STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555122	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Park Care Center	3700 H Street Sacramento, CA 95816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 follow proper food storage, hygienic dish handling and hand hygiene techniques in the kitchen when:Undated and unlabeled raw green squash were observed in the kitchen food refrigerator; Kitchen staff stacked wet meal tray lids on top of one another before allowing them to dry;Kitchen staff failed to follow proper hand hygiene during handling of soiled dishes during dishwashing; and,Kitchen staff failed to follow proper hand hygiene during food preparation.These failures had the potential for all 77 residents in the facility to receive expired food, place all residents at risk for food-borne illness related to improper hand hygiene and place all residents at risk for exposure to possible biological growth on wet meal tray lids.1.During a concurrent observation and interview on 1/20/26 at 7:59 a.m., with Dietary Manager (DM), in the kitchen, unlabeled and undated raw green squash was observed in a stainless steel container in the food refrigerator. Approximately 11 raw whole green squash were observed in the container with no labels, open date, or use by date. DM stated, she did not see any label or dates.During an observation on 1/20/26, at 8:01 a.m., in the kitchen, DM was observed speaking to kitchen staff, stating they had to label and date the foods in the refrigerator.2. During an observation on 1/21/26, at 9:57 a.m., in the kitchen, DA 2 was observed stacking wet meal tray lids on top of one another. Water was observed to drip from the lids being stacked by DA 2.During an interview on 1/21/26, at 9:57 a.m., with DA 2, DA 2 stated, the meal tray lids were clean and she was stacking them. DA 2 stated, the lids were still wet.During an interview on 1/21/26, at 9:58 a.m., with DM, DM stated, the lids were still wet and should not be stacked while wet.3. During an observation on 1/21/26, at 11:07 a.m., in the kitchen, DA 1 dropped a meal tray lid on the floor while washing soiled dishes and wearing gloves. DA 1 picked up the lid from the floor and placed the soiled lid into the dishwasher while wearing the soiled gloves. The dishwasher completed its cycle washing the dishes, DA 1 still wearing the soiled gloves opened the dishwasher and removed the clean dishes by touching the crate the dishes were stacked in. DA 2 was observed to touch the same crate DA 1 touched and began to unload the clean dishes with bare hands. During an interview on 1/21/26, at 11:08 a.m., with DM, DM stated, the correct way to use the dishwasher was to have one staff rinsing the dirty dishes and loading the dishwasher, then another staff member removes the clean dishes, the staff washing the dirty dishes should not remove the clean dishes from the dishwasher because their hands were dirty. DM further stated, if a staff member drops something on the floor they need to perform hand hygiene after picking up the item. 4. During an observation on 1/21/26, at 11:20 a.m., in the kitchen, [NAME] 2 was wearing gloves while preparing fresh lettuce for a salad. [NAME] 2 trimmed the lettuce and threw the scraps of lettuce away into the trash can touching the trash can liner. [NAME] 2 still wearing the same gloves continued to prepare the fresh salad trimming lettuce throwing scraps away and touching the trash can liner multiple times without performing hand hygiene. During an interview on 1/21/26, at 11:22 a.m., with DM, DM stated, [NAME] 2 needs to perform hand hygiene if she touched the trash can during food prep. During a review of the facility's policy and procedure (P&P) titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices dated 2022, the P&P indicated, Food and nutrition services employees follow appropriate hygiene and sanitary (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	procedures to prevent the spread of foodborne illness.6.Employees must wash their hands: .f. after handling soiled equipment or utensils; g. during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or h. after engaging in other activities that contaminate hands. During a review of the facility's P&P titled, Hand Washing Procedure dated 2023, the P&P indicated, When hands need to be washed: .8. touching trash can or lid.

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to ensure the Quarterly Minimum Data Set (MDS-a federally mandated resident assessment tool) assessments for 10 of 13 sampled residents (Resident 22, Resident 35, Resident 36, Resident 5, Resident 45, Resident 48, Resident 49, Resident 4, Resident 83, and Resident 92) were completed within the required timeframe, for a census of 77.These failures increased the potential for care plans not to be updated to reflect resident's current condition. A concurrent interview and record review was conducted with the MDS Coordinator (MDSC) on 1/22/26 starting at 2:34 p.m. The MDSC stated the facility has 14 days after Assessment Reference Date (ARD-look back or observation period) to complete the assessments and 14 days to transmit once the assessment was completed. The MDSC confirmed the following information:-Resident 22's quarterly MDS assessment with ARD on 12/14/25 was due to be closed and locked on 12/27/25. The MDSC confirmed the assessment was completed and transmitted on 1/21/26 and the assessment was late;-Resident 35's quarterly MDS assessment with ARD on 12/12/25 was due to be completed on 12/26/25. The MDSC confirmed the assessment was late and it was completed and transmitted on 1/20/26;-Resident 36's quarterly MDS assessment with ARD on 12/18/25 was due to be completed on 12/31/25. The MDSC confirmed the assessment was completed and transmitted on 1/21/26;-Resident 5's quarterly MDS assessment with ARD on 12/6/25 was due to be completed on 12/20/25. The MDSC confirmed it was completed and transmitted on 1/20/26;-Resident 45's quarterly MDS assessment with ARD on 12/13/25 was due to be completed on 12/27/25. The MDS confirmed the assessment was completed and transmitted on 1/21/26;-Resident 48's quarterly MDS assessment with ARD on 12/22/25 was due to be completed on 1/5/26. The MDSC confirmed the assessment was in progress and it was late; -Resident 49's quarterly MDS assessment with ARD on 12/13/25 was due to be completed on 12/27/25. The MDSC confirmed the assessment was late and it was completed and transmitted on 1/21/26; -Resident 4's quarterly MDS assessment with ARD on 12/4/25 was due to be completed on 12/18/25. The MDSC confirmed the assessment was late and it was completed and transmitted on 1/20/26. -Resident 83's quarterly MDS assessment with ARD on 12/4/25 was due to be completed on 12/18/25. The MDSC confirmed the assessment was completed and transmitted on 1/20/26; and, -Resident 92's quarterly MDS assessment with ARD on 12/19/25 was due to be completed on 1/1/26. The MDSC confirmed the assessment was completed and transmitted on 1/21/26. During an interview with the Director of Nursing (DON) on 1/23/26 at 12:54 p.m., the DON stated her expectation was for the assessments to be done timely based on the ARD. The DON further stated when assessments are not done timely there is potential for not identifying the problem and this delays the interventions. A review of the facility's policy and procedure (P & P) dated October 2023 and titled, Resident Assessments indicated, OBRA [Omnibus Budget Reconciliation Act of 1987]-Required Assessments are federally mandated, and therefore, must be performed to all residents .OBRA assessments include: .Quarterly Assessment .The resident assessment coordinator is responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments. A review of the Resident Assessment Instrument (RAI) Manual dated October 2025 indicated the Quarterly MDS Assessment completion date is no later than ARD + 14 calendar days and the transmission date is no later than MDS completion date + 14 calendar days.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS-a federally mandated resident assessment tool) assessments for 13 of 13 sampled residents (Resident 22, Resident 24, Resident 35, Resident 36, Resident 5, Resident 45, Resident 48, Resident 49, Resident 4, Resident 82, Resident 83, Resident 92, and Resident 6) were completed and transmitted within the required timeframe, for a census of 77. These failures had the potential for residents not to receive individualized plan of care based on their specific needs. A concurrent interview and record review was conducted with the MDS Coordinator (MDSC) on 1/22/26 starting at 2:34 p.m. The MDSC stated the facility has 14 days after Assessment Reference Date (ARD-look back or observation period) to complete the assessments and 14 days to transmit once the assessment was completed. The MDSC confirmed the following information:-Resident 22's quarterly MDS assessment with ARD on 12/14/25 was due to be closed and locked on 12/27/25. The MDSC confirmed the assessment was completed and transmitted on 1/21/26 and the assessment was late;-Resident 24's significant change in condition assessment (SCSA) with ARD on 12/12/25 was due to be completed on 12/26/25. The MDSC confirmed the assessment was completed and transmitted on 1/21/26 and the assessment was late;-Resident 35's quarterly MDS assessment with ARD on 12/12/25 was due to be completed on 12/26/25. The MDSC confirmed the assessment was late and it was completed and transmitted on 1/20/26; - Resident 36's quarterly MDS assessment with ARD on 12/18/25 