STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555333	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Meadows Care Center	1550 Third Street Lincoln, CA 95648

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered in accordance with manufacturer guidelines and prescriber instructions for one (1) of ten (10) sampled residents (Resident 47), when the facility failed to identify and correct the inappropriate administration times for glipizide, a medication requiring administration approximately 30 minutes before meals for effective blood sugar control. Glipizide doses were instead scheduled at standardized times that did not align with mealtimes or manufacturer recommendations. This failure created the potential for uncontrolled blood sugar and diseaseˆrelated complications. Findings:A review of the clinical record showed Resident 47 was admitted on [DATE] with diagnoses including primary hypertension (high blood pressure) and atrial fibrillation (irregular heartbeat). In 2024, diagnoses were updated to include uncontrolled type 2 diabetes mellitus. Physician orders for glipizide included:- Glipizide 5 mg (milligram, strength) oral tablet, give 1 tablet by mouth twice daily for type 2 diabetes mellitus, Do not give more than 30 minutes before meal. Start date 5/2/2026; discontinued 5/19/2026; scheduled at 8:00 a.m. and 8:00 p.m.- Glipizide 5 mg tablet, 1 tablet by mouth twice daily for type 2 diabetes mellitus, Do not give more than 30 minutes before meal. Start date 4/4/2025; discontinued 5/2/2026; scheduled at 8:00 a.m. and 8:00 p.m.During a medication observation on 5/18/2026 at 8:24 a.m., Licensed Nurse (LN 1) prepared and administered multiple oral medications to Resident 47, including glipizide 5 mg, after the start of breakfast, not prior to the meal as ordered.During an interview and concurrent record review on 5/18/2026 at approximately 1:30 p.m., LN 1 read the glipizide order and acknowledged the medication was not administered before the meal. LN 1 stated the medication could be given after eating and that the 8:00 a.m. dose had a oneˆhour before and oneˆhour after administration window.During a phone interview on 5/19/2026 at 2:22 p.m., the Consultant Pharmacist (CP) stated glipizide should be administered 30 minutes before meals. The CP acknowledged the order instructions reflected this requirement. After reviewing Resident 47's clinical record, the CP confirmed glipizide was scheduled at 8:00 a.m. and 8:00 p.m., which are not before mealtimes and acknowledged the resident had an order dating back to 2025. The CP acknowledged he did not make a recommendation to correct the administration times. He stated the facility does not have standard administration times for medications intended to be given before meals or with meals and relies on medicationˆspecific instructions. He stated that in 2024 he requested comments be added to reflect glipizide administration before meals for this resident.During an interview and concurrent review of physician orders, the May 2026 Medication Administration Record (MAR), and the facility's meal schedule on 5/20/2026 at 11:04 a.m., the Director of Nursing (DON) stated that glipizide should be administered 30 minutes before meals. The DON acknowledged that mealtimes are staggered by resident room location, with start times of 7:10 a.m. for breakfast, 12:10 p.m. for lunch, and 5:10 p.m. for dinner.The DON reviewed Resident 47's glipizide orders and MAR dated 4/4/2025 through 5/19/2026 and 4/4/2026 through 5/2/2026, which were scheduled for 8:00 a.m. and 8:00 p.m. The DON acknowledged the Consultant Pharmacist did not identify the medicationˆtiming issue. The DON confirmed these administration times were not appropriate for a (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication intended to be given before meals and stated that administering glipizide outside of manufacturer guidelines could lead to uncontrolled blood sugars.A review of the prescribing information for glipizide, revised December 2023, indicated: .glipizide was more effective when administered about 30 minutes before, rather than with, a test meal in diabetic patients. Further review indicated: Dosage and Administration: glipizide should be given approximately 30 minutes before a meal to achieve the greatest reduction in postˆprandial (after eating) hyperglycemia. (high blood sugar)During a review of the facility's., Medication Administration [Times], not dated, indicated the following times for medication administration: twice daily: 8 a.m. and 4 p.m.; three times daily: 8.m., 2 p.m. and 8 p.m. or 8 a.m. 2 p.m. and 10 p.m.During a review of the facility's policy and procedure titled, Consultant Pharmacist Services Provider Requirements, version 3 (not dated), indicated, The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. In collaboration with facility staff the consultant pharmacist helps to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical services. This includes: .2. Evaluating the process of receiving and interpreting prescribers' orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing.administering, monitoring responses to and using and/or disposing of all medications, biologicals and chemicals. Further review indicated, Specific activities that the consultant pharmacist performs includes: 1) Reviewing the medication record (medication regimen review) pf each resident at least monthly. incorporating federally mandated standards of care in addition to other applicable professional standards .and documenting the review in the resident's medical record. 2) Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders as well as recommendations for changes in medication therapy and monitoring of medication therapy at least monthly.During a review of the facility's policy and procedure titled, Administering Medications, revised date October 2025, indicated, . 2. Medications are administered in accordance with prescriber orders, including any required time frame. 3.Medications re administered within (1) hour of their prescribed time, unless otherwise specified (for example before and after meal orders).