STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555542	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer House	415 P Street Sacramento, CA 95814

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet professional standards of quality for three of 13 sampled residents (Resident 20, Resident 36 and Resident 2) when:Resident 20's medical record was not updated with the correct diagnosis;Resident 20's physician's order to wear a cervical collar was not followed;Resident 36's physician's order for weight monitoring was not followed; andResident 2's physician's order for daily weights was not followed.These failures resulted in an inaccurate medical record for Resident 20, Resident 36 and Resident 2 and had the potential for injury to Resident 20's neck. Findings: 1.Resident 20 was admitted to the facility in Fall of 2025 with diagnoses which included injury of the spinal cord in the neck area, fracture of the neck and lower back spine. A review of the Resident 20 Physician's Progress note (PN) dated 10/30/25 indicated, Late Entry: Psych Evaluation.medical history of significant.anxiety, depression, schizophrenia (a serious mental health condition that affects how people think, feel and behave).Patient was started on [Brand Name] (Olanzapine, a medication used to treat schizophrenia).during last visit. A review of Resident 20's Medication Administration Records (MAR, used to document medications taken by each individual) indicated, OLANZapine Oral Tablet 5 MG [a Milligram, unit of measurement] (Olanzapine) Give 1 tablet by mouth at bedtime for schizophrenia m/b auditory hallucinations -Start Date- 10/23/2025 2000. A review of Resident 20's Electronic Medical Records (EMR, an electronic record of health-related information on an individual) on 12/03/25 at 10:23 a.m., indicated no schizophrenia diagnosis in the medical diagnosis section. A review of Resident 20's Minimum Data Set (a standardized assessment tool used in nursing homes), dated 10/27/25, indicated Resident 20 had no diagnosis of schizophrenia. During an interview on 12/3/25 at 9:47 a.m., Resident 20 confirmed that he was aware of receiving Olanzapine. Resident 20 further stated that the medication was prescribed to help manage the voices he heard. Resident 20 also mentioned that he had previously been on this medication. During a concurrent interview and record review with License Nurse 3 (LN 3) on 12/3/25 at 10:13 a.m., LN 3 confirmed that Resident 20 had a physician's order for Olanzapine 5 mg at bedtime, prescribed for schizophrenia and hallucinations and confirmed that there was no documented diagnosis of schizophrenia in the resident's medical record, nor was the diagnosis reflected in the resident's MDS. LN 3 further emphasized the importance of maintaining accurate medical records and stated that all pertinent information should be documented in the resident's EMR. (continued on next page)

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	During a concurrent interview and record review with MDS coordinator, the MDS Coordinator stated that a resident's MDS should be routinely updated to accurately include current medical diagnoses. The MDS Coordinator further stated, We should have updated the patient's MDS and medical diagnosis information in our system. The MDS Coordinator confirmed that Resident 20 did not have a documented diagnosis of schizophrenia in either the MDS or the medical diagnosis section. During an interview with the Director of Nursing (DON) on 12/4/25 at 8:11 a.m., the DON emphasized the importance of documenting medical diagnoses in the resident's MDS. The DON also confirmed that Resident 20's MDS and medical records were missing a diagnosis of schizophrenia and stated that the MDS should have been updated accordingly. The DON further stated that maintaining complete and accurate documentation was a requirement and expectation under CMS guidelines. 2. Resident 20 was admitted to the facility in Fall of 2025 with diagnoses which included injury of the spinal cord in the neck area, fracture of the neck and lower back spine. A review of Resident 20's Minimum Data Set (a standardized assessment tool used in nursing homes), dated 10/27/25, indicated Resident 20 had an active diagnosis of Fractures and Other Multiple Trauma. A review of Resident 20's Order Summary Report (ORS) indicated, c-collar [cervical collar, instrument used to support the neck and spine and limit head movement after an injury] to be worn at all times d/t [due to] spinal injury, dated 10/17/25. A review of Resident 20's MDS, dated [DATE], indicated Resident 20 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating Resident 20 was cognitively intact. During a concurrent observation and interview on 12/3/25 at 9:47 a.m., Resident 20 was observed lying in bed without the prescribed cervical collar in place. When