was due to be completed on 12/31/25. The MDSC confirmed the assessment was completed and transmitted on 1/21/26; -Resident 5's quarterly MDS assessment with ARD on 12/6/25 was due to be completed on 12/20/25. The MDSC confirmed it was completed and transmitted on 1/20/26; -Resident 45's quarterly MDS assessment with ARD on 12/13/25 was due to be completed on 12/27/25. The MDSC confirmed the assessment was completed and transmitted on 1/21/26; -Resident 48's quarterly MDS assessment with ARD on 12/22/25 was due to be completed on 1/5/26. The MDSC confirmed the assessment was in progress and it was late; -Resident 49's quarterly MDS assessment with ARD on 12/13/25 was due to be completed on 12/27/25. The MDSC confirmed the assessment was late and it was completed and transmitted on 1/21/26; -Resident 4's quarterly MDS assessment with ARD on 12/4/25 was due to be completed on 12/18/25. The MDSC confirmed the assessment was late and it was completed and transmitted on 1/20/26. -Resident 82's Annual MDS assessment with ARD on 12/4/25 was due to be completed on 12/18/25. The MDSC confirmed the assessment was completed and transmitted on 1/20/26; -Resident 83's quarterly MDS assessment with ARD on 12/4/25 was due to be completed on 12/18/25. The MDSC confirmed the assessment was completed and transmitted on 1/20/26; -Resident 92's quarterly MDS assessment with ARD on 12/19/25 was due to be completed on 1/1/26. The MDSC confirmed the assessment was completed and transmitted on 1/21/26; and, -Resident 6's discharge MDS assessment with ARD on 1/7/26 was due to be completed on 1/21/26. The MDSC stated Resident 6 was discharged on 1/7/26 and she confirmed the assessment was not completed. During an interview with the Director of Nursing (DON) on 1/23/26 at 12:54 p.m., the DON stated her expectation was for the assessments to be done timely based on the ARD. The DON further stated when assessments are not done timely there is potential for high probability of not identifying the problem and this delays the interventions. A review of the facility's policy and procedure (P & P) dated October 2023 and titled, Resident Assessments indicated, OBRA [Omnibus Budget Reconciliation Act of 1987]-Required Assessments are federally mandated, and therefore, must be performed to all residents .OBRA assessments include: .Quarterly Assessment .Annual Assessment .Significant Change in Status Assessment (SCSA) .Discharge Assessment (return anticipated and return not anticipated) .The resident assessment coordinator is responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments. A review of the facility's P & P dated October 2023 and titled, MDS Completion and Submission Timeframes (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, .Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. A review of the Resident Assessment Instrument (RAI) Manual dated October 2025 indicated the following:-Annual MDS Assessment completion date is no later than ARD + 14 calendar days and the transmission date no later than care plan completion [14 days] + 14 calendar days;- Significant Change in Status (SCSA) Assessment completion date is no later than 14th calendar day after determination of the significant change + 14 calendar days and the transmission date is no later than care plan completion date + 14 calendar days;-Quarterly MDS Assessment completion date is no later than ARD + 14 calendar days and the transmission date is no later than MDS completion date + 14 calendar days; and-Discharge Assessment completion date is no later than discharge date + 14 calendar days and the transmission date is no later than MDS completion date + 14 calendar days.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review the facility failed to follow therapeutic diets (a nutritionally tailored meal plan prescribed by a physician and planned by a dietitian to treat, manage, or prevent specific medical conditions) for four of 77 residents who receive meals from the kitchen (Resident 44, Resident 78, Resident 90, and Resident 94).These failures had the potential to cause negative health outcomes for Resident 44, Resident 78, Resident 90, and Resident 94.During an observation on 1/21/26, at 11:53 a.m., during tray line (the placing of prescribed diets on residents meal trays) in the kitchen, Dietary Aid (DA) 1 did not place the fortified diet (a prescribed diet, deliberately increasing the calorie and protein density of regular meals to combat involuntary weight loss and malnutrition) item (2 individual packs of margarine) on Resident 78's lunch tray. DA 2 placed the tray onto the tray cart without the fortified item. Resident 78's meal tray ticket (piece of paper which contains the ordered therapeutic diet with the residents name, allergies, and food preferences) was observed to indicate, Fortified.During an interview on 1/21/26, at 11:53 a.m., with Dietary Manager (DM), DM Stated the fortified item for lunch today was 2 packets of margarine.During an observation on 1/21/26, at 12:00 p.m., during tray line in the kitchen, DA 1 placed the regular dessert item on Resident 44's meal tray. Resident 44's meal tray ticket was observed to read, Pureed diet. DA 2 placed Resident 44's meal tray onto the meal cart with the regular dessert item orange blossom parfait, which was observed to contain whole pieces of fruit.During an interview on 1/21/26, at 12:03 a.m., with [NAME] 2, [NAME] 2 stated, the pureed dessert item for today was chocolate pudding.During an observation on 1/21/26, at 12:11 p.m., DA 1 placed a salt packet on Resident 90's meal tray. Resident 90's meal tray ticket was observed to read NAS (no added salt). DA 2 placed Resident 90's meal tray onto the meal cart with the salt packet on the meal tray.During an observation on 1/21/26, at 12:21 p.m., DA 1 placed a margarine packet onto Resident 94's meal tray. Resident 94's meal tray ticket was observed to read Low Fat/Low Chol (cholesterol). DA 2 was observed to place Resident 94's meal tray onto the meal cart with the margarine on the meal tray.During a review of the facility's Winter Menu Spreadsheet dated 1/21/26, spreadsheet indicated Low Fat/Cholesterol .no margarine/Jelly as desired.During an interview on 1/21/26, at 3:13 p.m., with Registered Dietician (RD) RD stated, it is her expectation that all kitchen staff follow therapeutic diets for all residents.During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diet, dated 2017, the P&P indicated, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow infection prevention and control standards and provide a safe and sanitary environment for census of 77 residents, when:Enhanced Barrier Precautions (EBP-an infection control policy to reduce transmission of multi-drug resistant organisms, MDRO, using personal protective equipment, PPE, for residents with wounds, indwelling devices, or known colonization with specific pathogens) were not followed when performing resident care for Resident 94; and,Sanitary conditions in the laundry were not maintained and the cover for the carts were not in good condition. These failures had the potential to result in the spread of infection among residents and staff. 1. A review of Resident 94's admission Record, indicated Resident 94 was admitted to the facility in November 2025 with multiple diagnoses including metabolic encephalopathy (brain dysfunction caused by chemical imbalance, organ failure, or infection causing confusion or altered consciousness), orthopedic aftercare (care after surgery including care for incision), multiple rib fractures, fracture of vertebra, systemic lupus erythematosus (auto immune disease causing inflammation and damage to organs), Immunodeficiency due to drugs (immune system unable to fight off infection and disease), autoimmune hepatitis (chronic liver disease where immune system attacks the liver), and laceration of left buttock. A review of Resident 94's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 11/17/25, indicated Resident 94 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 94 was cognitively intact. A review of Resident 94's Care Plan . Enhanced Barrier Precautions: Resident requires enhanced barrier precautions during high-contact resident care activities . initiated 11/11/25, indicated .Interventions .Place EBP notification/signage near resident room doorway to alert staff/visitors of precautions .Utilize PPE (gown and gloves .) during high-contact activities (e.g., Dressing, bathing/showering, transferring, hygiene, linen changes, brief changes, toileting assistance, device care, wound care) . During an observation on 1/20/26 at 9:34 a.m., observed EBP signage at Resident 94's doorway. During an observation on 1/20/26 at 9:58 a.m., observed Director of Nursing (DON) and Certified Nursing Assistant (CNA) 1 enter Resident 94's room. Observed DON and CNA 1 put on gloves but did not put on gowns. Observed DON and staff member reposition Resident 94 in bed using draw sheet. During an interview on 1/20/26 at 10:01 a.m. with CNA 1, CNA 1 stated she did not wear a gown when repositioning Resident 94. CNA 1 acknowledged Resident 94 was on EBP and she should have worn a gown when repositioning resident. During an interview on 1/20/26 at 10:05 a.m. with the DON, the DON stated she did not wear a gown when repositioning Resident 94. The DON stated a gown was not required when repositioning a resident as it was not a high-contact activity. Requested EBP policy. During an interview on 1/20/26 at 12:19 p.m. with Registered Nurse (RN) 1, RN 1 stated for a resident on EBP need to wear gown and gloves for high- contact activities including changing sheets, changing briefs, transfers, and wound care. When asked if repositioning is considered a high- contact activity, RN 1 stated, Yes and would wear gown and gloves. A review of the facility Policy and Procedure (P&P) titled Enhanced Barrier Precautions, revised (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/24, indicated .Enhanced barrier precaution (EBPs) are utilized to prevent spread of multi-drug resistant organisms (MDROs) to residents . Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant (MDROs) during high contact resident care activities . EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply .Gloves and gowns are applied prior to performing the high contact resident care activity .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include . transferring .providing bed mobility .changing linens .The facility may use EBPs at its discretion for residents who do not have a chronic wound, indwelling medical device, or infection/colonization with a CDC [Centers for Disease Control] targeted MDRO 2. During an observation conducted on 1/22/26 at 8:06 a.m., in the clean side of the laundry room, the two air vents had gray fuzzy material, one vent was above the table, the other vent was directly above a covered cart with clothes, and the fan blades were covered with gray fuzzy material. During a concurrent observation and interview with the Laundry Staff (LS) on 1/22/26 starting at 8:13 a.m., the LS stated the table in the laundry was used for folding clean clothes and linens. The LS confirmed the two vents had dust particles, the clean linen cart cover had a tear on the sides and clear tape was used to cover the edges of the cart handles, the cart containing resident's clothes had discolored cover with dust particles on the bottom area, the fan blades were dusty and the two sides and back of the fan were covered with thick gray fuzzy material. The LS stated he used the fan 3 weeks ago. The LS further stated the fan is blowing cold air directly in the folding table and he would turn off the fan when folding clothes because dusts will transfer to the clothes. During a concurrent observation and interview with the Maintenance Supervisor (MS) on 1/22/26 at 8:36 a.m., the MS confirmed there was a tear on the plastic/tarp covering the cart used to deliver clean linens. The MS further stated he was informed by the LS about the tear yesterday and the purpose of the cover was for infection control. In a follow up interview with the LS on 1/22/26 at 8:45 a.m., the LS confirmed the vent was directly on the table used for folding clothes and the dust from the vent can transfer to the clean clothes. The LS stated he put a tape on the handles of the cart to prevent dust from going inside the clean laundry. In a follow up interview with the MS on 1/22/26 starting at 8:52 a.m., the MS stated the dusty equipment [fan] in the laundry room was a portable swamp cooler (effective for cooling rooms in hot, dry climates). The MS further stated the laundry staff should sweep and mop after every shift. The nurse surveyor (NS) showed the pictures taken in the laundry room to MS. The MS agreed the vents were dirty, the swamp cooler was dirty, the floor had lint and discoloration, the material covering the cart for the clean linen was torn, and the material covering the cart containing the resident's clothes had some discolorations. During an interview with the Infection Preventionist (IP) on 1/22/26 starting at 4:14 p.m., the IP stated she inspects the laundry every day. The NS showed the pictures taken in the laundry room to IP and the IP confirmed the vents had dust particles, the floor was dirty, the material/cloth covering the residents clothes was dirty, the tarp covering the cart to deliver the clean linens was torn and taped, the swamp cooler was dusty, and the bottom of the cart with residents clothes was dirty. During an interview with the Director of Nursing (DON) on 1/23/26 at 12:29 p.m., the DON stated there was a need for aftercare in the laundry including the cover of the cart. The DON further stated if the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	laundry is not clean there is a possibility of contamination of the clean clothes/linen. The DON's expectation was for staff to keep the laundry room clean. The DON agreed items (clothes/linen) in the laundry goes to the residents. A review of the facility's policy and procedure (P & P) dated December 2023 and titled, Infection Prevention and Control Program indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .The IPCP is a facility-wide effort involving all disciplines and individuals . A review of the facility's P & P revised January 2014 and titled, Departmental (Environmental Services) - Laundry and Linen indicated, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen .Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts. A review of the facility's P & P revised August 2019 and titled, Cleaning and Disinfection of Environmental Surfaces indicated, Environmental surfaces will be cleaned and disinfected according to current CDC [Centers for Disease Control and Prevention] recommendations for disinfection of healthcare facilities .Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g. daily, three times a week) and when surfaces are visibly soiled .Horizontal surfaces will be wet dusted regularly (e.g., daily, three times a week) using clean cloths moistened with an EPA - registered [[environmental protection agency has evaluated and approved this product meeting regulatory requirements for safety of use] hospital disinfectant (or detergent).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Park Care Center	3700 H Street Sacramento, CA 95816

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review, the facility failed to complete an annual MDS assessment (Minimum Data Set assessment is a mandatory, standardized clinical evaluation of residents in U.S. Medicare/Medicaid-certified nursing homes, assessing their overall health, functional abilities like activities of daily living, cognition, mood, diagnoses, and preferences to create individualized care plans and ensure quality) timely for one of 22 sampled residents (Resident 82). This failure had the potential for Resident 82 to not receive quality care. During a concurrent interview and record review with the Minimum Data Set Coordinator (MDSC) on 1/22/26, at 3:15 p.m., Resident 82's MDS assessments were reviewed. Resident 82's annual MDS assessment ARD (assessment reference date: 14 days after the resident is admitted) indicated 12/4/25. MDSC stated, Resident 82's annual MDS assessment was due to be completed on 12/18/25 which is 14 days after the ARD, and it was completed on 1/20/26. MDSC stated, the annual assessment was late. During an interview with the Director of Nursing on 1/23/26 at 12:54 p.m., the DON stated her expectation was for the assessments to be done timely based on the ARD. The DON stated when assessments are not done timely there is potential for high probability of not identifying the problem and this delays the interventions.A review of the facility's policy and procedure dated October 2023 and titled, MDS Completion and Submission Timeframes indicated, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes .Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.During a review of the Resident Assessment Instrument Manual dated October 2025, the Manual indicated, required assessment timing for annual assessment completion was ARD +14 calendar days.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to ensure a significant change in status assessment (SCSA- a comprehensive assessment that needs to be completed when the interdisciplinary team determined resident meets the guidelines related to improvement or decline in condition) was completed within 14 days from the time the change was identified for one of 22 sampled residents (Resident 24). This failure increased the potential for Resident 24 to not receive appropriate care. A review of the admission Record indicated Resident 24 had a diagnosis of palliative care (specialized medical care focusing on providing relief of pain and symptoms of serious illness) in June of 2025. A review of Resident 24's HOSPICE DISCHARGE SUMMARY indicated effective end of day on 12/4/25, Resident 24 was discharged from Hospice due to .stabilized & no longer meets criteria. During a concurrent interview and record review with the Minimum Data Set Coordinator (MDSC) on 1/22/26 at 3:07 p.m., the MDSC stated Resident 24 came off from Hospice on 12/5/25 and a SCSA was scheduled on 12/12/25. The MDSC further stated the SCSA was completed 1/21/26 and MDSC confirmed this was late. During an interview with the Director of Nursing on 1/23/26 at 12:54 p.m., the DON stated her expectation was for the assessments to be done timely based on the Assessment Reference Date (ARD). The DON further stated when assessments are not done timely there is potential for not identifying the problem and this delays the interventions.A review of the facility's policy and procedure dated October 2023 and titled, MDS Completion and Submission Timeframes indicated, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes .Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.A review of the Resident Assessment Instrument (RAI) Manual dated October 2025 indicated, the SCSA should be completed on the 14th calendar day after determination that significant change in resident's status occurred.