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure its medication error rate remained below 5%. The facility's medication error rate was 6.67%, with two errors identified during 30 medication administration opportunities. Errors were observed for two of five sampled residents (Resident 47 and Resident 16) when Resident 47 received glipizide, a medication used to control blood sugar, at the wrong time, which was not in accordance with the physician's orders or the manufacturer's specifications and Resident 16 did not receive her asˆneeded (PRN) dose of hydralazine, a medication prescribed for the treatment of high blood pressure, despite having an elevated blood pressure reading that met the parameters for administration per the physician's order. These failures resulted in residents being placed at risk for complications related to uncontrolled blood sugar and uncontrolled high blood pressure.Findings:1. During a medication observation on 5/18/2026 at 8:24 a.m. at the 1 B medication cart, Licensed Nurse (LN 1) prepared eight oral medications for Resident 47, including one tablet of glipizide 5 mg (milligram, strength) Resident 47 was observed taking all her medications with water.A review of Resident 47's clinical record indicated the following physician order:-Glipizide oral tablet 5 mg, (milligram, mg, strength) give one tablet by mouth two times a day for Diabetes Mellitus Type II (DM2, chronic condition, high blood sugar). Do not give more than 30 minutes before meal. Order start date: 5/2/2026.Scheduled administration times, 8 a.m. and 8 p.m.During an interview and concurrent clinical record review on 5/18/2026 at approximately 1:30 p.m., LN 1 read Resident 47's glipizide order, including, ?do not give more than 30 minutes before meal.' LN 1 acknowledged the medication was not given before the meal and breakfast was approximately at 7 a.m. She stated the medication could be given after eating that the 8 a.m. dose had a oneˆhour before and oneˆhour after administration window.During a phone interview on 5/19/2026 at 2:22 p.m. with the Consultant Pharmacist (CP), the CP stated that glipizide should be given 30 minutes before meals. The CP reviewed Resident 47's clinical record and acknowledged the order instructions indicated, do not give more than 30 minutes before meal. The CP reviewed the prescribing information and read that glipizide should be given approximately 30 minutes before a meal to achieve the greatest reduction in high blood sugar after eating.During an interview and concurrent clinical record review of physician orders and the May 2026 Medication Administration Record on 5/20/2026 at 11:04 a.m. with the Director of Nursing (DON), the DON stated that glipizide should be administered 30 minutes before meals. The DON acknowledged Resident 47's glipizide was not given before breakfast and that this could contribute to uncontrolled blood sugar levels.A review of the prescribing information for glipizide, revised December 2023, indicated: .glipizide was more effective when administered about 30 minutes before, rather than with, a test meal in diabetic patients. Further review indicated: Dosage and Administration: glipizide should be given approximately 30 minutes before a meal to achieve the greatest reduction in postˆprandial (after eating) hyperglycemia (high blood sugar).During a review of the facility's policy and procedure titled, Administering Medications, revised date October 2025, indicated, . 2. Medications are administered in accordance with prescriber orders, including any required time frame. 3.Medications re administered within (1) hour of their prescribed time, unless otherwise specified (for example before and after meal orders).2. During a medication observation on 5/18/2026 at 8:57 a.m. at the 2A medication cart with Licensed Nurse (LN 2), LN 2 stated she needed to take Resident 16's blood pressure before administering her morning medications. LN 2 was observed taking Resident 16's blood pressure on her left arm while the resident was sitting at the side of her bed; the reading was 164/78 mmHg (millimeters of mercury, pressure measurement). LN 2 then prepared seven oral medications for the resident, who was observed taking them with water.A review of Resident 16's clinical record indicated the following physician order: Hydralazine oral tablet, give 1 tablet by mouth every 12 hours as needed for hypertension (HTN, high blood pressure); give if systolic blood pressure (SBP-the top number of a blood pressure reading, measuring the maximum pressure exerted on artery walls when (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the heart beats and pumps blood to the body) is greater than 150 mmHg. On 5/18/2026 at 9:03 a.m., the resident's blood pressure was documented as 164/78 mmHg, with an SBP of 164 mmHg, exceeding the ordered parameter requiring administration of PRN hydralazine.During an interview and concurrent clinical record review on 5/18/2026 at approximately 12 p.m. at the 2A medication cart with LN 2, when asked about Resident 16's hydralazine order, LN 2 stated the medication is given on the evening shift. After reviewing the order further, LN 2 acknowledged that hydralazine was ordered as needed for SBP greater than 150 mmHg, confirmed that the resident's SBP earlier that morning was 164 mmHg, and acknowledged that the PRN hydralazine was not administered as ordered.During an interview and concurrent clinical record review of Resident 16's physician orders, progress notes, blood pressure readings, and the May 2026 Medication Administration Record (MAR) on 5/20/2026 at approximately 11:50 a.m. with the Director of Nursing (DON), the DON stated she expects nursing staff to follow provider orders for asˆneeded blood pressure medications. The DON acknowledged the resident's blood pressure that morning was above the ordered parameter and that the asˆneeded hydralazine should have been given. She confirmed the medication was not administered and acknowledged the resident was at risk for complications related to untreated elevated blood pressureDuring a review of the facility's policy and procedure, titled, Physician Orders, revised October 2025, indicated, The licensed staff shall carry out physician/nurse practitioner's orders as prescribed. Further review indicated, Orders for medications may include: a. Name and strength of the drug. b. Number of doses, start and stop date, and/or specific duration of therapy. c. Dosage and frequency of administration. d. Route of administration. e. Clinical condition or symptoms for which the medication is prescribed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of ten sampled residents (Resident 16) was free from a significant medication error when staff did not administer a prescribed asˆneeded (PRN) antihypertensive medication as ordered by the physician.This deficient practice placed the resident at risk for complications associated with uncontrolled high blood pressure, including stroke, heart attack, and kidney damage.Findings:A review of Resident 16's clinical record, indicated she was admitted to the facility on [DATE] with some of the following diagnoses: high blood pressure (hypertension), atrial fabulation (irregular heartbeat), diastolic heart failure (decreased blood flow to the body) and chronic kidney disease stage 3 (moderate kidney damage).A review of Resident 16's