinical document titled, Progress Note, dated 6/13/25 at 2:28 PM, indicated, .Type: Nurse Notes. Author contacted RP [RESPONSIBLE PARTY NAME] .to Increase medication [PSYCHIATRIC MEDICATION NAME] and awaiting call back for consent. Nursing care will continue. During a concurrent interview and record review on 12/5/25 at 1:17 PM with the Director of Nurses (DON), the DON stated if staff were aware of Resident 3's report of suicidal ideation it was her expectation that the change of condition would have been documented and an Interdisciplinary team (IDT, group of healthcare professionals who assess and coordinate care) meeting would have been held and the needs of Resident 3 would have been determined. The DON further stated Resident 3's care plan should have been updated to reflect the care needs, the social services department should have followed up with Resident 3 for 72 hours, and if indicated, Resident 3 should have been assigned continual staff monitoring. The DON confirmed Resident 3 did not have a change of condition documented, her care plans were not updated, and there was no documentation in her clinical record to indicate staff monitored her for suicidal ideation during the month of 6/25. A review of a facility policy titled, Suicide Threats, revised 12/07, indicated, .Resident suicide threats shall be taken seriously and addressed appropriately. Staff shall report any resident threats of suicide immediately to the Nurse Supervisor/Charge Nurse. After assessing the resident in more detail, The Nurse Supervisor/Charge Nurse shall notify the resident's Attending Physician and responsible party, and shall seek further direction from the physician. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report any changes in the resident's behavior immediately. Staff should document details of the situation objectively in the resident's medial record.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe medication and medical supply storage in the medication cart (a mobile cart with stored medications and supplies needed for administration), refrigerator, and the medication room (a locked room used to store medications and supplies) for a census of 52 residents when:1. When Resident 35's expired Sennosides (a stimulating laxative used to treat constipation) 8.6 milligrams (mg, unit of measurement), and Resident 33's expired Meclizine Hydrochloride 25 mg (an antihistamine used to prevent and treat nausea, vomiting, and dizziness) were stored in the medication cart.2. a. Discontinued Intravenous (IV, tube that is placed into a vein to deliver fluids and medications) medication belonging to a discharged resident (Resident 99) was stored in an active storage area in the refrigerator of the medication room. b. Expired (outdated) nutrition powder was stored in the active storage areas of the medication room. This failed practice had the potential for risk for medication error, resident injury, adverse (bad) effects, and possible hospitalization for the residents who could have been given the medication.Findings 1. During a concurrent observation and interview on 12/04/2025 at 4:00 p.m. with Licensed Nurse (LN) 1, there were three expired oral medications stored in medication cart 2, two bottles of Senokot 8.6 mg were labeled with Resident 35's name with an expiration date of 7/31/2025. The third bottle labeled, Meclizine 25 mg with Resident 33's name listed on the bottle and an expiration date of 8/30/2025. During an interview on 12/4/25 at 4:00p.m. with Licensed Nurse 1, (LN 1) LN 1 confirmed there were two bottles of expired Senokot and one bottle of expired Meclizine left in the medication cart 2. LN 1 stated reason expired meds should not be left in the medication cart was because the medication could lose its effectiveness. During an interview on 2/5/25 at 08:54 a.m. with the Director of Nursing (DON), the DON stated facility should not have left or stored expired medications in the medication cart. The DON stated the staff should have removed the medication from the medication cart once the medication was expired and placed the discontinued medications in the cabinet in the medication room for disposition (destruction). The DON stated reasons expired med should not be left in the med cart when a medication was discontinued or a resident had been discharged from the facility was because inadvertent administration of medication to a resident could either cause adverse (bad) effects or ineffective (does not work) treatment. Review of facility's policy and procedure (P&P) titled, Medication Storage In The Facility, dated 1/25, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, spoiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. O. Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified. 