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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 observation, interview, and record review, the facility failed to meet professional standards of care for one of twenty-two sampled residents (Resident 9) when Resident 9 received a dose of medication that was ordered for another resident (Resident 40).This failure had the potential to result in Resident 9 experiencing adverse effects from receiving a medication not ordered for her. A review of Resident 9's admission Record indicated Resident 9 was initially admitted to the facility in January 2025 and readmitted in December 2025 with multiple diagnoses including cellulitis (bacterial skin infection) of left lower leg, lymphedema (tissue swelling caused by accumulation of fluid due to damaged or blocked lymph nodes), and dyspnea (difficulty breathing). A review of Resident 40's admission Record indicated Resident 40 was admitted to the facility in December 2025 with multiple diagnoses including metabolic encephalopathy (brain dysfunction caused by chemical imbalance, organ failure, or infection causing confusion or altered consciousness), pressure ulcer (damage to skin and underlying tissue caused by prolonged pressure) of sacral region (base of the spine), and diabetes (a condition characterized by high blood sugar resulting from the body's inability to produce or use insulin, a hormone that regulates blood sugar). A review of Resident 9's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 1/6/26, indicated Resident 9 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 9 was cognitively intact. A review of a written form Prescriber's Orders, for Resident 40, dated 1/14/26, indicated .Start on metformin [medication to treat diabetes] 500 mg [milligrams] PO [by mouth] BID [two times a day] for DM2 [Diabetes Mellitus Type 2-body resists insulin or does not make enough] A review of an electronic order for Resident 9, dated 1/14/26, indicated . Metformin .Give 500 mg by mouth two times for DM2 PO BID A review of Resident 9's .Medication Administration Record, for 1/1/26 to 1/31/26, indicated Resident 9 received one dose of Metformin 500 MG on 1/15/26 and refused the medication on 1/16/26. A review of Resident 9's SBAR [Situation Background Assessment Recommendation] Communication Form, dated 1/16/26, indicated .change in condition: Received metformin dose .This started on: 01/15/2026 During an interview on 1/21/26 at 8:17 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 9 does not have diabetes but received a dose of metformin that had been ordered for Resident 40. RN 1 stated the medication was ordered initially on a physical order form for Resident 40 but was ordered in the electronic record for Resident 9. RN 1 stated, It was ordered by mistake. RN 1 stated Resident 9 received one dose of metformin 500 mg on 1/15/26. RN 1 stated on 1/16/26, Resident 9 refused the dose of metformin 500 mg, stating she did not have diabetes. RN 1 reviewed the orders and found the medication had been ordered for Resident 40 but had been transcribed into the electronic orders for the wrong resident, Resident 9. RN 1 stated it was Resident 9 who recognized the order error. When asked what the potential harm to Resident 9 may have been, RN 1 stated Resident 9 may have had an allergic reaction to the medication. RN 1 stated, Should always double check orders they [nurses] are putting in. During an interview on 1/21/26 at 11:27 a.m. with Resident 9, Resident 9 stated they tried to give her a medication for her blood sugar. Resident 9 stated she notified the nurse she was not a diabetic. Resident 9 stated they got her confused with another resident. During an interview on 1/22/26 at 2:27 p.m. with the Director of Nursing (DON), the DON stated Resident 9 was given metformin by mistake. The initial order was written on a paper form for Resident 40 on 1/14/26 and the nurse transcribed the order into the electronic record for Resident 9. The DON stated the nurse did not notice she was in the wrong chart. The DON stated the first dose was given on 1/15/26, and then on 1/16/26, when the nurse was going to give the dose, Resident 9 responded that she was not a diabetic. The DON stated, Nurse should have verified correct chart. She clicked and saved to wrong chart. Did not look back to ensure correct chart. The DON stated Resident 9 could have had adverse effects to the medication including loose stools or back pain. A review of the facility's Policy and Procedure (P&P) titled Medication and Treatment Orders, revised 7/16, indicated .Orders for (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications and treatments will be consistent with principles of safe and effective order writing . Medications shall be administered only upon written order of the person duly licensed and authorized to prescribe such medications in this state .Drugs and biologicals must be recorded on the physician's order sheet in the resident's chart A review of the facility's P&P titled Administering Medications, revised 4/19, indicated . Medications are to be administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber's orders, including any required time frame . If a dosage is believed to be inappropriate or excessive for a resident .the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns . The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) before giving the medications . Medications ordered for a particular resident may not be administered to another resident

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure the resident's fingernails were maintained in a clean and trimmed manner for one of 22 sampled residents (Resident 7), when Resident 7 was observed with long, untrimmed fingernails.This failure had the potential to negatively impact Resident 7's psychosocial well-being and placed him at risk for skin injury leading to infection. A review of the admission Record indicated the facility admitted Resident 7 in the beginning of 2025 with multiple diagnoses, which included Parkinson's disease (a progressive disease of the nervous system that affects movement, balance and muscle control, characterized by tremors, stiffness, slowness, and balance issues) and left-sided hemiplegia (paralysis of the arm, leg, and trunk).A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/9/26 indicated that Resident 7 had moderately impaired cognition. The MDS section of functional assessment indicated that Resident 7 required maximum assistance with grooming and personal hygiene.A review of Resident 7's care plan addressing ADLs (activities of daily living, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) dated 1/7/25 indicated Resident 7 required assistance with ADLs. The interventions indicated, .Daily assistance with ADL care. The care plan interventions did not address Resident 7's needs for personal hygiene, fingernail care and toenail care.During an observation and interview on 1/20/26 at 1:38 p.m., Resident 7 was observed sitting in wheelchair in his room. Resident 7 answered appropriately to all questions and stated that he required lots of assistance from the staff. Resident 7's fingernails were noted long with sharp uneven edges. Resident 7 stated, I don't like them to be that long. If I find someone to trim them.sometimes it's hard to find someone.During a concurrent observation and interview in Resident 7's room on 1/20/26 at 2:20 p.m., Certified Nursing Assistant (CNA 3) stated she was assigned to provide care to the resident. CNA 3 validated that Resident 7's fingernails were long and should have been trimmed. After a moment CNA 3 added that the resident wanted to leave them this long, for which Resident 7 replied, I don't like them too long, sometimes it catches on my clothes and scratches my skin. I want them cut short.During an interview on 1/22/26 at 2:50 p.m., with Director of Nursing (DON), the DON stated that Resident 7 was dependent on staff for maintenance of good personal hygiene, including nail care. The DON explained that there were no showers scheduled for residents on Sundays and CNAs were responsible for trimming resident's fingernails and toenails on Sundays. The DON stated the expectation was that CNAs provided nail care timely and according to resident's wishes. The DON reviewed Resident 7's ADL care plan and acknowledged that the care plan was broad and not individualized to address fingernails and toenails. The DON stated, ADLs care plan should address hygiene and nails, especially for resident who is dependent on staff for ADLs.A review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, dated 3/18, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently, will receive the services necessary to maintain good. grooming and personal and oral hygiene.

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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. Based on observation, interview, and record review, the facility failed to ensure the residents environment was free of accident hazards, received adequate supervision and safe use of mechanical lift (used in transferring resident from bed to chair or vice versa) for one of 22 sampled residents (Resident 77), when Resident 77 was not safely transferred using a mechanical lift.This failure placed Resident 77 at risk for serious injuries, including fall, harm, or death and had the potential to affect Resident 77's psychosocial well-being.A review of the admission Record indicated the facility admitted Resident 77 in the summer of 2025 with multiple diagnoses, which included right-sided hemiparesis and hemiplegia (weakness and paralysis of the arm, leg, and trunk), left leg below the knee amputation, and muscle weakness.A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/27/25 indicated that Resident 77 was cognitively intact. The MDS section of functional assessment indicated that Resident 77 required maximum assistance with all ADLs (activities done every day such as eating, personal hygiene, bathing, dressing, and toileting) and totally depended on transfer.A review of physician progress note dated 1/16/26 indicated that Resident 77 had history of falls with collarbone and ribs fractures in the past.A review of the care plan dated 6/20/25 indicated that Resident 77 was at risk for falls related to altered balance while standing and/or walking and unsteady gait. The care plan goal indicated, Will not experience a fall related to risk factors. The interventions indicated, Anticipate and meet needs.Keep within supervised view as much as possible.Keep call light within