clinical record indicated a physician's order, dated 4/28/26, for hydralazine oral tablet 50 mg (milligram, strength), give 1 tablet by mouth every 12 hours as needed for hypertension, give if systolic blood pressure (SBP, the top number of a blood pressure reading, measuring the maximum pressure exerted on artery walls when the heart beats and pumps blood to the body) is greater than 150 mmHg (millimeters of mercury, measurement of pressure).During an interview and concurrent clinical record review on 5/18/2026 at approximately 12 p.m. at the 2A medication cart with Licensed Nurse (LN 2), LN 2 was asked about Resident 16's hydralazine order. LN 2 initially stated that the medication is given on the evening shift. After reviewing the order further, LN 2 acknowledged the medication was to be administered as needed when the systolic blood pressure (SBP) exceeded 150 mmHg. LN 2 confirmed that Resident 16's blood pressure earlier that morning was 164/78 mmHg-above the ordered SBP threshold requiring administration. LN 2 acknowledged the PRN hydralazine was not given as prescribed.A review of Resident 16's blood pressure readings, physician orders, nursing notes and the May 2026 Medication Administration Record (MAR), conducted with the Director of Nursing (DON) on 5/20/2026 at approximately 11:50 a.m., identified over 15 missed opportunities to administer PRN hydralazine within the required 12ˆhour dosing intervals. In each instance, the resident's systolic blood pressure (SBP) exceeded the physicianˆordered parameter of greater than 150 mmHg, yet hydralazine was not administered. The untreated elevated SBP readings were:5/20 at 6:57 a.m. (161/78 mmHg),5/19 at 6:56 a.m. (160/80 mmHg) and 3:54 p.m. (160/77 mmHg),5/18 at 6:40 a.m. (185/75 mmHg) and 9:03 a.m. (164/78 mmHg),5/14 at 9:00 p.m. (177/81 mmHg),5/13 at 7:37 a.m. (170/90 mmHg),5/12 at 6:33 a.m. (176/89 mmHg),5/11 at 3:35 a.m. (158/81 mmHg),5/10 at 6:47 a.m. (158/72 mmHg),5/8 at 7:29 a.m. (155/87 mmHg) and 4:56 p.m. (161/73 mmHg),5/7 at 3:20 p.m. (157/72 mmHg),5/6 at 6:41 a.m. (153/73 mmHg),5/5 at 6:28 a.m. (168/62 mmHg),5/4 at 5:23 p.m. (182/81 mmHg) and 5:34 p.m. (153/73 mmHg),5/3 at 6:36 a.m. (172/80 mmHg), and5/2 at 6:43 a.m. (153/74 mmHg).During an interview on 5/20/2026 at approximately 11:50 a.m., the Director of Nursing (DON) stated she expects nursing staff to follow provider orders for all asˆneeded blood pressure medications. The DON acknowledged that Resident 16 had repeated elevated systolic blood pressure readings that were above the ordered parameter on numerous occasions and were not treated. She confirmed that the PRN hydralazine should have been administered when the resident met the required SBP threshold, and acknowledged the medication was not given. The DON further acknowledged that failing to administer the ordered PRN antihypertensive medication placed the resident at risk for complications related to untreated elevated blood pressureDuring a review of the facility's policy and procedure, titled, Physician Orders, revised October 2025, indicated, The licensed staff shall carry out physician/nurse practitioner's orders as prescribed. Further review indicated, Orders for medications may include: a. Name and strength of the drug. b. Number of doses, start and stop date, and/or specific duration of therapy. c. Dosage and frequency of administration. d. Route of administration. e. Clinical condition or symptoms for which the medication is prescribed.

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	555333	A. Building B. Wing	05/21/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, interview, and record review, the facility failed to ensure that two out of 19 sampled residents (Resident 7 and Resident 85) received an ongoing activity program that met their psychosocial needs (a combination of mental health, emotional, spiritual, or behavioral needs important to a person), as required by their comprehensive plans of care. The facility did not maintain documentation showing that either resident received ongoing activities.This failure placed both residents at risk for psychosocial, emotional, spiritual, and mental decline and prevented them from achieving their highest practicable well^being.Findings:1a. A review of Resident 7's clinical record indicated Resident 7 was admitted March of 2026 and had diagnoses that included metabolic encephalopathy (a condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function), cerebral infarction (damage to a part in the brain due to a disrupted blood flow), dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities), and muscle weakness.A review of Resident 7's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 3/26/26, indicated Resident 7 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 10 out of 15 which indicated Resident 7 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 7's MDS Preferences for Customary Routine and Activities, dated 3/26/26, indicated it was very important for Resident 7 to do his favorite activities, and it was somewhat important for Resident 7 to listen to music he like. A review of Resident 7's care plan, dated 3/25/26, indicated, Activities- Customary Routine: [Resident 7] has preferences for customary routine and activities including Watching TV, Game shows, and phone to talk tofamily .Provide activity materials like books, magazines, TV, radio, arts and crafts .in accordance with resident's interest .Support [Resident 7] choices for preferences regarding customary routine and activities.A review of Resident 7's ACTIVITY ASSESSMENT, dated 3/24/26, indicated, [Resident 7] prefers independent leisure activities in his room due to his illness. Watch TV, Watching Game shows with his wife. Talking on his cell phone .During an observation on 5/18/26 at 8:54 a.m. of Resident 7, in Resident 7's room, Resident 7 was observed awake and lying on his bed. Resident 7 did not respond to greetings. There was no music playing in the room, the TV was off, and there were no books, magazines, radio, or phone noted in the room.During an observation on 5/19/26 at 10:17 a.m. of Resident 7, in Resident 7's room, Resident 7 was observed lying on his bed, eyes closed, and breathing was unlabored (something natural, flowing, or relaxed, and doesn't require effort). There was no music playing in the room, the TV was off, and there were no books, magazines, radio, or phone noted in the room.During another observation on 5/19/26 at 3:36 p.m. of Resident 7, in Resident 7's room, Resident 7 was observed lying on his bed, eyes closed, and breathing was unlabored. There was no music playing in the room, the TV was off, and there were no books, magazines, radio, or phone noted in the room.During an observation on 5/20/26 at 9:45 