asked, Resident 20 stated, It was removed last night by a staff member, but they never came back to put it back on today. My doctor told me to wear it all the time. Resident 20 further stated that a nurse had visited him earlier that day but did not reapply the cervical collar. The cervical collar was observed resting on the left bedside table. Resident 20 later confirmed that the collar belonged to him. During a concurrent interview and record review with License Nurse 3 (LN 3) on 12/3/25 at 10:13 a.m., LN 3 confirmed that she did not offer the cervical collar to Resident #20. LN 3 stated that Resident 20 was required to always wear the cervical collar and stated that failure to do so could negatively impact the resident's healing process. LN 3 further explained that if Resident 20 was found without the cervical collar, staff should offer it to him and to encourage its use. During a concurrent observation and interview with the Director of Nursing (DON) in Resident 20's room on December 4, 2025, at 10:07 a.m., the DON confirmed that the physician's order for Resident 20 to wear a cervical collar was current and that the resident should be wearing it at all times. The DON confirmed that Resident 20 was observed in bed without the cervical collar in place and emphasized that physician orders were important and must be followed by staff. 3. Resident 36 was admitted to the facility in Summer of 2025 with diagnoses which included digestive system (includes the anus, appendix, esophagus, gallbladder, large intestine, liver, pancreas, rectum, small intestine, and stomach) surgery and malnutrition from inadequate protein and calorie intake. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 36's Medication Review Report (MRR) indicated, Resident does have the capacity to understand choices and make medical decisions. A review of Resident 36's Care Plan Conference (CPC) date 11/14/25 indicated, Patient has PEG tube [percutaneous endoscopic gastrostomy, is a small tube that goes through the skin and muscle into the stomach] in situ [in place]. A review of Resident 36's MRR indicated, admission weight. May weigh resident weekly or monthly as indicated. With order date of 5/4/25. A review of Resident 36's MRR indicated, NPO [nothing by mouth] diet NPO texture, NPO consistency, with order date of 5/4/25. A review of Resident 36's Care Plan (CP) indicated, [Resident's name] is at risk for altered nutritional status.Weigh on admission, monthly and as indicated., initiated on 5/4/25. The CP also indicated, Wt [weight] loss: [Resident's name] has weight loss.Resident will not have acute complications related to weight loss, Initiated on 7/4/25. A review of Resident 36's Weights and Vitals (WV) records on 12/3/25 indicated that the last documented weight was 105.4 lbs. (pounds, unit of weight measurements) on 7/9/25. No weight entries were recorded for the months of August, September, October, November, or December. During an interview on 12/3/25 at 12:49 p.m., Resident 36 reported that she was currently receiving tube feeding. She also stated that she did not recall the last time staff offered to obtain her weight and stated, They use a machine to lift me up so they can take my weight. Resident 36 indicated an interest in knowing her present weight. During a concurrent interview and record review with Licensed Nurse 3 (LN 3) on 12/3/25 at 1:23 p.m., LN 3 stated that Restorative Nursing Assistants (RNA) were primarily responsible for obtaining residents' weights, which were typically ordered weekly. She further stated that it was important to document residents' weights to monitor changes and support physician decisions, especially for residents with CHF (congestive heart failure). LN 3 confirmed that Resident 36's last recorded weight was on 7/9/25. During an interview with the Director of Nursing (DON) on 12/4/25 at 8:11a.m., the DON stated that weights should be obtained weekly or as ordered. She further stated that if a resident refused, staff were expected to document the refusal and report it to the dietitian or physician. The DON also stated that missing weight data could impact the accuracy of diagnoses and treatment decisions. The DON also confirmed that Resident 36's weight documents were missing for the months of August, September, October, November, and December. A review of the facility's policy and procedures (P&P) titled, PHYSICIANS ORDERS, indicated, It is the policy of this facility to ensure that:.treatments are administered according to standards of clinical practice upon the written order of a person duly licensed and authorized to prescribe. The Licensed Nurse or Therapist will note Physician's Orders upon receipt of orders and carry orders out in a timely manner. 