2. During a concurrent observation and interview on 12/3/25 at 8:40 a.m. with Licensed Nurse (LN) 2, an inspection of the facility's main medication room was conducted. The following expired and/or discontinued medications and supplements were stored in the medication room and the refrigerator: (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Intravenous [IV, refers to giving medications or fluids through a needle or tube inserted into a blood vessel] bag of . [name redacted, Resident 99] .IV DAPTOMY [medication used to treat infections] 700MG [milligram, unit of measurement]/NS [normal saline, meaning sterile salt water] 50 .DIRECTIONS.INFUSE 700 MG INTRAVENOUSLY DAILY @ [at] 100ML [unit of measurement, milliliter/ HR [hourly].Fill Date.11/6/25.PREP [preparation] TIME 4:25 PM.LOT .11/08/25.4:25 PM. for a discharged Resident 99. b. Three boxes of Juven.Therapeutic Nutrition Powder.FOR WOUND HEALING.AMINO ACID.Arginine.Glutamine., had expiration dates of 8/25, 5/25, and 9/25. LN 2 acknowledged Resident 99's IV antibiotic was stored in the locked refrigerator and stated she was a Licensed Vocational Nurse (LVN) and was unsure how long the medication was good for after being reconstituted (mixing medication with a solution) by the pharmacy. LN 2 explained the facility's Registered Nurses administered IV medications to residents. LN 2 acknowledged the Juven mix should not be in the medication room because it was expired, and staff could not give it to residents because it was not safe to consume. LN 2 stated the Juven mix contained extra amino acids and was used for residents with wounds as it aids wound healing. LN 2 further explained Juven needed to be recommended by the dietician for residents with wounds. During a concurrent observation, inspection of the facility's main medication storage room, and interview on 12/3/25 at 9:15 a.m. accompanied by the Director of Nurses (DON) in the facility's main medication storage room, the DON stated Resident 99's IV antibiotic Daptomy expired on 11/8/25 at 4:25 p.m., and stated Resident 99 had been discharged from the facility. The DON explained once IV antibiotics were received from the pharmacy the expectation was, the antibiotic should have been administered to the residents within three to six hours. The ADM stated expired resident medications should not be stored due to the risk of expired medications accidentally administered to the residents. The DON further explained that residents who were discharged from the facility should not have their medication stored in the facility's medication refrigerator. The DON explained expired medication and/or supplements could have harmed the resident, and/or the medications could have been ineffective, and/or caused adverse (bad) effects to the resident. The DON acknowledged the three boxes of Juven mix were expired and past the used by dates. The DON stated expired medications and/or supplement mixes should not be kept or stored due to not wanting them to be available for staff to administer to residents. Review of facility policy and procedure (P & P) titled, MEDICATION STORAGE IN THE FACILITY, revised 1/25, indicated, .Medications and biologicals are stored safety, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized.Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal.Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified.		

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

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the total actual staffing hours worked Per Patient Day (PPD - a metric system used to measure staffing to resident ratio over 24 hours). This failure could have given a false sense of the facility being adequately staffed to meet the resident's needs. Findings: During a concurrent observation and interview on 12/4/25 at 11:43 a.m. with the Director of Staff Development/Infection Preventionist (DSD/IP), the facility's document titled, Census and Direct Care Services Hours Per Patient Day (DHPPD), dated 12/4/25, was posted on the staff bulletin board, without an Actual Direct Care Service (ADCS - actual hours nursing staff works per resident in a day) hours on it, and with no staff signature. The DSD/IP stated she completed the actual direct care services hours on the DHPPD form either on the following work day during the day shift, or before she left the facility at 4:30 p.m. The DSD/IP further stated the reason she completed a DHPPD form each day was so that the residents, visitors, and families were aware of the amount of nursing staff assigned per resident for a 24-hour time period. During a concurrent interview and observation on 12/5/25 at 08:11 a.m. with the Director of Nursing (DON), the DON confirmed the