a.m. of Resident 7, in Resident 7's room, Resident 7 was observed lying on his bed, eyes closed, and breathing was unlabored. There was no music playing in the room, the TV was off, and there were no books, magazines, radio, or phone noted in the room.During a concurrent interview and record review on 5/20/26 at 12:21 p.m. with the Activities Director (AD), Resident 7's activity records were reviewed. The AD confirmed that there were no records that Resident 7 was provided with any ongoing activity that meets his psychosocial needs. The AD stated that Resident 7's preferred activities should have been provided to maintain his psychosocial wellbeing.1b. A review of Resident 85's clinical record indicated Resident 85 was admitted December of 2022 and had diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions causing memory loss and confusion), dementia, and muscle weakness.A review of Resident 85's MDS Cognitive Patterns, dated 1/8/26, indicated Resident 85 had a BIMS score of 5 out of 15 which indicated Resident 85 had a severely impaired cognition. A review of Resident 85's MDS (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Preferences for Customary Routine and Activities, dated 1/8/26, indicated it was very important for Resident 85 to have books, newspapers, and magazines to read, to listen to music she likes, to do her favorite activities, to participate in religious services or practices, and it was somewhat important to be around animals such as pets.A review of Resident 85's care plan, revised 4/7/25, indicated, ACT [activity] 1:1 [one-on-one]: [Resident 85] prefers to engage in activities such as: watching TV in bed, 1:1 in room visits. Dx [diagnosis] of Alzheimer's . A further review of Resident 85's care plan goals and interventions, revised 1/2/25, indicated, [Resident 85] has Dx Alzheimer's, she needs reminders for activities, 1;1 in room visits are in place .Offer one-to-one activity visits and ask reminiscing/open-ended questions about: Encourage to attend a group activities of interest .Offer supplies and equipment needed.A review of Resident 85's ACTIVITY PARTICIPATION REVIEW, dated 4/7/26, indicated, [Resident 85] enjoys art work, crafting and watching movies.During an observation on 5/18/26 at 10:19 a.m. of Resident 85, in Resident 85's room, Resident 85 was observed awake and lying on her bed. The TV was off, and there were no art or crafting materials noted in the room.During an observation on 5/19/26 at 10:10 a.m. of Resident 85, in Resident 85's room, Resident 85 was observed awake and lying on her bed. The TV was off, there was no music playing in the room, and there were no books, magazines, radio, art or crafting materials noted in the room.During an observation on 5/20/26 at 9:50 a.m. of Resident 85, in Resident 85's room, Resident 85 was observed awake and lying on her bed. The TV was off, there was no music playing in the room, and there were no books, magazines, radio, art or crafting materials noted in the room.During a concurrent interview and record review on 5/20/26 at 12:21 p.m. with the AD, Resident 85's activity records were reviewed. The AD confirmed that there were no records that Resident 85 was provided with any ongoing activity that meets her psychosocial needs. The AD stated that Resident 85 would be at risk for psychosocial decline and activity decline which may lead to depression if an ongoing activity program was not provided.During an interview on 5/20/26 at 2:58 p.m. with the Director of Nursing (DON), the DON stated that an ongoing activity program should be provided to the residents. The DON further stated that residents would be at risk for isolation, psychosocial decline, and mental health concerns if an ongoing activity program was not consistently provided.A review of the facility's policy and procedures (P&P) titled, Activity Programs, revised 10/2025, indicated, Activity programs are designed to meet the interests of and support the physical, mental and psychosocial wellbeing of each resident .2. Activities offered are based on the preferences of residents. 3. The Activities Program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities .6. Activities are scheduled 7 (seven) days a week and residents are given an opportunity to contribute to the planning, preparation, conducting of the programs .9. Activities are documented in the resident's medical record .11. Individualized and group activities are provided that: a. Reflect the choices of the residents .A review of the facility's P&P titled, Individual Activities and Room Visit Program, revised 10/2025, indicated, Individual activities will be provided for those residents whose situation or condition prevents participation in other types of activities, and for those residents who do not wish to attend group activities. Residents who are able to maintain an independent program will have supplies available to them .1. Individual activities are provided for individuals who have conditions or situations that prevent them from participating in group activities, or who do not wish to do so. 2. For those residents whose condition or situation prevents participation in group activities, and for those who do not wish to participate in group activities, the activities program provides individualized activities consistent with the overall goals of an effective activities program. 3. Individualized activities offered are reflective of the resident's activity interests, as identified in the activity assessment, progress notes and the resident's comprehensive care plan. 4. It is recommended that residents with in-room activity programs receive, at a minimum, three in-room visits per week. A typical in-room visit is ten to fifteen minutes in length, but may be longer if appropriate for the resident .6. Residents who choose not to attend group activities are encouraged to participate in independent activities. It is the responsibility of the facility and the (continued on next page)