reach.A review of Resident 77's care plan addressing mobility and ADLs dated 6/20/25 indicated that the resident will have needs anticipated and met by staff. The care plan did not address level of assistance the resident required with ADLs, transfer and mobility.During an observation on 1/21/26 at 6:17 a.m., outside of Resident 77's room, Resident 77 was observed suspended in the air in a Hoyer lift sling (a mechanical lift with attached sling that the resident sits in during the transfer) unattended by nursing staff with no staff present in the room. The resident was elevated off the floor and positioned several feet away from the bed and was not supported by the bed or wheelchair. A Certified Nursing Assistant (CNA 4) was observed leaving the room adjacent to Resident 77's room and explained that she went to look for another staff to help with resident's transfer. CNA 4 then closed the door, moved the lift with resident and lowered the resident to the bed without another staff's assistance.During an interview on 1/21/26 at 6:25 a.m., CNA 4 explained, I left him [Resident 77] in the air and went looking for help in the next room because I saw another CNA there prior to that. CNA 4 did not provide any answer whether she asked another staff to assist with transfer while preparing Resident 77 for transfer. CNA 4 stated, I understand it was very wrong to attempt to transfer resident by myself, [I] should have someone with me to assist with transfer. It's not safe - resident could have fallen and injured, I understand I placed him at huge risk for falls.During an interview with CNA 1 on 1/21/26 at 7:55 a.m., CNA 1 explained that 2 and sometimes 3 staff were required to assist with transferring a resident while using a mechanical lift. CNA 1 added, Resident's safety is very important.I get help before I place the resident on the sling and then we transfer resident together.During an observation and interview on 1/21/26 at 8:05 a.m., Resident 77 was sitting in the dining room. Resident 77 was responding in the language other than English. CNA 1 who was assisting the resident with breakfast explained that Resident 77 was alert and oriented, however he spoke very limited English. Resident 77 explained that he remembered that earlier this morning another CNA was getting him out of bed alone while using machine and he had to be suspended in the air on a sling while the CNA left the room. When Resident 77 was asked how he felt while he was suspended in the air, the resident replied, I was scared.During an interview on 1/21/26 at 10:15 a.m., the Director of Nursing (DON) stated that residents should not be left unattended while suspended in the Hoyer lift and acknowledged the staff are required to remain with the residents at all times during transfers. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON explained that facility's process was to always use 2 staff during mechanical lift transfers and never attempt to transfer the resident alone. The DON validated that Resident 77's left leg below knee amputation and paralysis of his right side made him even more vulnerable because it could make the sling unbalanced in the air and the lift could have flipped over. The DON added, Not acceptable to leave resident suspended in the air and look for help. Not safe. Accident could happen - Hoyer legs might not be opened correctly and moved, or straps gave up and resident might have ended up on the floor with injuries. The DON stated her expectations for CNAs were to always collaborate with nurse or another CNA to assist with transfers when using mechanical lift.A review of the facility's policy titled, Safety and Supervision of Residents, dated 7/17 indicated, Our facility strives to make the environment as free from accidental hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.A review of the policy titled, Lifting Machine, Using a Mechanical, dated 7/17 indicated, At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift.Mechanical lifts may be used for tasks that require.Transferring a resident from bed to chair.Staff must be trained and demonstrate competency using the machines.utilized by the facility. The policy indicated further that mechanical lift required continuous supervision to prevent injuries.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided according to professional standards for three of 22 sampled residents (Resident 104, Resident 42, and Resident 27) when:Resident 104 and Resident 42's nebulizer masks were not stored in a bag after use;Resident 42's BiPAP (bilevel positive airway pressure- breathing device providing higher pressure when breathing in to help open the lungs and a lower pressure when breathing out making it easier to exhale) order was incomplete; andResident 27 did not have an order for CPAP (continuous positive airway pressure - treatment for obstructive sleep apnea) in the clinical record and CPAP was not used until over one month after admission to the facility. These failures increased the risk for Resident 104 and 42 to develop respiratory infections due to improper storage of masks, and for Resident 42 and Resident 27 to experience respiratory distress and discomfort.1a. A review of the admission Record indicated Resident 104 was admitted [DATE] with diagnoses including lobar pneumonia (an infection/inflammation in one or more section of the lungs) and pleural effusion (excessive accumulation of fluid in between the lungs and chest wall). A review of Resident 104's physician order dated 1/17/26 indicated Ipratropium-Albuterol Solution [used to relax and open the airways, making breathing easier] .1 vial inhale orally every 6 hours for COPD [Chronic obstructive pulmonary disease- a chronic lung disease causing difficulty in breathing]. During a concurrent observation and interview on 1/20/26 at 8:06 a.m. inside Resident 104's room, a nebulizer mask was on top of the bedside dresser next to a pair of nonskid socks. Resident 104 stated she was getting breathing treatment every 4 hours, and she received a breathing treatment 2 hours ago. A follow up observation was conducted on 1/2026 at 9:14 a.m., Resident 104's nebulizer mask was on top of the bedside dresser. During a concurrent observation and interview with Licensed Nurse 1 (LN 1) on 1/20/26 starting at 9:15 a.m., inside Resident 104's room, LN 1 confirmed the nebulizer mask was on top of the dresser. The LN 1 stated they are supposed to keep the mask inside a respiratory bag. The LN 1 confirmed there was no bag to store the mask at bedside. The LN 1 further stated it is the facility's infection control protocol to put the mask in a bag when not in use. 1b. A review of the admission Record indicated Resident 4 was admitted November of 2023 with diagnoses including congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and COPD. A review of Resident 42's physician order dated 1/10/26 indicated, Ipratropium-Albuterol .inhale orally every 8 hours as needed for SOB [shortness of breathing] or wheezing [high pitched whistling sound] via nebulizer. A review of Resident 42's Medication Administration Record (MAR) for January 2026 indicated Resident 42 received the nebulizer treatment on 1/3/26 and no treatments administered thereafter. During an observation on 1/20/26 at 2:18 p.m., Resident 42 was lying in bed with ongoing oxygen, eyes were closed, a mask attached to a tubing was on top of her bedside dresser. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with LN 5 and Resident 42 on 1/20/26 at 3:49 p.m., LN 5 confirmed the mask on top of Resident 42's dresser was used for nebulizer treatment. The LN 5 further stated the nebulizer mask should be inside a bag. The LN 5 was asked to check the date on the mask, and the LN 5 stated he could not see the date when the nebulizer mask was replaced. Resident 42 was unable to state when she had the nebulizer treatment. During an interview with the Director of Nursing (DON) on 1/23/26 at 12:22 p.m., the DON stated her expectation was for the nebulizer mask to be inside the infection pouch or container when not in use. A review of the facility's policy and procedure dated November 2011 and titled Departmental (Respiratory Therapy) - Prevention of Infection indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment .Infection Control Consideration Related to Medication Nebulizers .After completion of therapy .remove the nebulizer container .rinse the container .dry on a clean paper towel .Store the circuit in plastic bag, marked with date and resident's name, between uses. 2. A review of Resident 42's physician order dated 1/10/26 indicated, .Bipap [sic] Settings: Inspiratory___cmH2O [centimeters of water pressure- unit of measurement], . Expiratory___cmH2O .at bedtime or when napping every 12 hours as needed . Further review of Resident 42's physician order dated 11/9/25 for BiPAP did not indicate the settings in the body of the order. During a concurrent interview and record review on 1/22/26 at 10:33 a.m. with the LN 1., Resident 42's BiPAP order was reviewed. The BiPAP order indicated, no setting was included in the order. The LN 1 stated Resident 42 uses a BiPAP, and the LN 1 confirmed the BiPAP order did not include the setting. During a concurrent interview and record review on 1/23/26 at 12:38 p.m. with the DON, Resident 42's clinical records was reviewed. The clinical record indicated Resident 42 had BiPAP orders since 11/9/25. The DON stated Resident 42's BiPAP orders on 11/9/25 and 1/10/26 did not include the settings. The DON further stated her expectation was for BiPAP orders to include the settings in the body of the order. A review of the facility's policy and procedure dated March 2015 and titled, CPAP/BiPAP Support indicated, .To provide the spontaneously breathing resident with continuous positive airway pressure .Review the physician's order to determine the oxygen concentration and flow .CPAP .and BiPAP .can be used in conjunction with ventilation to improve oxygenation .BiPAP delivers CPAP but allows separate settings for expiration (EPAP [expiratory positive airway pressure-increase pressure during expiration to keep airways open]) .and inspiration (IPAP [inspiratory positive airway pressure-higher pressure level delivered during inhalation to keep airways open]) .Document .Mode and settings for the CPAP/IPAP/EPAP . 3. A review of Resident 27's admission Record indicated Resident 27 was admitted to the facility in December 2025 with multiple diagnoses including heart failure (heart does not pump blood as well as it should), respiratory failure with hypoxia (low blood oxygen), acute pulmonary edema (buildup of fluid in the lungs), and obstructive sleep apnea (OSA- sleep disorder where breathing repeatedly starts and stops during sleep). (continued on next page)