posted DHPPD on the bulletin board did not include an actual direct care service on it. The DON stated that the facility should have visibly posted the actual PPD, so visitors and residents could have seen and had knowledge of what the facility's actual staff to resident ratio was for the day. The DON also stated when the actual PPD hours were entered late or on the following day, the facility may have had inaccurate data posted. Review of facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, dated 7/16, the P&P indicated, Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (Registered Nurses [RNs], Licensed Practical Nurses [LPNs], and Licensed Vocational Nurses [LVNs]) and the number of unlicensed nursing personnel (Certified Nursing Assistant [CNAs]) directly responsible for resident care will be posted in a prominent location (accessible to the residents and visitors) and in a clear and reasonable format. 3 The information recorded on the form shall include: . a. The name of the facility. f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift. g. The actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and un-licensed nursing staff working for the posted shift. 4. When computing hours of direct care staff working split shifts count only the total number of hours the individual is actually scheduled to work for the shift information being posted. (Example: You are posting data for the Day Shift. A CNA reports to work and is scheduled to work four (4) hours on the Day Shift and four (4) hours on the Evening Shift. In computing the number of hours worked for that shift, count only the four (4) hours scheduled for the Day Shift. The remaining four (4) hours would then be counted towards the totals on the Evening Shift.)		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a total of seven (7) shared resident bedrooms (rooms 1, 3, 5, 8, 10 and 11) measured at least 80 square feet (sq. ft. - unit of measurement) per resident. This failure had the potential to result in a lack of sufficient space for the provision of resident care, to maintain privacy, and to allow for space to house the residents' personal property. Findings: During a concurrent observation and interview on 12/5/25 at 11:57 a.m. with the Maintenance Supervisor (MS), the MS confirmed there were a few rooms that did not meet the minimum 80 sq. ft. per resident in the shared bedrooms (room [ROOM NUMBER], 3, 8, 10, 11, and two other rooms). The MS measured room [ROOM NUMBER] and room [ROOM NUMBER] with a tape measure. rooms [ROOM NUMBERS] had three residents occupied in the rooms. The MS confirmed room [ROOM NUMBER] measured at 135 inches (unit of measurement) in width and 243.5 inches in length, room [ROOM NUMBER] measured at 135.5 inches in width and 246 inches in length. During a concurrent interview and record review on 12/5/25 at 11:34 a.m. with the ADM, the Department's (California Regulatory Department) document titled, Client Accommodation Analysis (CAA), dated 10/08, completed by the facility's ADM, was reviewed. The ADM confirmed the room measurements. The ADM provided the following documented room measurements for the resident rooms which did not meet the minimum space requirement of 80 sq. ft. per resident in shared bedrooms: Room Occupancy Required/actual sq. ft. Sq. Ft. per resident 1 3 residents 240/231 sq. ft. 77.3 3 residents 240/229 sq. ft. 76.35 3 residents 240/230 sq. ft. 76.666 3 residents 240/232 sq. ft. 77.38 3 residents 240/231 sq. ft. 77.10 3 residents 240/238 sq. ft. 79.311 3 residents 240/229 sq. ft. 76.3 During a concurrent observation and interview on 12/5/25 at 2:40 p.m. with the Certified Nursing Assistant (CNA) 2, CNA 2 demonstrated how she moved the beds, bedside tables, and nightstands to provide care for residents in the rooms. CNA 2 stated the CNAs had to move beds to make enough room for the lift machine (a device that assists with lifting heavy or immobile residents from the bed) and during transfers (moving a resident from one location to another location), especially with two people assistance (two people assist with the resident transfer). CNA 2 further stated the room was a bit tight, but they made use of the space that was available. During an interview on 12/4/25 at 2:47 p.m. with Resident 21, Resident 21 stated there was no concern with the room size, staff had enough space for the residents' ADL (activities of daily living - bathing, brushing hair, brushing teeth) care and enough space in the room for the equipment. Based on the findings during the recertification survey, the Department recommends granting the continuation of the Room Waiver, contingent upon compliance with federal regulations at Resident Rights (481.10) and Physical Environment (483.90).		