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	555333	A. Building B. Wing	05/21/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activity staff to make regular contact with residents who choose to pursue independent activities, maintain appropriate records and offer supplies, as needed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview and record review, the facility failed to provide treatment and services necessary to maintain or improve range of motion (ROM) and mobility for one of 19 sampled residents (Resident 10) when the facility did not follow the physicianˆordered Restorative Nursing Program (RNA program-program- interventions that actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning) frequency for active range of motion (AROM) and bed mobility exercises.This failure had the potential for Resident 10 to experience decline in ROM, decreased mobility, and failure to achieve her highest practicable wellˆbeing.Findings:A review of Resident 10's clinical record indicated Resident 10 was admitted in December 2025 with diagnoses that included metabolic encephalopathy (a condition where the brain does not receive enough nutrients or oxygen to function properly, leading to altered brain function), cerebral infarction (damage to a part in the brain due to a disrupted blood flow), absence of left leg below knee, and muscle weakness.A review of Resident 10's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 5/8/26, indicated Resident 10 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 indicating moderately impaired cognition. The MDS Functional Abilities dated 5/8/26 indicated Resident 10 was dependent for toileting hygiene, shower/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene, and needed substantial/maximal assistance with oral hygiene and upper body dressing. The MDS also showed substantial/maximal assistance was needed for rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, and chair/bedˆtoˆchair transfers.A review of Resident 10's care plan, dated 2/22/26, indicated, Restorative Nursing- Range of Motion: Resident [Resident 10] at risk for decline and/ or complications with range of motion in joints, decreased mobility and movement, decreased muscle strength, decreased functional use of extremity, pain, deformity, contracture, and/or skin breakdown. Requires a restorative nursing range of motion program to lower extremities, upper extremities.A review of active physician's orders dated 4/22/26 indicated the following: RNA for AROM Program: BUE (bilateral upper extremities) & BLE (bilateral lower extremities) 3x/wk or as tolerated. as needed 3x/wk. RNA for Bed Mobility Program: Supine <> Sitting EOB (edge of bed) 3x/wk or as tolerated. as needed 3x/wk.During an interview on 5/18/26 at 8:22 p.m., Resident 10 stated she was very upset because she was not receiving the RNA program she had been referred to. She stated she only received one exercise last weekend, although she was supposed to receive exercises three times a week. She stated she needs to get her exercises so she could get better.During a concurrent interview and record review on 5/19/26 at 11:55 a.m. with Restorative Nurse Assistant (RNA) 1, Resident 10's RNA flowsheet for the past 30 days were reviewed. RNA 1 confirmed that Resident 10 only received AROM of BLE and LUE on 4/20, 4/21, 4/25, 4/26, 4/27, 4/30, 5/5, 5/6, and 5/17. RNA 1 also confirmed that Resident 10 only received bed mobility exercise one time on 5/17. RNA 1 further confirmed that Resident 10 did not get his exercises in accordance with the ordered RNA program frequencies which were three times a week and there were no documented refusals of Resident 10. RNA 1 stated the RNA frequency order should have been followed in order for Resident 10 to maintain and improve her mobility function. RNA 1 further stated there would be a risk for decline in range of motion if Resident 10's RNA program frequency was not followed.During an interview on 5/20/25 at 1:30 p.m. with the Director of Staff Development (DSD), the DSD stated RNA program frequency should have been followed and there should always be documentation if the resident refused. The DSD further stated Resident 10 would be at risk for contracture and decline in mobility if the RNA program was not followed.During an interview on 5/20/26 at 2:58 p.m. with the Director of Nursing (DON), the DON stated that she would expect that RNA program frequency would be followed. The DON further stated that the resident would be at risk for functional decline if the RNA program frequencies were not followed.A review of the facility's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555333	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Meadows Care Center	1550 Third Street Lincoln, CA 95648

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policies and procedures titled, RNA Program, dated 8/2025, indicated, 1. Facility should have designated certified and trained RNA staff to fully provide the RNA treatment as recommended for each resident based on current RNA caseload .4. Upon completion of the screen, if therapy identifies that there is a need for a restorative program, nursing staff will obtain order for therapy evaluation. 5. RNA to be provided per physician's order .

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	555333	A. Building B. Wing	05/21/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure emergency kits (eˆkits) were replaced within the facility's required timeframe and failed to prevent staff from removing medications from previously opened eˆkits. This deficient practice had the potential to result in medications not being available when needed for residents.Findings:During an observation, inspection, and concurrent interview on 5/18/2026 at 9:34 a.m., I inspected the medication room with Supervisor Nurse (SˆLN). I observed three refrigerated eˆkits stored in the white medication refrigerator labeled Station 2. Two of the eˆkits had red plastic ties, indicating they had been opened, and one eˆkit remained sealed. I opened the two eˆkits with the red plastic ties for inspection. One eˆkit contained a log indicating it had been opened that morning. The second eˆkit contained two logs documenting medication removal on 5/6/26 at 2:00 p.m. and 5/17/26 at 4:16 p.m. SˆLN confirmed the observations and stated that eˆkits were required to be replaced and returned to the pharmacy within 72 hours of being opened. During an interview on 5/20/2026 starting at 11:04 a.m., with the Director of Nursing (DON), the DON stated that eˆkits needed to be replaced within 3 days of being opened. The DON acknowledged that medication might not be available to residents in need when opened eˆkits were not returned to the pharmacy in a timely manner. The DON also acknowledged that staff must not access or obtain medications from a previously opened eˆkit. During a review of the facility's policy and procedure titled, Emergency Kits, reviewed October 2025, indicated, .E. When an emergency or starter dose of a medication is needed, the nurse breaks the container seal and removes the required medication. F. As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the kit. The nurse flags the kit with a red color-coded lock to indicate the need for replacement of kit.H. If exchanging kits, when the replacement kit arrives, the receiving nurse gives the used kit to the pharmacy personnel for return to the pharmacy. I. If exchanging kits, opened kits are placed with sealed kits within 72 hours of opening.