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McKinley Park Care Center	3700 H Street Sacramento, CA 95816

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 27's Minimum Data Set (MDS-federally mandated assessment tool), Cognitive Patterns, dated 12/17/25, indicated Resident 27 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 27 was cognitively intact. A review of Resident 27's Order Summary Report, printed 1/22/26, did not indicate order for CPAP. A review of Resident 27's Internal Medicine Discharge summary, dated [DATE], from acute hospital, indicated diagnosis of .OSA Sleep study from August 2025 .optimal CPAP setting was 13 cmH20 [pressure setting measured in centimeters of water] . Nocturnal [night] CPAP can be followed at SNF [Skilled Nursing Facility] A review of Resident 27's Skilled Nursing Facility Admit Orders, dated 12/10/25, from acute hospital, indicated .Secondary Diagnoses .OSA A review of Resident 27's Internal Medicine Discharge summary, dated [DATE], from acute hospital, indicated .Discharge Diagnoses .OSA . Sleep study from August 2025 .optimal CPAP setting was 13 cmH20 . Nocturnal CPAP can be followed at SNF A review of Resident 27's Physician's Orders, dated 1/6/25, indicated .Start using CPAP, while asleep family needs to bring it to patient . A review of Resident 27's Physician's Orders, dated 1/9/25, indicated .Res [resident] has orders from [acute care hospital] for CPAP 13 cm H20 for napping and sleeping A review of a Delivery Ticket, from respiratory equipment provider, dated 1/12/26, indicated CPAP machine and supplies were delivered to the facility on 1/12/26. A review of Resident 27's Progress Note, dated 1/14/26, Nurse Practitioner Note, indicated .The patient now has a CPAP she is using A review of Resident 27's Progress Note, dated 1/19/26, Nurse Practitioner Note, indicated .Regarding her respiratory status, the patient has persistent hypercapnia [excessive buildup of carbon dioxide in the blood] . though her CPAP compliance is currently hindered by a poorly fitting mask for which she is awaiting a replacement. During an interview on 1/20/26 at 10:32 a.m. with Resident 27, Resident 27 stated her CPAP machine did not come until about a week ago, but the mask was the wrong size. Resident 27 stated they had ordered a large mask, but she needed a medium which had arrived yesterday. Resident 27 stated facility did not provide a CPAP on admission to the facility, but she had been using a CPAP prior to admission. Resident 27 stated, I think they dropped the ball when I came in and did not order it. During a concurrent interview and record review on 1/22/26 at 11:58 a.m. with Licensed Nurse (LN) 1, Resident 27's Order Summary was reviewed. The Order Summary did not include an order for CPAP. LN 1 stated Resident 27 has a CPAP at bedside and there was not an order for CPAP. LN 1 stated she asked Resident 27 if she had been wearing the CPAP and resident told her the mask did not fit. LN 1 stated there were orders per acute care hospital recommendation for CPAP on 1/6/26 and 1/9/26 but were not transcribed into electronic orders. LN 1 stated Resident 27 was admitted to the facility on [DATE], sent to hospital on [DATE], and returned to facility 12/24/25. LN 1 acknowledged that the CPAP was not on Resident 27's Medication Administration Record (MAR), so there was no (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of the application of CPAP. LN 1 confirmed there were no orders on when to apply CPAP or what the settings were. LN 1 stated if there are no orders, need to follow up with the doctor. During an interview on 1/22/26 at 12:14 p.m. with the Director of Nursing (DON), the DON stated when the facility became aware that Resident 27 needed a CPAP, asked resident if she had her own and to have family bring it in. Family was not able to locate the CPAP, so facility ordered a CPAP and it was delivered on 1/12/26, but the mask was too big. New mask was ordered. The DON acknowledged that the hospital discharge summaries on 12/10/25 and 12/24/25 indicated OSA and need for CPAP. The DON acknowledged there was no order for CPAP until written recommendation orders from the acute hospital on1/6/26 to start CPAP and 1/9/26 with CPAP settings. The DON acknowledged these orders were not placed in electronic record and were not indicated on MAR so there was no documentation that the CPAP was applied. The DON stated if the order recommendation from hospital was not transcribed into the orders, interventions may be missed and not reflected in the patient chart. The DON stated if CPAP not included in the orders, there will not be documentation if CPAP was used or if resident refused. The DON acknowledged that Resident 27 did not use CPAP from 12/10/25 to 12/19/25 and from 12/24/25 to 1/12/26. A review of the facility's Policy and Procedure (P&P) titled CPAP/BIPAP Support, revised 3/15, indicated .To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen .To improve arterial oxygenation (Pa02) in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive /obstructive lung disease .Review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure [positive pressure that remains in the airways at the end of the respiratory cycle] .for the machine .Notify the physician if the resident refuses the procedure A review of the facility's P&P titled Medication and Treatment Orders, revised 7/16, indicated .Orders for medications and treatments will be consistent with principles of safe and effective care

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to provide pain management in accordance with professional standards and resident centered care plans for two of 22 sampled residents (Resident 73 and Resident 18) when:The facility failed to reassess Resident 73 for pain within the required one-hour timeframe after receiving a PRN (as needed) pain medication.The facility failed to consistently assess Resident 18's pain and offer non-pharmacological (strategies that do not involve use of pain medications) interventions. These failures had the potential for Resident 73 and Resident 18 to be in pain and have ineffective pain management.1.During an observation on 1/20/26, at 10:49 a.m., in Resident 73's room. Resident 73 was observed to be moaning that her stomach was hurting. During an interview on 1/20/26, at 10:50 a.m., with Resident 73, Resident 73 stated her stomach was hurting and she was constipated. Resident 73 stated she got pain medicine earlier, but she is still in pain. During an interview on 1/20/26, at 11:03 a.m., with the Director of Nursing (DON), the DON stated, it is her expectation that pain reassessments are completed within one hour after giving a PRN pain medication, that is the standard. During a concurrent observation and interview on 1/20/26, at 11:05 a.m., with DON and Resident 73, in Resident 73's room. The DON performed a pain assessment on Resident 73. Resident 73 stated, her pain was 9 out of 10 in her stomach area. During a concurrent interview and record review on 1/20/26, at 11:10 a.m., with Minimum Data Set (MDS: a federally mandated, standardized, and comprehensive assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a resident's functional, clinical, and cognitive status.) Coordinator, Resident 73's Medication Administration Record (MAR) dated 1/20/26 was reviewed. MAR indicated, Resident 73 was given Tylenol at 0914 (9:14 a.m.) with a pain level charted as 3. MAR indicated, no pain reassessment was completed at this time. MDSC stated, she did not see any pain reassessment charted for the 0914 Tylenol administration. During an interview on 1/20/26, at 11:20 a.m., with Registered Nurse (RN) 1, RN 1 stated, she was assigned to Resident 73 and gave Resident 73 PRN Tylenol at 0914. RN stated, she did not reassess Resident 73's pain level yet after giving her Tylenol at 0914. During a review of Resident 73's MAR dated 1/20/25, MAR was updated by RN, I was charted for the administration of Tylenol at 0914, indicating the medication was Ineffective. During a review of Resident 73's Care Plan dated, 11/15/25, Care Plan indicated, Resident 73 was at risk for pain. Interventions for care plan indicated, Administer medications as ordered. Monitor for possible adverse effects of pain management interventions.Assess pain every shift and as indicated. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management dated 2022, the P&P indicated, The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain.3. Monitor the following factors to determine if the resident's pain is being adequately controlled: a. The resident's response to interventions and level of comfort over time (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of the admission Record indicated the facility admitted Resident 18 in 2021 with multiple diagnoses, including rheumatoid arthritis (RA, a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), spinal stenosis (narrowing of the spinal column, which often causes pain and numbness in the neck, back, hands, and legs), and muscle weakness. A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/10/25 indicated that Resident 18 was cognitively intact. A review of the care plan dated 5/7/23 indicated that Resident 18 was at risk for pain and discomfort related to RA and spinal stenosis. The approaches to pain management indicated, Assess.signs/symptoms of distress or pain.Administer pain medication as ordered.Consider pre-medicating for pain to optimize participation.Provide alternative comfort measures.heat, cold applications, massage, relaxation, positioning. During an observation and interview on 1/20/26 at 10:38 a.m., Resident 18 was lying in bed dressed in a hospital gown. Resident 18 was responding to all questions appropriately. Resident 18 stated, I'm always in pain, I have bad arthritis and pointed to her disfigured fingers. Resident 18 rated her pain as 5, on a scale of zero to 10. Resident 18 stated that all she was offered was Excedrin (a medication used to relieve headaches and other minor aches) and Tylenol (over the counter medication used to relieve headache, muscle aches, and toothaches) and they were not effective for her chronic conditions. Resident 18 added, Nobody asks me if I'm in pain. If I tell my nurse I'm hurting, all she offers [is] Excedrin or Tylenol. During an interview on 1/21/26 at 9:05 a.m., Resident 18 was in her bed. Resident 18 stated, I can't get out of