4. Resident 2 was admitted to the facility late 2024 with diagnosis which included a condition where the kidneys were unable to filter waste and extra fluid from the body. Resident 2 received dialysis (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(process that removes waste and excess fluid from the body) twice a week. During a review of Resident 2's Order Recap Report [ORR], the ORR indicated an order was placed on 10/21/25 for weights to be taken daily. During a review of Resident 2's electronic health record (EHR), effective date ranges from 1/1/25-12/31/25, the EHR indicated the last weight was entered on 10/31/25. During a concurrent interview and record review on 12/3/25 at 11:32 a.m. with the DON and Nurse Consultant (NC) of Resident 2's EHR, the DON and NC confirmed Resident 2 had an order for daily weights which were not entered daily. The NC stated staff should be following the physician orders. The DON stated residents on dialysis should have an accurate weight in the EHR. During a review of the facility's policy and procedure (P&P) titled, Physicians Orders, undated, the P&P indicated, .Medications and treatments are administered according to standards of clinical practice. During a review of the facility's P&P titled, DIALYSIS SERVICES, undated, the P&P indicated, It is the policy of this facility to provide adequate and appropriate care to dialysis clients in coordination with the dialysis center, under the management and direction of the resident's attending physician.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure residents were assisted with activities of daily living (ADL, basic self-care tasks) to maintain personal hygiene for two of 13 sampled residents (Resident 33 and Resident 23) when nail care was not performed.These failures increased the risk of infection and had the potential to diminish the residents' sense of dignity. 1.Resident 33 was admitted to the facility mid-2023 with diagnosis which included stroke with loss of movement to one side of the body, and high blood sugar. During a review of Resident 33's Minimum Data Set (MDS, federally mandated resident assessment tool) dated 9/29/25, the MDS indicated resident 33 could not perform personal hygiene (wash/dry face and hands) without full assistance from a staff member. During an observation and interview on 12/1/25 at 9:28 a.m. with Resident 33 in her room, Resident 33's right hand fingernails were long with thick dried dark matter underneath each nail, there was dried dark matter around the cuticles. Resident 33 stated it would be nice if her nails were clean. During a concurrent observation and interview on 12/1/25 at 9:35 a.m. of Resident 33's fingernails with Licensed Nurse (LN 1), LN 1 confirmed Resident 33's nails were not clean. LN 1 stated she would expect nails to be cleaned and trimmed, because it was important for the residents to look clean, and for hygienic and infection control reasons. During an interview on 12/3/25 at 10:21 a.m. with the Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP was shown a picture of Resident 33's nails. The DSD/IP stated staff were supposed to clean all resident's hands before meals, she stated it was important to keep nails clean, and she would expect staff to clean and trim the nails of all residents every Sunday. During a review of Resident 33's Care Plan Report [CP], initiated 10/4/23 and 10/10/23, the CP's indicated, .Keep fingernails short .Monitor/document residents abilities for ADLs and assist as needed . During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living [ADL], Supporting, dated 3/18, the P&P indicated, .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently.including appropriate support and assistance with: hygiene. During a review of the facility's P&P titled, Fingernails/Toenails, Care of, dated 2/18, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. 2. Resident 23 was admitted to the facility in May of 2025 with diagnosis that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following non-traumatic intracerebral hemorrhage (bleeding in the brain) affecting left dominant side. A review of Resident 23's Care Plan (CP), revised on 11/3/25, indicated, Mr. [Resident 23] Is at risk for altered ADL's [activities of daily living].Provide assistance with ADLs as indicated. During an observation on 12/2/25 at 11:19 a.m., Resident 23's fingernails on his left hand were untrimmed and contained a dark brown substance underneath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/3/25 at 10:39 a.m., Resident 23's fingernails still had not been trimmed and cleaned by staff. During a concurrent observation and interview on 12/4/25 at 7:48 a.m. with Licensed Nurse 2 (LN 2), LN 2 confirmed that nail care had not been provided and stated that staff were expected to perform nail care on Sundays.