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	555333	A. Building B. Wing	05/21/2026

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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 an opened foil medication pouch containing budesonide ampules (an inhaled medication used to reduce airway inflammation) for Resident 28 which was observed stored in 2B Medication Cart (one of two medication carts sampled) was labeled with the date it was opened, as required by manufacturer specifications and the facility's policies and procedures. This failure created the potential for administering expired or ineffective medication to Resident 28.Findings:During an inspection of the 2B Medication Cart on [DATE] at approximately 10:20 a.m. with Licensed Nurse (LN 3), an opened and undated foil pouch of budesonide prescribed for Resident 28 was observed stored in the cart. LN 3 reviewed the manufacturer's labeling on the pouch which indicated, once the foil envelope is opened, use the ampules within two weeks. Date Opened_____ He stated he would discard the medication because he did not know when it expired. He acknowledged the pouch had not been dated when it was opened.During an interview with the Director of Nursing (DON) on [DATE] starting at 11:04 a.m. the DON reviewed pictures of the opened foil pouch with the manufactures labeling instructions. The DON acknowledged the medication pouch should have been dated when it was opened.During a review of the facility's policy and procedure, titled, Medication Storage and Labeling, reviewed [DATE], indicated, Medications are labeled in accordance with applicable federal and state requirements and currently accepted pharmacy practices.Review of the prescribing instructions for budesonide, revised [DATE], indicated, How should I store budesonide inhalation suspension? Budesonide inhalation suspension vials can be stored for 2 weeks after opening the protective aluminum foil envelope. Further indicated, Patient Instructions for Use: 1. Budesonide inhalation solution comes in a sealed protective aluminum foil envelope.Record the date that you opened the foil in the space provided on the envelope

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the prepared menu and did not meet the nutritional needs of two out of 19 sampled residents (Resident 21 and Resident 5) when staff did not serve Resident 21 and Resident 5 an 8 fl oz (fluid ounce- unit of volume used to measure liquids) of milk during 5/18/26 lunch meal. This failure had the potential to result in Resident 21 and Resident 5 not meeting and maintaining their nutritional needs and achieving their highest practicable wellbeing. Findings:1a. A review of Resident 21's clinical record indicated Resident 21 was admitted May of 2024 and had diagnoses that included diabetes (elevated sugar in the blood), severe protein-calorie malnutrition (PCM- a severe nutritional deficiency where inadequate intake of protein and calories leads to dangerous changes in body composition, function, and weight loss), and dementia (memory loss that interferes with daily functions).A review of Resident 21's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/24/26, indicated Resident 21 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 7 out of 15 which indicated Resident 21 had a severely impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 5's MDS Functional Abilities, dated 2/24/26, indicated Resident 21 needed set-up or clean-up assistance with eating.A review of Resident 21's active physician's order, dated 11/24/25, indicated, Regular diet .Minced and Moist texture [of food] .Thin consistency [of liquids] .A review of Resident 21's NUTRITIONAL RISK REVIEW (QUARTERLY), dated 2/23/26, indicated, Regular diet .Minced and Moist texture .Thin consistency .continue current plan of care .A review of Resident 21's Care Plan Report, revised 2/24/26, indicated, Nutritional Risk: [resident 21] is at [x] at risk for .nutritional imbalance related to malnutrition, mechanically altered diet, therapeutic diet .A review of Resident 21's Care Plan Report, revised 2/24/26, indicated, Malnutrition: Resident has a diagnosis of protein calorie malnutrition .Intake is variable, limited by cognitive andfunctional deficits. h/o [history of] wt [weight] loss .increased needs for wt gain/v. protein repletion .altered nutrition .During a concurrent observation and interview on 5/18/26 at 12:19 p.m. with Resident 21 in the dining room, Resident 21's lunch meal was observed which included a glass of pinkish beverage. Resident 21's meal ticket was checked and indicated, Standing Orders: > 8 fl oz. Beverage > 8 fl oz. Milk. Resident 21 confirmed that she did not receive a glass of milk and stated she wanted her milk, but it was not given to her.During a concurrent observation and interview on 5/18/26 at 12:23 p.m. with the Certified Nurse Assistant (CNA) 2 in the dining room, CNA 2 confirmed that Resident 21 was not served with an 8 fl oz of milk. CNA 2 checked Resident 21's meal ticket and stated that if it was indicated in the meal ticket, then Resident 21's milk should have been provided from the kitchen.1b. A review of Resident 5's clinical record indicated Resident 5 was admitted December of 2025 and had diagnoses that included hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body) following cerebral infarction (damage to a part in the brain due to a disrupted blood flow) affecting left non-dominant side, congestive heart failure (a serious condition in which the heart does not pump blood as efficiently as it should), and dementia.A review of Resident 5's MDS Cognitive Patterns, dated 4/11/26, indicated Resident 5 had a BIMS score of 4 out of 15 which indicated Resident 5 had a severely impaired cognition. A review of Resident 5's MDS Functional Abilities, dated 4/11/26, indicated Resident 5 needed set-up or clean-up assistance with eating.A review of Resident 5's Care Plan Report, revised 12/17/25, indicated, Nutritional Risk (Moderate): Resident is at moderate nutritional risk related to dysphagia [difficulty swallowing] diet .A review of Resident 5's active physician's order, dated 12/23/25, indicated, Regular diet .Pureed texture [smooth, pudding-like consistency of food requiring no chewing] .Thin consistency [of liquids], for Pt [patient] approved for meltable snacks .A review of Resident 5's Care Plan Report, revised 1/7/26, indicated, Malnutrition: Resident is at risk for malnutrition due to end of life processes .A review of (continued on next page)