bed, too much pain sitting in wheelchair. Everything hurts, my neck, my lower back, my legs. Resident 18 stated she had some ointment applied to her shoulders earlier this morning which helped to alleviate her pain a little. Resident 18 stated, Pain is 5 out of 10.It helped a little, but as soon as I move, pain comes back. if moved or repositioned, pain is 9-10. During an interview on 1/21/26 at 9:55 a.m., Licensed Nurse (LN 3) explained every resident must be assessed for pain every shift and should have orders for pain assessment and non-pharmacological interventions. LN 3 stated, Assess pain level on scale from 1 to10, ask location, quality of pain.Offer non-pharmacological interventions - reposition, heat, cold, distraction.Reassess, if not effective check medication list what is ordered for pain. LN 3 stated that she usually assessed pain in residents assigned to her toward the end of shift. During an observation and interview on 1/22/26 at 8:22 a.m., Resident 18 was sitting in bed eating breakfast. Resident 18 stated, Pain, as usual, about 4 [out of 10], my feet, shoulder and back. I did not ask for Tylenol or Excedrin because they are not helping.I always tell my nurses that these medications not working, and they continue offering them. Resident 18 stated she hoped that nurses will contact her physician and report that her pain medications were not relieving her chronic pain. During an interview with Certified Nursing Assistant (CNA 5) on 1/22/26 at 4:05 p.m., CNA 5 stated that Resident was alert and able to verbalize her needs. CNA 5 stated the resident would get to wheelchair but was not able to stay there long because her back hurt. CNA 5 added that Resident 18 frequently complained of back and legs pain and requested pain medication. CNA 5 stated he notified nurses regarding the resident's request for pain medication right away. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LN 2 on 1/23/26 at 12:57 p.m., LN 2 stated she was familiar with Resident 18 and her needs. LN 2 validated that Resident 18 was frequently complaining of pain in her shoulders, knees, and legs. When LN 2 was asked about the resident's pain management, LN 2 replied, [I] administer whatever is ordered, she gets Voltaren ointment [a topical medication applied to skin for temporary relief of pain and inflammation] and we apply it to that part of her body that hurts. She never moans or groans. LN 2 stated that she usually asked Resident 18 if she was in pain during morning medications administration but did not provide the answer when asked what other interventions were offered to Resident 18 to manage her pain. During an interview and record review on 1/21/26 at 10:15 a.m., Director of Nursing (DON) was asked to explain the process for residents' pain management. The DON stated nurses were required to assess resident for pain every shift per standing physician's order. The DON explained, If resident complain of pain, first offer non-pharmacological interventions.If non-pharmacological interventions did not relieve pain, offer pain medications. Reassess for effectiveness one hour after medications administration. The DON stated that pain assessment should be accurate based on resident's rating of pain or facial grimacing, moaning for non-verbal or confused. The DON stated that residents' pain level should be assessed and documented every shift. During continued interview and record review with DON on 1/21/26 at 10:15 a.m., the DON acknowledged that the Resident 18's underlying RA, spinal stenosis, and chronic back pain significantly predisposed the resident to experience pain. The DON reviewed Resident 18's Medication Administration Record (MAR) and stated she was unable to find if the resident's pain was assessed every shift. The DON stated that Resident 18's MARs indicated that Resident 18 did not have non-pharmacological interventions offered for pain. The DON stated that nursing documented Resident 18's blood pressure, heart rate, respirations every shift but that assessment did not indicate that resident's pain was assessed. The DON stated that her expectation for nurses was to assess resident's pain at least once a shift using scale from 1 to 10, offer non-pharmacological interventions, like heat, cold, reposition, distraction and if not effective offer medications. The DON stated that the physician should be contacted if prescribed medications were not effective. A review of the facility's policy titled, Pain Assessment and Management, dated 3/15, indicated, The pain management program is based on a facility-wide commitment to resident comfort. The policy explained that pain management was a multidisciplinary care process that included assessing the potential for pain, effectively recognizing the presence of pain, addressing the underlying causes of the pain, developing and implementing approaches to pain management, and modifying the approaches as necessary. The policy directed nursing staff to assess and re-assess the resident's pain at least each shift.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, the facility failed to identify trauma triggers for one of 22 sampled residents (Resident 83) with post-traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).This failure had the potential for Resident 83 to experience re-traumatization (re- experience a traumatic event causing similar stress reactions) and possible increased symptoms such as restlessness, irritability and social withdrawal. A review of the admission Record indicated Resident 83 was admitted to the facility May of 2022 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) and PTSD. Resident 83's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 12/4/25 indicated Resident 83 was cognitively intact. A review of Resident 83's care plan dated 12/31/25 indicated, [Resident 83] has impaired visual function [related to] [Resident 83] stated she lost her eye due to her retina detaching due to res. having diabetes. [Resident 83] had a prosthetic put in resulting in PTSD. During an interview on 1/21/26 at 1:04 p.m., with Resident 83 inside her room, Resident 83 stated yes when she was asked if she had experienced a traumatic event in her life. Resident 83 further stated her spouse knocked her left eye and detached her retina. Resident 83 was further asked what triggers her trauma, Resident 83 responded, if people are loud and if they say her name loud. Resident 83 was not sure if facility staff knew about these triggers. During a concurrent interview and record review on 1/23/25 starting at 9:05 a.m., with the Social Services Director (SSD), Resident 83's Annual Social History Assessment and care plan were reviewed. The Annual Social History Assessment did not indicate Resident 83 had significant life events and the care plan did not indicate the triggers. The SSD stated she was familiar with Resident 83. The SSD stated Resident 83 had PTSD diagnosis on admission. The SSD further stated it is important to know the cause of the traumatic event and the triggers to provide resident with appropriate help. The SSD added they will not be able to prevent re-traumatization if they did not identify triggers for the traumatic event. During an interview on /23/26 at 1:01 p.m., with the Director of Nursing (DON), the DON stated her expectation was for SSD to determine the root cause, triggers, and monitor manifestations for residents with PTSD. The DON further stated the importance of knowing the triggers is to prevent episodes of re-traumatization. During an interview on 1/23/26 at 3:02 p.m., with Licensed Nurse 2 (LN 2), the LN 2 stated Resident 83 has PTSD. The LN 2 further stated she cannot say the triggers for Resident 83's PTSD. The LN 2 described Resident 83 as wanting to be by herself, likes to sleep and plays on her phone. A review of the facility's policy and procedure dated August 2022 and titled, Trauma Informed Care and Culturally Competent Care indicated, To guide staff in providing care that is culturally competent and trauma-informed .To address the needs of trauma survivors by minimizing triggers and/or re-traumatization .Traumatic events which may affect residents during their lifetime include .physical .abuse .For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence can trigger profound re-traumatization .Some common triggers may include .exposure to loud noises .develop individualized care plans that address past trauma in collaboration with the resident and family .Identify and decrease exposure to triggers that may re-traumatize the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was less than five (5) percent (%). The facility had a cumulative medication error rate of 7.4% consisting of two errors for one Resident (Resident 42) in a sample size of 27 opportunities for error.This failure had the potential to jeopardize Resident 42's health and well-being.During a medication pass observation on 1/21/26 at 7 a.m., with Licensed Nurse (LN 3), LN 3 was observed preparing Resident 42's morning medications. LN 3 placed Resident 42's medications, including Ferrous Sulfate (iron supplement for anemia) and Carvedilol (heart failure and blood pressure medication) in a small plastic cup, added less than one teaspoon of apple sauce and administered to the resident. LN 3 explained that the resident prefers to take her medications with small amount of apple sauce. LN 3 did not offer Resident 42 any snacks or food before leaving the resident's room. There was no food observed on Resident 42's bedside table. There were no breakfast trays available in the hallway available for residents. LN 3 returned to medication cart but did not document that she administered Carvedilol.A review of Resident 42's physician order, dated 1/10/26 indicated that Ferrous Sulfate 325 milligram (mg, unit of measurement), 1 tablet was to be given with food. Further review of Resident 42's orders indicated that Carvedilol 3.125 mg tablet was to be administered twice a day at the specific times 9 a.m., and 7 p.m.During an interview and concurrent record review with LN 3 on 1/21/26 at 9:51 a.m., LN 3 stated that medications should be administered as ordered by physician and at the times specified by physician. LN 3 stated that the facility's process was to administer medications one hour before and one hour after scheduled times. LN 3 stated that breakfast in this side of the hall where Resident 42 resided was usually served approximately from 8 - 8:15 a.m. Upon reviewing Resident 42's physician orders and medication administration records, LN 3 validated that the order for Ferrous Sulfate indicated