STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555349	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vacaville Convalescent and Rehabilitation Center	585 Nut Tree Ct. Vacaville, CA 95687

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to provide care and services in accordance with the current professional standards of nursing practice for two of 24 sampled residents (Resident 40 and Resident 124), when:Wound care orders were not updated and implemented as written for Resident 40; and,Wound care orders were not updated and implemented per the physician's verbal order for Resident 124.These failures had the potential for Resident 40 and Resident 124 to receive inadequate wound care with increased risk of complications.Findings: 1. A review of Resident 40's admission Record (AR) indicated Resident 40 was admitted to the facility in February 2026 with diagnoses which included chronic osteomyelitis (a persistent, long-term bone infection leading to bone destruction) in the right arm and polyneuropathy (damage to multiple peripheral nerves in the hands and feet). During a review of Resident 40's Wound Care Plan (WCP), dated 3/2/26, the WCP indicated, Cleanse with normal saline (a sterile, isotonic solution), skin prep on periwound (area around the wound), collagenase [brand name] (a prescription, sterile enzymatic debriding agent used to remove dead tissue from severe burns and chronic skin ulcers, facilitating wound healing), alginate, pack with 1/2 inch iodoform packing (per surgeon) and cover with DSD (dry sterile dressing) foam. During a concurrent observation and interview on 3/5/26 at 8:53 a.m. in Resident 40's room, with Treatment Nurse (TN) 2, Resident 40's wound care was observed. TN 2 stated Resident 40's wound care indicated to pack the wound with iodoform strip (sterile cotton gauze ribbons with iodoform, an antiseptic compound used to pack open or infected wounds), cover the iodoform strips with a small square of calcium alginate (a highly absorbent and sterile dressing) and cover the wound with a foam dressing. During a concurrent interview and record review on 3/5/26 at 9 a.m. Resident 40's treatment order dated 2/23/26 was reviewed with TN 2. Resident 40's treatment order indicated, Apply skin prep around the wound bed, calcium alginate on top and pack with 1/2 inch iodoform strips and apply foam dressing. TN 2 stated, The order is a bit confusing, the iodoform strips go on first, then the calcium alginate, that's what the surgeon wanted. TN 2 indicated wound rounds were conducted every Monday with the wound care specialist and the facility treatment nurse. During a review of Resident 40's Wound Care Plan (WCP), dated 3/2/26, the WCP indicated, Cleanse with normal saline (a sterile, isotonic solution), skin prep on periwound (area around the wound), collagenase [brand name] (a prescription, sterile enzymatic debriding agent used to remove dead tissue from severe burns and chronic skin ulcers, facilitating wound healing), alginate, pack with 1/2 inch iodoform packing (per surgeon) and cover with DSD (dry sterile dressing) foam. During a concurrent interview and record review on 3/5/26 at 3:08 p.m. with Licensed Nurse (LN) 4, (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 40's WCP dated 3/2/26 was reviewed. LN 4 confirmed the WCP form was the physician's updated treatment order. LN 4 stated, Every Wednesday there is a team meeting where residents' wounds are discussed, and treatment orders are reviewed and updated. LN 4 confirmed Resident 40's treatment orders had not been updated. During a concurrent interview and record review on 3/5/26 at 3:15 p.m. with TN 2, Resident 40's WCP dated 3/2/26 was reviewed. TN 2 confirmed Resident 40's wound care orders had not been updated after wound rounds on 3/2/26. TN 2 confirmed the wound care provided to Resident 40 since 3/2/26 was incorrect. TN 2 acknowledged the importance of updating treatment orders within a timely manner and as written, to ensure appropriate wound care was provided to prevent wounds from deteriorating. TN 2 stated physician orders should be followed as written to determine what treatment was working or if a different treatment might need to be started. During an interview on 3/6/26 at 11:50 a.m. with the Director of Nursing (DON) the DON stated licensed nurses were expected to follow physician orders as written and to contact the physician for clarification if needed. The DON acknowledged following the physician orders for wound treatment allowed the treatment nurse and physician to evaluate if the treatment was working and beneficial for the patient. During a review of the facility's policy and procedures (P&P) titled, Wound Care, dated 2021, the P&P indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.Verify that there is a physician's order for this procedure. 