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure that one of 13 sampled residents (Resident 4) were offered sufficient fluid intake to maintain proper hydration.This failure placed Resident 4 at risk for dehydration.Findings:Resident 4 was admitted to the facility in September of 2025 with diagnoses that included multiple sclerosis (a nervous system disease that affects the brain and spinal cord). A review of Resident 4's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/5/25, indicated Resident 4 required set-up assistance to drink fluids. A review of Resident 4's Care Plan (CP), revised 11/13/25, indicated, Ms. [Resident 4] is at risk for fluid volume deficit (Dehydration) R/T [related to] impaired mobility.offer fluids as tolerated or as indicated by diet order.A review of Resident 4's fluid intake sheet indicated Resident 4 had 240 milliliters (ml, 240ml of fluid is equal to one cup) on 12/3/25 and 240ml on 12/1/25.During a concurrent observation and interview on 12/1/25 at 1 p.m., Resident 4 was observed lying in bed with no water available within reach. Resident 4 stated she was thirsty and wanted water. During a concurrent observation and interview on 12/2/25 at 8:43 a.m., with Certified Nursing Assistant 3 (CNA 3), Resident 4's bedside table was not within her reach and did not have any water or fluid available for her to drink. Resident 4 indicated that she was thirsty and nodded yes when asked if she wanted water. CNA 3 confirmed that Resident 4 did not have water within reach despite Resident 4 being thirsty. During an observation on 12/2/25 at 3:30 p.m., Resident 4's water cup was placed on her nightstand, which was not reachable by Resident 4. Resident 4 nodded yes when asked if she was thirsty. During an observation on 12/3/25 at 10:34 a.m., Resident 4 did not have water available, and her bedside table was not within reach. During an interview on 12/3/25 at 3:27 p.m. with the Director of Nursing (DON), the DON indicated she expected facility staff to offer water to residents for hydration and comfort. During a review of the facility Policy and Procedure (P&P) titled, Hydration - Clinical Protocol, revised 11/10, the P&P indicated, The staff will provide supportive measures such as providing fluids and adjusting environmental temperature.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe medication storage for a census of 49 when expired medications were available for residents use and medications were not stored properly.These failures had the potential for residents to receive ineffective medications and placed residents at risk for cross contamination. Findings: During a concurrent observation and interview on 12/2/25 at 10:33 a.m. of the medication cart with Licensed Nurse (LN 2), a nasal spray and eye drops stored next to oral medications were observed. LN 2 confirmed the findings and stated the nasal sprays and eye drops should not be mixed with oral medications. Also, a clear plastic bag labeled only with a resident's first name contained an oral inhaler and a nasal spray was observed. LN 2 confirmed the findings and stated the inhaler, and nasal spray should not be stored together due to cross contamination.During a concurrent observation and interview on 12/2/25 at 11:30 a.m. of the medication supply closet with LN 2 multiple vitamins and anti-diarrhea medications were found expired. LN 2 confirmed the findings and stated the medications needed to be discarded so residents would not receive expired medications.During an interview on 12/3/25 at 3:33 p.m. with the Director of Nursing (DON), the DON was shown pictures of expired medications and items stored together in the medication cart. The DON confirmed the findings and stated the different medications should not be stored together and expired medications should have been discarded because of the potential for cross contamination and infection.During a review of the facility policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/23, the P&P indicated, Medication Storage: if the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding retuning or destroying these items.Medications are stored in an orderly manner in cabinets, drawers.Medications for external use.are clearly marked as such, and are stored separately from other medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure food was prepared and stored in a safe and sanitary manner for a census of 48 residents who received food prepared from the kitchen, when:1. Trash can by the hand washing station was found without plastic liner with used gloves, paper towels and coffee creamer cups;2. Food debris was found on several kitchen utensils inside the plastic tray, while the bottom of the tray designated for storing clean kitchen utensils contained visible dirt and food debris;3. Several plastic water pitchers and metal pans were found stacked wet and stored at the clean and ready-to-use storage areas;4. Water collected in the plastic pan under refrigerator one's evaporator located on