to administer medication with food. LN 3 stated that Resident 42 received her medications, including Ferrous Sulfate at 7 a.m., and would have to wait an hour or longer for her food. LN 3 stated that receiving iron without food could upset Resident 42's stomach.During a continued interview with LN 3 on 1/21/26 at 9:51 a.m., LN 3 stated that Resident 42's Carvedilol was scheduled to be administered at 9 a.m., but it was administered two hours prior scheduled time. LN 3 stated she did not document Carvedilol administration at 7 a.m., because it was too early to document and the system won't allow me to document. LN 3 acknowledged that Carvedilol was not administered as directed and specified by the physician.A review of the manufacturer's instruction for Carvedilol indicated that medication should be taken with food or after the meal to slow the rate of absorption (the process of a drug moving from the stomach into blood stream) and reduce the incidence of orthostatic effects (sudden drop in blood pressure, causing dizziness, lightheadedness, or faint feeling).During an interview on 1/21/26 at 10:51 a.m., the Director of Nursing (DON) stated that the timeframe for medications administration was one hour before and one hour after scheduled time. The DON stated her expectation for nurses was to administer medications timely and as ordered by physician and as specified on the medication administrations records. The DON stated that if the order indicated to administer Ferrous Sulfate with food, the medication should be administered with food. The DON stated that her expectation was that nurses do not administer Resident 42's medications two hours prior scheduled times because the resident might experience unpleasant side-effects. The DON stated that nurses should document medications immediately after medications were administered. The DON stated that waiting to document medication that was administered more than two hours prior was not a safe practice.A review of the facility's policy titled, Administering Medications, dated 4/19 indicated, Medications are administered in a safe and timely manner.in accordance with prescriber order, including any required time frame.Medications are administered within one (1) hour of their prescribed time, unless otherwise specified. The policy further directed the individual who administered medication to check the label THREE (3) times to verify.right time.before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe storage, labeling and effective accountability of the medications in accordance with accepted professional standards, when a bottle of Lyrica (a prescription medication to treat pain; controlled medication with potential for abuse) tablets was stored unsecured on the open shelf in medication room and Fluticasone Propionate and Salmeterol Inhalation Powder (inhalation medication to treat lung disease and relieve allergic symptoms) for Resident 73 was stored inside Medication Cart 1 not dated when opened.These failures had the potential for controlled substance medication diversion due to lack of secure storage and for Resident 73 to receive expired medication with reduced potency. During an observation and interview with Licensed Nurse (LN 4) in the Medication Room on [DATE] at 7:54 a.m., four paper bags with medications were observed on an open shelf in medication room. LN 4 explained that medications in the bag were brought by residents from home and once the resident was discharged , the medications were returned to resident. A bottle of Lyrica 150 milligram (mg, unit of measurement) with resident's name was observed inside one of the bags. LN 4 acknowledged that the medication was a controlled substance with high risk for abuse and it was not safe to keep it on the open shelf. LN 4 explained that nurses should have counted Lyrica tablets and locked it up until resident's discharge.During an interview on [DATE] at 10:45 a.m., storage of controlled substance was discussed with Director of Nursing (DON). The DON stated that controlled substances should be stored locked and not stored on the open shelf. The DON added, Narcotics [controlled substance] patients supply, or medications brought from home should be counted, documented and locked. Apparently, nurses did not realize there were controlled substances in the bag and did not lock them up. On [DATE] at 10:22 a.m., during inspection of Medication Cart 1 and accompanied by LN 4, Resident 73's partially used multidose (contain more than one dose of medication) Fluticasone Propionate was observed in one of the drawers with no open date documented. LN 4 explained that the facility followed the expiration date printed on the medication which indicated expiration date of 12/2026. The instructions on the box for Fluticasone indicated, Discard fluticasone propionate.inhalation powder inhaler 1 month after opening the foil pouch. The label with Resident 73's name on the medication indicated that it was dispensed from pharmacy on [DATE], which was over 60 days ago. LN 4 acknowledged that since there was no open date, medication might be expired.A review of Resident 73's clinical records contained a physician order dated [DATE] to administer Fluticasone Salmeterol Inhalation Aerosol Powder orally two times a day for shortness of breath. Resident 73's Medication Administration Record (MAR) for December of 2025 indicated the resident was administered Fluticasone twice a day. The MAR for [DATE] indicated that the resident continued receiving Fluticasone twice a day.During an interview on [DATE] at 2:51 p.m., the DON validated that the label indicated that Fluticasone inhaler was dispensed and delivered on [DATE]. The DON stated that because there was no open date, it was not known when the medication was opened, and the resident might have been administered expired medication that was not effective. The DON stated her expectation was that nurses put an open date on the box or medication when they open and discard if not used within 30 days as directed by instructions.A review of the facility's policy titled, Medication Labeling and Storage, dated 2/23, indicated, Controlled substances and other drugs subject to abuse are separately locked in permanently affixed compartments.Multi-dose vials that have been opened or accessed.are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date .The nursing staff is responsible for maintaining medication storage and preparation areas in a.safe manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555122	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinley Park Care Center	3700 H Street Sacramento, CA 95816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 provide 80 square feet (sq ft) per resident in 8 resident rooms.This failure had the potential to affect residents' care and residents' quality of life. A review of the facility's room measurements conducted on 1/20/26 indicated: room [ROOM NUMBER]- 156 sq ft- 2 residents- 78 sq ft per residentroom [ROOM NUMBER]- 154 sq ft - 2 residents-77 sq ft per residentroom [ROOM NUMBER]-156 sq ft-2 residents-78 sq ft per residentroom [ROOM NUMBER]-230 sq ft-3 residents-76.7 sq ft per residentroom [ROOM NUMBER]-228 sq ft-3 residents-76 sq ft per residentroom [ROOM NUMBER]-238 sq ft-3 residents-79.3 sq ft per residentroom [ROOM NUMBER]-220 sq ft-3 residents-73.3 sq ft per residentroom [ROOM NUMBER]-223 sq ft-3 residents-74.3 sq ft per resident During an interview on 1/20/26 at 8:07 a.m. with the Administrator (ADM), the ADM stated the facility does not have a room waiver in place for rooms that have less than 80 sq ft per resident. The ADM stated he will look into it. During an interview on 1/20/26 at 8:45 a.m. with the ADM, the ADM confirmed he did not have a room waiver letter. The ADM stated he contacted The Department after the last survey in 2024 but did not hear back and did not follow up. During an interview on 1/20/26 at 10:38 a.m. with Resident 18 in room [ROOM NUMBER] C, Resident 18 stated they use a mechanical lift to get her out of bed. Resident 18 stated they seem to have enough room to maneuver the lift and has not heard staff complain about not having enough room. During an interview on 1/20/26, at 11:20 a.m., with Registered Nurse (RN) 1, RN 1 stated, she was assigned to rooms [ROOM NUMBERS] today. RN 1 stated, she had no concerns regarding the room sizes.During an interview on 1/20/26 at 4:27 p.m. with the ADM, the ADM acknowledged room measurements for rooms 1,5, 16, 26, 28, 33, 34, 35, did not meet the requirement for 80 sq ft per resident. The ADM stated he had not applied for the room waiver. During an interview on 1/22/26 at 3:00 p.m. with Certified Nursing Assistant (CNA) 5, CNA 5 was assisting resident in room [ROOM NUMBER] B. CNA 5 stated mechanical lifts are used for residents in room [ROOM NUMBER] A and 34 C. CNA 5 stated there have been no issues using the mechanical lifts in the room. During a concurrent observation and interview on 1/23/26 at 8:48 a.m. with Resident 92 in room [ROOM NUMBER] A, observed a transfer pole at bedside and a wheelchair near the closet. Resident 92 stated she has been in room [ROOM NUMBER] A for one year. Resident 92 stated she had enough space in the room and privacy when the curtain is closed. Resident 92 stated she used the bathroom in her wheelchair for the first time yesterday and there was no problem with space. During a concurrent observation and interview on 1/23/26 at 10:18 a.m. with Resident 45 in room [ROOM NUMBER] B, observed resident in a bariatric (oversized) bed. Resident 45 stated she had been in this room for several years. Resident 45 stated the staff use a mechanical lift to get her out of bed. Resident 45 stated there was not enough space for all her things currently, but when there were only two residents in the room it was fine. Resident 45 stated she has told everyone about the lack of space, but nothing has been done. During an interview on 1/23/26 at 12:19 p.m. with Resident 32 in room [ROOM NUMBER] C, Resident 32 stated she had been in this room since November 2025 and there was enough space for three residents. During an interview on 1/23/26 at 1:49 p.m. with CNA 6, CNA 6 stated she was working in room [ROOM NUMBER] today but has worked in room [ROOM NUMBER] and 34. CNA 6 stated residents in rooms 35 A and 35 C both use mechanical lifts and wheelchairs. CNA 6 stated there was enough space to use mechanical lifts and wheelchairs and had not heard any complaints from residents or family. The Department recommends approval of room size waiver for rooms 1, 5, 16, 26, 28, 33, 34, 35.