2. During a review of Resident 124's AR, dated 3/5/26 (print date), the AR indicated Resident 124 was admitted to the facility in February of 2026 with diagnoses which included bladder cancer and anemia (a condition where the body does not have enough healthy red blood cells). During a concurrent observation and interview on 3/5/26 at 9:16 a.m. with Treatment Nurse (TN) 1 providing wound care to Resident 124, TN 1 prepared treatment supplies at the treatment cart outside the room. TN 1 mixed zinc oxide (a type of topical medication) with A&D ointment (a type of topical medication enriched with vitamins A and D) in approximately equal proportions in the same medication cup. TN 1 brought the mixed ointments along with other supplies to the bedside and removed the old dressing and exposed Resident 124's wound at the tailbone. The wound measured approximately 1.5 centimeters (cm, unit of measurement). TN 1 cleansed the area with saline (salty water solution) moistened gauze and applied prepared zinc oxide and A&D ointment mixture to the wound. During a concurrent interview and record review on 3/5/26 at 2:16 p.m. with TN 1, Resident 124's Medications Administration Record (MAR) for March 2026 was reviewed. The MAR indicated the prescribed current treatment order of applying zinc oxide to the tailbone wound, but no orders for mixing in A&D ointment were found. TN 1 confirmed that there were no orders to mix these ointments. During an interview on 3/5/26 at 2:32 p.m. with LN 2, LN 2 stated that Resident 124 probably had a verbal order by the doctor to mix in zinc oxide and A&D ointments together, and it wasn't updated in the system. During an interview on 3/5/26 at 2:46 p.m. with Medical Doctor (MD 1), MD 1 confirmed that mixing of zinc oxide and A&D ointments for Resident 124's wound treatment was talked about. During a concurrent interview and record review on 3/6/26 at 2:05 p.m. with LN 2, Resident 124's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	original treatment order dated 2/27/26 was reviewed and indicated zinc oxide treatment. LN 2 confirmed that when TN 1 mixed zinc oxide with A&D ointments together on 3/5/26, she was not following the order as written, and nurses were expected to follow the orders. During a review of the facility's P&P titled, Medication and Treatment Orders, dated July 2016, the P&P indicated, Orders for medications and treatments will be consistent with principles of safe and effective order writing.All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order.Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order. During a review of the facility's P&P titled, Medication Administration-General Guidelines, dated March 2018, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.Medications are administered in accordance with written orders of the attending physician. During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require substantial amount of specific knowledge of the following: (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement treatment, disease prevention, or rehabilitative regiment . ordered by and within the scope of licensure of a physician .as defined by Section 1316.5 of the Health and Safety Code. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing 1997 State of California Department of Consumer Affairs. pp. 5)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations and interviews the facility failed to ensure the facility garbage and refuse was properly contained for a census of 87, when two out of two dumpsters were continually left open and uncovered. This failure had the potential for pest infestations, environmental hazards and foul odors to affect the residents' surrounding environment.Findings: During an observation on 3/3/26 at 7:33 a.m. in the small parking lot adjacent to the facility kitchen, a gray metal dumpster was observed with the lid open. During a concurrent observation and interview on 3/3/26 at 8:35 a.m. with the Registered Dietician (RD) and the Dietary Services Supervisor (DSS), in the small parking lot, two large dumpers were observed uncovered. The RD and DSS confirmed one dumpster contained garbage and refuse, and the other dumpster contained cardboard for recycling. The RD and DSS confirmed dumpster lids needed to be closed to keep rodents away. During an interview on 3/6/26 at 1:04 p.m. with the Administrator (Admin), the Admin acknowledged the dumpster lids were difficult to close and remained open and uncovered throughout the duration of the survey and confirmed the dumpster lids should be closed to keep pests away. The Admin acknowledged the facility did not have a policy and procedure for the containment and disposal of garbage and refuse containers.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure one of 24 sampled residents (Resident 42) was free from unnecessary medications, when Resident 42 was prescribed a psychotropic medication (any drug that affects behavior, mood, thoughts or perception) with no adequate indications. This failure had the potential to place Resident 42 at risk for adverse effects of the psychotropic medication.Findings: During a review of Residents 42's admission Record (AR), the AR indicated Resident 42 was admitted in late 2024 with diagnoses which included anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). During a review of Resident 42's Medication Review Report (MRR), dated 12/27/24, the MRR indicated. [Resident 42] has the Capacity to Make Medical Decision. During a review of Resident 42's Medication Review Report (MRR), dated 12/22/25, the MRR indicated a physician's order, Lorazepam [an antianxiety medication], 0.5 mg. tablet, by mouth every 8 hours as needed [PRN] for anxiety/Muscle Spasms m/b [manifested by] Fearful Feelings Affecting Quality of Life. The lorazepam order had no end date and was indefinite. During a review of Resident 42's Medication Administration Record (MAR), the MAR indicated the lorazepam 0.5 mg was administered 25 times after the medication review date of 1/5/26. During a concurrent observation and interview on 3/3/26 at 10:36 a.m. in Resident 42's room, Resident 42 was alert and verbally responsive, calm and in no distress. When asked about her care, Resident 42 indicated she had frequent pain but were handled and taken care of and had no