the top of the metal shelf used to store resident foods;5. Liquid was observed leaking from the bowl onto the base and surrounding countertop during food processor operations. Staff used a wiping cloth taken from another countertop to clean the liquid from the bowl, base, drive shaft, and counter. The same cloth was reused to wipe these areas on two separate occasions,6. Water was observed leaking from the hot water faucet at the coffee station onto the bottom of the metal shelf, where clean resident coffee urns were stored. A mixture of clear and brown liquid was observed on the shelf surface beneath the urns; And7. Sanitized dishes were placed near the handwashing station and directly beneath the soap dispenser. A white foamy substance was observed on the tray holding the sanitized coffee cups.These failures decreased the facility's potential to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.Findings:1. During the initial kitchen tour and a concurrent observation and interview with Dietary Aide 2 (DA 2) on 12/1/24 at 8:35 a.m., a trash can located under the handwashing sink was found without a plastic liner and contained several used gloves, paper towels, and several coffee creamer cups. DA 2 confirmed the findings and stated, Normally, they should put a garbage bag inside and it should not have any trash in it, adding that the liner should have been replaced after the previous shift disposed of trash.During an interview with the Dietary Consultant (DC) on 12/3/25 at 2:50 p.m., the DC stated that trash cans and bins should not be overflowing and must be kept clean. The DC emphasized that plastic liners should be replaced each time trash was removed, and no trash should be disposed of in bins without liners. The DC further stated that failing to follow these practices may lead to cross-contamination and attract pests in the kitchen.A review of the facility document titled Job Description, dated 2023, the document indicated, Position: Dietary Aide. Cleaning as assigned. Keep work area clean,A review of the facility policy and procedures (P&P), titled Sanitation, dated 2023, indicated, The kitchen staff is responsible for all the cleaning.2. During a concurrent observation and interview with DA 2 on 12/1/25 at 8:45 a.m., food debris were found on several clean kitchen utensils inside a plastic tray. The bottom of the tray used for storing clean utensils contained visible dirt and food residue. DA 2 confirmed the findings and stated that resident food should not be prepared using those utensils.During an interview with the DC on 12/3/25 at 2:50 p.m., During an interview with the DC on 12/3/25 at 2:50 p.m., the DC stated that kitchenware and utensils must be free of food debris and residue. The DC also emphasized that kitchenware and utensils should appear visibly clean before being stored. The DC further explained that storing unclean items may lead to food safety concerns and cross-contaminationA review of the facility P&P titled, Dishwashing, dated 20123 (SIC), the P&P indicated, Gross food particles shall be removed by carefully scraping and pre-rinsing in running water.A review of the facility P&P titled, Sanitation, dated 2023, the P&P indicated, All utensil, counters, shelves, and equipment shall be kept clean maintained in good repair.3. During the initial kitchen tour and a concurrent interview with the DC on 12/1/25 at 9:12 a.m., several plastic pitchers and metal pans were observed stacked while still wet on the clean dish rack. The DC confirmed the findings and stated that these items should be completely dry before being stored. The DC further stated that using unsanitized or dirty dishes during food preparation could lead to foodborne illness and presents a food safety concern. A review of the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility P&P titled, Dishwashing, dated 20123 (SIC), the P&P indicated, Dishes are to be racked loosely without overlapping. Dishes are to be air dried in racks before stacking and storing.4. During a concurrent observation of the resident food refrigerator (refrigerator 1) and an interview with the Dietary Manager (DM) on 12/1/25 at 9:29 a.m., a plastic pan more than halfway filled with water leaking from the bottom of the evaporator was found placed on top of the metal shelf used to store resident food. The DM confirmed the findings and stated that the evaporator had been broken for some time but could not recall when the problem beganDuring a concurrent observation and interview with the Maintenance Supervisor (MS) on 12/1/25 at 9:44 a.m., inside Refrigerator 1, the MS stated it was the first time he became aware of the evaporator leaking and denied prior knowledge of the issue. The department made multiple attempts to obtain maintenance logs for the refrigerators and freezers from the MS but did not receive any documentation.During