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	555333	A. Building B. Wing	05/21/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 5's NUTRITIONAL RISK REVIEW (QUARTERLY), dated 4/10/26, indicated, Regular diet .Pureed texture .Thin consistency, for Pt approved for meltable snacks .Continue to honor food preferences as arise. Allow adequate time for meals, Assist with meals/fluids as needed, Encourage adequate nutrition and hydration .During a concurrent observation and interview on 5/18/26 at 12:35 p.m. with Resident 5 in Resident 5's Room, Resident 5's lunch meal was observed which included a glass of brownish beverage. Resident 5's meal ticket was checked and indicated, Standing Orders: > 8 fl oz. Beverage > 8 fl oz. Milk. Resident 5 confirmed that he did not receive a glass of milk. Resident 5 stated he wanted some milk, but he was not given any milk.During a concurrent observation and interview on 5/18/26 at 12:37 p.m. with CNA 3 in Resident 5's room, CNA 3 confirmed that Resident 5 was not served with an 8 fl oz of milk. CNA 3 checked Resident 5's meal ticket and stated the milk should have been provided since it was in Resident 5's meal ticket. CNA 3 further stated Resident 5's meal ticket should have been followed. During an interview on 5/20/26 at 1:35 p.m. with the Food Services Director (FSD), the FSD stated standing orders in the resident meal tickets should be followed and be given with the meal. The FSD further stated there would be a risk that residents could not meet their desired intake and supplement for the day if the meal tickets are not followed.During an interview on 5/20/26 at 2:58 p.m. with the Director of Nursing (DON), the DON stated that resident meal tickets should be followed. The DON further stated that the residents would be at risk of nutritional problems if the meal contents are not complete. A review of the facility's policies and procedures titled, DIET ORDERS, dated 2023, indicated, POLICY: Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department. PROCEDURE: Nursing will send a Diet Order Communication slip to the Food & Nutrition Services Department. The FNS Director or [NAME] in charge will make or adjust the diet profile and tray card as prescribed .

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	555333	A. Building B. Wing	05/21/2026

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review, the facility failed to provide the appropriate assistive eating utensil to one out of 19 sampled residents (Resident 85) when staff did not provide Resident 85 with a scoop plate (an adaptive, high-walled dish designed to help individuals with limited motor skills, tremors, or single-hand dexterity to eat independently) during the 5/18/26 lunch meal. This failure had the potential to result in Resident 85 being unable to independently eat properly which could have caused nutritional problems.Findings:A review of Resident 85's clinical record indicated Resident 85 was admitted December of 2022 and had diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions causing memory loss and confusion), dementia (memory loss that interferes with daily functions), moderate protein-calorie malnutrition (PCM- a severe nutritional deficiency where inadequate intake of protein and calories leads to dangerous changes in body composition, function, and weight loss), and muscle weakness.A review of Resident 85's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 1/8/26, indicated Resident 85 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 5 out of 15 which indicated Resident 85 had a severely impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 85's MDS Functional Abilities, dated 1/8/26, indicated Resident 85 needed supervision or touching assistance with eating.A review of Resident 85's care plan, revised 1/7/25, indicated, Malnutrition: [Resident 85] is at risk for malnutrition due to .dementia .malnutrition.A review of Resident 85's active physician's order, dated 1/7/26, indicated, Fortified diet [foods or drinks that have had extra vitamins, minerals, or proteins deliberately added to them] .Regular texture [of food] .Thinconsistency [of liquids].A review of Resident 85's NUTRITIONAL RISK REVIEW, dated 4/9/26, indicated, Adaptive Feeding Equipment SCOOP PLATE to be provided during all meals to facilitate independence with self-feeding .Continue plan of care Allow adequate time for meals, Assist with meals/fluids as needed, Encourage adequate nutrition and hydration.During a concurrent observation and interview on 5/18/26 at 12:44 p.m. with Resident 85 in Resident 85's Room, staff served Resident 85's lunch meal on a regular white dinner plate. Resident 85 displayed weak and unsteady hands while attempting to scoop food from the plate.Review of Resident 85's meal ticket showed the instruction: Adap. [adaptive] Equip Scoop Plate. Resident 85 confirmed the scoop plate was not provided and stated that having the scoop plate would have helped scoop food properly and prevented the meal tray from becoming cluttered.During a concurrent observation and interview on 5/18/26 at 12:46 p.m. with Certified Nurse Assistant (CNA) 3 in Resident 85's room, CNA 3 confirmed that staff did not provide a scoop plate. CNA 3 reviewed the meal ticket and stated that Resident 85 should have received a scoop plate with every meal.During an interview on 5/20/26 at 1:35 p.m. with the Food Services Director (FSD), the FSD stated that adaptive equipment listed on a resident's meal ticket should be provided with every meal to support the resident's independence with eating. The FSD further stated that residents could not eat properly if required adaptive equipment was not provided.During an interview on 5/20/26 at 2:58 p.m. with the Director of Nursing (DON), the DON stated that adaptive eating utensils should always be provided to residents requiring such equipment in order to promote their independence with eating.A review of the facility's policies and procedures titled, Assistance with Meals/Mealtime Policy, dated 10/2025, indicated, Residents Who May Benefit from Assistive Devices: 1. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. 2. Assistance will be provided to ensure that residents can use and benefit from special eating equipment and utensils .