concerns. During a concurrent interview and record review on 3/6/26 at 11:24 a.m. with Licensed Nurse (LN) 3, LN 3 confirmed Resident 42's lorazepam last order date was 12/22/25 and indicated the order should have been reviewed and could be ineffective or could cause adverse effects to Resident 42. LN 3 stated Resident 42's lorazepam could have needed a discontinuation for lack of use. During a concurrent interview and record review on 3/6/26 at 11:50 a.m. with Director of Nursing (DON), the DON indicated all PRN psychotropic medications needed to have a 14-day end date and confirmed Resident's 42 lorazepam did not have an end date. The DON stated, The nurse will monitor during the care of the resident [on psychotropic medications] and the doctor will recheck the resident every two weeks. expected every 14 days review with new orders or discontinuation of order.to avoid risk to the patients.make sure the medication is working and beneficial for the patient. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 2/25, the P&P indicated, 3. PRN orders for psychotropic medications are limited to 14 days.a. For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection control and prevention practices when materials that had contact with room surfaces were brought from Resident 124's and Resident 129's rooms back to the clean treatment cart. This failure increased the potential for the spread of infections among residents in a census of 87.Findings: During a review of Resident 124's admission Record (AR), dated 3/5/26 (print date), the AR indicated that Resident 124 was admitted to the facility in February of 2026 with diagnoses which included bladder cancer and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 129's AR, dated 3/5/36 (print date), the AR indicated that Resident 129 was admitted to the facility in February of 2026 with diagnoses which included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and ESRD (End Stage Renal Disease-irreversible kidney failure). During an observation on 3/5/26 at 9:16 a.m. in Resident 124's room, Treatment Nurse (TN 1) prepared treatment supplies and creams at the treatment cart outside the room. TN 1 brought a hand sanitizer bottle to the bedside table inside the room, along with wound treatment supplies. After TN 1 completed wound treatment for Resident 124, she moved the hand sanitizer bottle from the bedside table to the table by the sink and, upon exit, took it back to the top of the treatment cart. TN 1 wiped the surface of the cart down with sanitizing wipes and then settled the hand sanitizer bottle down on its surface. During an observation on 3/5/26 at 9:40 a.m. TN 1 continued to provide wound treatment care to the residents and moved from Resident 124's room to Resident 129's room. TN 1 carried one tube of 2.5% lidocaine & 2.5% prilocaine (percent concentration, local anesthetic medication) cream and a box of plastic food wrap film to the bedside and set them on the blanket by the feet end of the bed. Resident 129 was in a wheelchair by the bedside. TN 1 applied cream treatment to the left arm and wrapped the area with a plastic wrap piece, which she took out of the box. After completing treatment, TN 1 carried the tube of cream and the box of plastic wrap back to the treatment cart and put them into the drawers with other creams and clean supplies. During an interview on 3/5/26 at 9:48 a.m. with TN 1, TN 1 confirmed that the hand sanitizer bottle was placed on table surfaces inside Resident 124's room and taken back to the treatment cart. TN 1 also confirmed that the tube of cream and the box of plastic wrap were taken to Resident 129's room and set on the bed surface. TN 1 further confirmed that the cream tube and the plastic wrap box were taken back to the treatment cart and placed in the drawers with creams and supplies used for other residents in the facility. TN 1 agreed that taking items from residents' rooms back to the treatment cart increased the risk of cross-contamination. During an interview on 3/6/26 at 9:18 a.m. with the Infection Preventionist (IP), IP confirmed that bringing hand sanitizer, cream tube, and a box of plastic wrap from resident rooms to the clean treatment cart presented a risk of cross-contamination and the spread of infections among facility residents. During a review of the facility's policy and procedures (P&P) titled, Medication Administration-General Guidelines, dated 3/18, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure hazardous chemicals were secured and inaccessible to residents when a housekeeping closet containing cleaning chemicals was left unattended, with the key hanging on the wall next to the door. This deficiency increased the risk of unauthorized access to hazardous chemicals and potential harm to the residents. Findings: During a concurrent observation and interview on 3/6/26 at 1:13 p.m. with the Administrator (Admin) in the hallway near room [ROOM NUMBER], an unattended housekeeping closet with a key hanging next to the door was observed. The Admin opened the closet using the key on the wall, and the closet contained bleach and other cleaning chemicals. The Admin confirmed that leaving the key out increased the risk of unauthorized access to the chemicals, including confused residents who may be harmed by misuse of these chemicals. During a review of the facility's policy and procedure (P&P) titled, Hazardous Materials Management Program,, dated 1/15/98, the P&P indicated, Storage of hazardous chemicals will be in a locked closet with only authorized and qualified personnel having access.