an interview with the DC on 12/3/25 at 2:50 p.m., the DC confirmed that the evaporator inside Refrigerator 1 was leaking and stated that the collected water should be discarded immediately. The DC further stated that the issue should have been reported and repaired promptly because the standing water may pose sanitation concerns and could affect the refrigerator's internal temperature, potentially compromising food safety.A review of the facility P&P titled, Sanitation, dated 2023, the P&P indicated, All equipment shall be maintained as necessary and kept in working order. The Maintenance Department will assist. as necessary in maintaining equipment.A review of the facility P&P titled, Maintenance Service, dated 12/2009 indicated, The maintenance director is responsible for maintaining the following records/reports. Maintenance Schedules.5. During the initial kitchen tour observation on 12/1/25 at 10:30 a.m., the cook was operating the food processor to puree resident food when liquid was observed leaking from the bottom of the processor bowl onto the base and countertop. The cook used a wiping cloth taken from a different countertop to clean the bowl, base, and counter, then placed the used cloth near the food processor. Without removing gloves or washing hands, the cook continued to puree food. When the liquid leaked again during operation, the cook reused the same cloth to wipe the bowl, base, drive shaft, and countertop, and again resumed food preparation without handwashing or changing gloves.During a concurrent observation and interview with the DC on 12/2/25 at 11:12 a.m., the DC confirmed the observation and stated that leaking liquid could pose a risk of food contamination. The DC stated that kitchen staff must wash their hands and change gloves each time they touch anything other than food during preparation and stated, they need to follow the facility protocol [hand washing].A review of the facility P&P titled, Sanitation, dated 2023, the P&P indicated, The FNS Director is responsible for instructing employees in the fundamental of sanitation in food service. All equipment shall be maintained as necessary and kept in working order. equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas. All Food and Nutrition Services staff shall know the proper hand washing technique. Note that hands must be thoroughly washed and clean.6. During a concurrent observation and interview with DA 2 on 12/2/25 at 11:01 a.m., water was observed leaking from the hot water faucet at the coffee station onto the bottom of the metal shelf where clean resident coffee urns were stored. A mixture of clear and brown liquid was present on the shelf surface beneath the urns. DA 2 confirmed the findings and stated, It has been leaking for 3 months now. [Maintenance Supervisor's name] put up a little spout to make sure dripping water goes into the bucket, but they should have fixed that properly.During an interview with the DC on 12/3/25 at 2:50 p.m., the DC confirmed the observation and stated that broken kitchen equipment poses food safety risks and may interfere with accurate food production processesA review of the facility P&P titled, Sanitation, dated 2023, the P&P indicated, All equipment shall be maintained as necessary and kept in working order. All utensils, counters, equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas.7. During a concurrent observation and interview with DA 2 on 12/1/24 at 8:35 a.m., sanitized plastic coffee cups were found placed on a tray directly beneath the soap dispenser near the handwashing station. A white foamy substance was observed on (continued on next page)

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	555542	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer House	415 P Street Sacramento, CA 95814

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the tray holding the cups. DA 2 confirmed the findings and stated that the cups were clean but should not have been stored in that location.During a concurrent observation and interview with the Nurse Consultant (NC) on 12/2/25 at 9:38 a.m., multiple sanitized dishes were observed lined up on a dishwasher tray placed on the countertop near the handwashing station. DA 1 was then observed washing hands at the station and water splashes were seen reaching the sanitized dishes nearby. NC confirmed the findings and stated that the clean dishes were placed too close to the handwashing area.During an interview with the DC on 12/3/25 at 2:50 p.m., the DC confirmed that sanitized dishes should not be placed near the handwashing area due to the risk of cross-contamination. The DC explained that when staff wash their hands, splashes may contaminate nearby clean dishes. A review of the facility P&P titled, Sanitation, dated 2023, the P&P indicated, All utensils, counters, equipment shall be kept clean.

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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 observations, interviews, and record review, the facility failed to follow proper infection control practices for two of 13 sampled residents (Resident 19 and Resident 23) when:1. Resident 23's tube feeding syringe (a large syringe used to administer nutrition through a tube placed in the stomach) was not labeled with a date, and2. Staff did not put on a gown while providing care to Resident 19 and Resident 23 who were on Enhanced Barrier Precautions (EBP, precautions taken to prevent the spread of disease and require the use of a gown and gloves).These failures had the potential to increase the spread of infection. Findings:1. Resident 23 was admitted to the facility in May of 2025 with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following non-traumatic intracerebral hemorrhage (bleeding in the brain) affecting left dominant side and dysphagia (trouble swallowing). During a concurrent observation and interview on 12/2/25 at 1:06 p.m. with Licensed Nurse 2 (LN 2), LN 2 was administering a tube feeding bolus (tube feeding given using a syringe instead of a pump; it is considered open-system) to Resident 23 with an unlabeled syringe. LN 2 confirmed that the syringe was unlabeled and indicated that tube feeding syringes should be labeled with a date. During an interview on 12/3/25 at 11:20 a.m. with the infection preventionist (IP), the IP indicated that tube feeding syringes should be labeled with a date to prevent staff from using it beyond 24 hours, as doing so could increase the risk of infection.During a review of the facility policy and procedure (P&P) titled, Enteral Feedings - Safety Precautions, revised 11/18, the P&P indicated, Change administration sets for open-system enteral feedings at least every 24 hours, or as specified by the manufacturer. 2. Resident 19 was admitted to the facility in November of 2025 with diagnoses that included pneumonia (an infection that affects one or both lungs and it causes the air sacs of the lungs to fill up with fluid or pus).A review of Resident 19's Care Plan (CP), revised on 10/2/25, indicated, Monitor adherence to EBP guidelines especially gown and gloves during high contact activities.During a concurrent observation and interview on 12/2/25 at 8:37 a.m., with CNA 5, CNA 5 was replacing Resident 19's soiled dressing used to cover his tracheostomy (an opening through the neck into the windpipe) scar. CNA 5 was not wearing a gown during the dressing change. CNA 5 verbally confirmed he was not wearing a gown and indicated staff should wear a gown if they provided direct care to Resident 19.A review of Resident 23's CP, revised on 11/3/25, indicated, Monitor adherence to EBP guidelines especially gown and gloves during high contact activities.During a concurrent observation and interview on 12/2/25 at 1:06 p.m. with LN 2, LN 2 did not wear a gown while administering a tube feeding bolus (tube feeding given using a syringe instead of a pump) to Resident 23. LN 2 confirmed that administering a tube feeding bolus to Resident 19 requires wearing a gown and acknowledged that she should have worn one prior to providing care.During an interview on 12/3/25 at 3:27 p.m. with the Director of Nursing (DON), the DON indicated she expected facility staff to follow the EBP guidelines when performing direct care for residents on EBP. The DON also indicated EBP were used to help prevent the transmission of disease-causing organisms. During a review of the facility P&P titled, Enhanced Barrier Precautions, revised 12/24, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs).Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include.device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.).wound care (any skin opening requiring a dressing).

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interviews, and record review, the facility failed to implement an effective pest control program to prevent cockroach infestation in the kitchen, dining hall, and surrounding areas when multiple cockroaches were observed in these locations.This failure posed a potential health risk to the 49 residents due to exposure to pests. Findings:During an interview with Resident 62 on 12/1/25 at 12:19 p.m., Resident 62 indicated that she woke up one night to find a cockroach on her body and after turning on the lights, she observed a large cockroach on the bathroom wall stating, We turned on the lights, and it was a big cockroach!During an interview with Resident 28 on 12/1/25 at 12:23 p.m., Resident 28 stated that she observed cockroaches crawling on the walls in the dining hall.During an interview with the Dietary Aide (DA 2) in the Kitchen on 12/1/25 at 2:35 p.m., DA 2 stated that the facility underwent a major pest control spray last month and that pest control services had been since visiting weekly to perform additional spraying in the kitchen. DA 2 further stated that cockroaches were entering the kitchen via the meal carts used to transport trays to and from resident rooms. DA 2 stated, They came upstairs and got in here [kitchen] via the carts. The facility's kitchen was located on the first floor of the building while the residents' living area was on the sixth floor with a residential apartment positioned between these levels.A concurrent observation and interview was conducted on 12/1/25 at 3:27 p.m., with the Nurse Consultant (NS) in the kitchen. The NS confirmed the presence of cockroaches under the sink behind the exposed pipes. The NS stated, We have been spraying them, but because there's assisted living upstairs, we don't know what's going on up there. It's a shared building. During an observation of the countertop and cabinets inside the dining hall on 12/2/25 at 3:25 p.m., a cockroach was seen crawling along the counter wall. The cockroach then scurried into an opening located between the countertop and the counter wall.During a concurrent observation and interview with Licensed Nurse 3 (LN 3) on 12/3/25 at 10:03 a.m., a cockroach was observed emerging from behind the medication cart and crawled on the wall near the entrance to the residents' dining area. Both the Department and LN 3 witnessed the presence of the cockroach during the observation.A review of facility documents from [Pest Control Vendor Name] indicated that pest control services were provided to the facility on the following dates: October 30, 2025, November 13, 2025, and November 20, 2025. The document also indicated, Target Issues: Cockroaches.A review of facility document from (agency name) titled, Official Inspection Report OIR dated 12/2/25, the OIR indicated, .13 live adult German cockroaches found between cabinet edge and countertop in the 6th floor dining room kitchenette. Fecal focal points found on sides of cabinet and inside the cabinet. Insulation around water pipes under dishwasher contributing to cockroach harborage. During an interview with Dietary Consultant (DC) on 12/3/25 at 3:51 p.m., the DC stated that cockroaches should not be present in the facility's kitchen, as they pose a risk of contaminating resident food and may lead to foodborne illness. The DC further stated, They [the facility] cannot have it [cockroaches] here in the facility.A review of the facility's Policy and Procedure (P&P) titled, Pest Control dated 5/2008 indicated, Our facility shall maintain an effective pest control program. to ensure that the building is kept free of insects and rodents. During a review of the facility's P&P titled, Homelike Environment, Revised 2/21, the P&P indicated, The Facility staff and management provides, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics may include:. Clean and sanitary environment.

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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 interview and record review, the facility failed to ensure accurate reconciliation of controlled medications for two of 13 sampled residents (Resident 56 and Resident 57) when random controlled medication audits did not reconcile.These failures resulted in the facility not having an accurate accountability of controlled substances and increased the potential for diversion. The controlled medication record for two random residents (Resident 56 and Resident 57) who received as needed controlled medications were requested for review during the survey.During a review of Resident 57's Medication Administration Record (MAR) dated 11/1-12/31/25, Resident 57 had orders for Hydromorphone (opioid analgesic) 4 mg to be given every two hours as needed for pain.During a review of Resident 57's CONTROLLED DRUG RECORD [CDR], [a form that keeps count of the number of narcotics dispensed to a resident], entries dated from 11/30/25-12/2/25, the CDR indicated one tablet of Hydromorphone 4 mg was removed from the medication card (pre-packaged medications dispensed from a pharmacy) on 11/30/25 at 11 p.m. This medication was not documented as given on the MAR.During a review of Resident 57's MAR dated 12/1/25, the MAR indicated Resident 57 had received Hydromorphone 4mg at 12:33 a.m., this medication was not documented as given in the CDR.During a review of Resident 56's MAR dated 11/1/25-11/30/25, Resident 56 had orders for Oxycodone (opioid analgesic) 5 mg to be given every 6 hours as needed for pain.During a review of Resident 56's CDR, the CDR indicated one tablet of Oxycodone 5 mg was removed from the medication card on 11/29/25 at 3:27 p.m. This medication was not documented as given on the MAR.During a review of Resident 56's MAR dated 11/25/25, the MAR indicated Resident 56 had received Oxycodone 5 mg at 3:42 a.m., this medication was not documented as given in the CDR.During a concurrent interview and record review on 12/2/25 at 2:20 p.m. with the Director of Nursing (DON) of Resident 56 and Resident 57 CDR and MAR, the DON confirmed the missing documentation on the CDR and MAR. The DON stated she would expect the CDR to be signed, It should be an accurate record.During a review of the facility's policy and procedure (P&P) titled, Controlled Substances, dated 4/07, the P&P indicated, The facility shall comply with all laws and regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule ll and other controlled substances.