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	555333	A. Building B. Wing	05/21/2026

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and record review, staff failed to provide a clean environment for residents when one of three outside dumpsters did not keep waste properly contained with the lid closed.This failure created the potential for an unsafe environment due to garbage storage area not being maintained in a sanitary condition to prevent a fly, rodent, or pest infestation that could spread diseases in the facility.Findings:During a concurrent observation and interview on 05/18/2026 at 8:35 a.m., the Food Services Director confirmed the top of one of three outside dumpsters was not closed. The Food Services Director verified that a piece of a bike from the rehab department was sticking up and out of the dumpster, preventing it from being properly closed.During an interview on 05/20/2026 at 10:25 a.m., the Food Services Director confirmed that garbage dumpsters not being closed attracted flies, bugs, and rodents. The Food Services Director confirmed the lid had not been closed.During a review of the facility's policy and procedure (P&P) titled: Garbage and Refuse Disposal, dated September 2025, the P&P indicated: Garbage and refuse containing food wastes will be stored in a manner that prevents pests. Outside dumpsters provided by garbage pickup services will be kept closed.

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	555333	A. Building B. Wing	05/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility did not follow and maintain an effective infection prevention and control program for one out of 19 sampled residents (Resident 5) when a visiting hospice staff did not wear the required personal protective equipment (PPE) during high-contact care for Resident 5, who was on enhanced barrier precaution (EBP- also known as enhanced standard precaution/ESP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] by targeted gown and glove use).This failure increased the risk of cross contamination and exposed Resident 5 to germs and infection.Findings:A review of Resident 5's clinical record indicated that Resident 5 was admitted in December 2025 and had diagnoses including hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body) following cerebral infarction (damage to a part in the brain due to disrupted blood flow) affecting the left non-dominant side, congestive heart failure (a serious condition in which the heart does not pump blood as efficiently as it should), and dementia (memory loss that interferes with daily functions).A review of Resident 5's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 4/11/26, showed that Resident 5 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 4 out of 15, indicating severely impaired cognition (mental process of acquiring knowledge and understanding).A review of Resident 5's care plan, dated 2/9/26, showed that Resident 5 required enhanced barrier precautions during high-contact resident care activities due to the history of infection or colonization (the process where microorganisms grow/multiply in or on a host without invading host tissues or causing disease) with a MDRO. The care plan intervention, dated 4/10/26, instructed staff to utilize PPE (gown and gloves; face-shield as indicated) during high-contact resident care activities, including dressing, bathing/showering, transferring, hygiene, brief changes, and toileting assistance.A review of Resident 5's active physician's order, dated 2/17/26, directed staff to use Enhanced Barrier Precautions for ADLs (activities of daily living), hygiene, toileting, and transferring/repositioning every shift for EBP.A review of Resident 5's active physician's order, dated 4/1/26, directed staff to cleanse excoriation (an injury where the outer layers of the skin are removed) on the left buttocks with soap and water, pat dry, apply triad (a type of wound dressing), and cover with foam dressing every day shift for excoriation on the left buttocks.During an observation on 5/18/26 at 9:40 a.m. in Resident 5's room, a staff member provided ADL and hygiene care to Resident 5 while wearing only gloves and not a gown. EBP signage was posted in front of Resident 5's room, indicating that for six groups of care activities, staff should use hand hygiene, gloves, and gowns for residents on Enhanced Standard Precautions, including morning and evening care, toileting and changing incontinence briefs, and mobility assistance.During a subsequent interview on 5/18/26 at 9:52 p.m. with Visiting Hospice Aide (VHA), the VHA confirmed that she wore only gloves while providing ADL and hygiene care to Resident 5. The VHA stated that she provided a partial bed bath, washed Resident 5's face, provided incontinence care, applied cream to Resident 5's bottom, and changed Resident 5's gown. The VHA stated she was not aware that Resident 5 was on EBP or that signage regarding EBP was posted in front of Resident 5's room. The VHA further stated that no facility staff informed her that Resident 5 was on EBP.A review of the list of residents on EBP, provided by the Infection Preventionist (IP) on 5/19/26 at 9:57 a.m., showed that Resident 5 was on EBP due to a chronic wound.During an interview on 5/20/26 at 1:44 p.m. with the IP, the IP stated that she expected staff and visiting hospice staff caring for residents to be aware of EBP and to always wear the required PPE when performing high-contact care for residents on EBP. The IP stated that failure to wear the required PPE could expose the resident to germs and potential infection.During an interview on 5/20/26 at 2:58 p.m. with the Director of Nursing (DON), the DON stated that staff should follow EBP and wear both gloves and gown when providing high-contact care to a resident on EBP to prevent cross contamination and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible infection of the resident.A review of the facility's policies and procedures titled, Multidrug-Resistant Organisms; Infection Precaution & Enhanced Standard Precautions, dated 10/2025, indicated, Appropriate precautions are taken when caring for individuals known to or suspected to have infection with a multidrug-resistant organism .Infection Precautions .b. EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .c. EBP are indicated for residents with any of the following: 1. Infection or colonization with MDRO when Contact Precautions do not otherwise apply; or 2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .