

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Meadowood A Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3110 Wagner Heights Road Stockton, CA 95209	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to provide food preparation and storage, as well as maintain kitchen equipment in accordance with professional standards for food safety for the 67 residents who ate facility prepared meals when: 1. One (1) box of carrots in the kitchen freezer was found without an open date;2. One (1) tote of thickener powder was found expired;3. Four (4) non-stick pans were discovered with significant scratches and areas where the non-stick coating was missing and;4. A blender stirring rod was found with deep gouges and broken with a piece of plastic missing. These failures had the potential to put residents at risk for foodborne illnesses and hazards. Findings: 1. During a concurrent observation and interview on 6/23/26, during the initial kitchen tour at 9:16 a.m., with the CDM (Certified Dietary Manager) in the kitchen freezer, one (1) box of carrots was found without an open date. The CDM confirmed that the box should have had an orange label on it with an open date. During an interview on 6/26/26 at 8:57 a.m., the CDM stated that any food items needed to be labeled properly and should have an open date. According to the CDM, once a product is opened and exposed to air, it begins to deteriorate. The CDM stated that the best practice is to write an open date whenever a product is opened. The CDM additionally stated that the absence of an open date presents safety concerns for residents, as food may be used beyond its recommended period, potentially increasing the risk of foodborne illnesses. A review of the facility's Policy and procedure (P&P) titled, PRODUCTION, PURCHASING, STORAGE, revised 1/26, the P&P indicated, .Cover, label and date unused portions and open packages. Use the Medvantage/Freshdate labeling system or complete all sections on an orange label. Products are good through the close of business on the date noted on the label.Date and rotate items; first in, first out (FIFO). 2. During a concurrent observation and interview on 6/23/26, during the initial kitchen tour at 9:22 a.m., with the CDM in the kitchen, one (1) tote of thickener powder was found with an expiration date of 6/18/26. The CDM confirmed that the thickener powder should have been discarded after its expiration date. During an interview on 6/26/26 at 9:07 a.m., the CDM stated the thickener powder should have been thrown away when it expired. The CDM stated that an expired thickener powder would not thicken the food properly and could put the residents at risk of aspiration. A review of the facility's P&P titled, PRODUCTION, PURCHASING, STORAGE, revised 1/26, the P&P indicated, .Foods past the use by, sell-by, best -by, or enjoy by date should be discarded.Discard food past the use-by or expiration date. 3. During a concurrent observation and interview on 6/23/26, during the initial kitchen tour at 9:27 a.m., with the CDM in the kitchen, four (4) non-stick fry pans were found with signs of over usage (e.g. scratched, discolored, dented and coating worn off cooking surface). The CDM confirmed the fry pans showed signs of over usage and should have been replaced. During an interview on 6/26/26 at 9:15 a.m., the CDM stated that scratched fry pans could lead to cross-contamination and should have been replaced. The CDM explained that kitchen staff were (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	utilizing metal spatulas with non-stick pans, rather than the designated high-temperature plastic spatulas intended for non-stick surfaces. The CDM said this put the residents at risk as Teflon flakes could have come off and go in the food and make it a physical hazard. The CDM stated it was very important to use proper equipment for safely cooking and preparing the food. A review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code, section 4-101.18, titled Nonstick Coatings, Use Limitation, indicated, .Multiuse KITCHENWARE such as frying pans, griddles, sauce pans, cookie sheets, and waffle bakers that have a perfluorocarbon resin coating shall be used with nonscoring or nonscratching UTENSILS and cleaning aids. A review of the US FDA 2022 Food Code, section 4-202.11, titled Food Contact Services, indicated, .Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts. 4. During a concurrent observation and interview on 6/23/26, during the initial kitchen tour at 9:30 a.m., with the CDM in the kitchen, a blender food stirring rod was found to have been extensively used when it was found with deep gouges and a missing piece of plastic. During an interview on 6/26/26 at 9:25 a.m., the CDM stated the blender rod was overly used and should have been replaced. The CDM stated that failing to promptly replace the food stirring rod exposed residents to potential harm, as fragments of plastic could have contaminated the food and posed a physical risk. The CDM further stated that it was important to keep the equipment in good condition to prevent any hazards to the residents. A review of the US FDA 2022 Food Code, section 4-202.11, titled Food Contact Services, indicated, .Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts. A review of the US FDA 2022 Food Code, Annex 7, titled Good Retail Practices (GRPs), indicated, .Good Retail Practices (GRPs) are systems to control basic operational and sanitation conditions within a facility, and if not controlled, they could be contributing factors to foodborne illness by introducing hazards (biological, chemical and physical), into the end product, either directly or indirectly. For example, equipment in disrepair, such as a cutting board with deep grooves/cuts, makes effective cleaning difficult or impossible, and thereby could introduce a bacterial hazard onto food that comes into contact with the board.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control practices for a census of 67 when:1. Staff did not wear an isolation gown (protective clothing to prevent transfer of infectious materials) and gloves before entering a designated isolation room (for exposed or suspected residents with infection) of Resident 93;2. Staff did not perform hand hygiene after blood pressure check and proceeded to prepare medications for Resident 42;3. Staff picked up a tablet of aspirin with her bare hands during medication preparation for Resident 65;4. Two pill cutters were found with white pill residues during medication cart inspection. These deficient practices created a potential for cross -contamination and transmission of infections. Findings: 1. A review of Resident 93's clinical record titled, Resident Face Sheet, indicated Resident 93 was admitted to the facility in 2026, with diagnoses of, but not limited to enterocolitis (inflammation of small and large intestine) due to Clostridium difficile (c-diff- a disease-causing bacterium that infects the large intestine causing infection and watery diarrhea). During an observation on 6/25/26, at 4:27 p.m., a room in the sequoia wing (residents' space in the facility) hallway 3 was labeled with contact precaution sign (to alert those entering the room regarding a possible infection and what type of personal protective equipment (PPE) was required to help stop the spread of germs from one person to another) was posted at the door outside Resident 93's room. The Resident Assessment Coordinator (RAC) was observed without PPE sitting on Resident 93's bed and touched Resident 93 who was under the Contact Isolation Precautions. During a concurrent observation and interview on 6/25/26 at 4:25 p.m., the Treatment Nurse (TN) confirmed that Resident 93 was on contact isolation precautions. The TN also confirmed that RAC was sitting on Resident 93's bed without wearing PPE. When asked TN about the risk of not following contact isolation precautions, the TN explained that the RAC could become contaminated and potentially spread infection throughout the facility. During an interview with the RAC on 6/25/26, at 4:30 p.m., the RAC confirmed that she was sitting on Resident 93's bed and she was not wearing gown and gloves. The RAC also confirmed that Resident 93 was on contact isolation precautions. During an interview on 6/26/26 at 2:46 p.m., with the Infection Preventionist (IP), the IP stated that staff were expected to wear isolation gowns and gloves prior to entering any contact isolation room. The IP explained that the RAC must sanitize her hands and don (to put on) the required gown and gloves before entering Resident 93's room. The IP stated that staff must avoid sitting on residents' beds or touching any personal belongings or residents with bare hands while in a contact isolation room. The IP explained that it was important for facility staff to follow contact isolation precautions to protect everyone in the facility and not following these precautions could lead to staff getting contaminated and spreading infection to residents. During an interview on 06/25/2026 at 4:37 p.m., the Director of Nursing (DON) confirmed that Resident (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 2 sampled residents (Resident 6) using a Continuous Glucose Monitor (CGM - a device that continuously checks a person's blood sugar levels throughout the day and night), when: 1. Resident 6 did not have a complete physician order for the use of a CGM; 2. There was no process to verify the quality control (a process to make sure something works correctly) and accuracy (being correct) of the device, and; 3. There was no documentation to ensure the nursing staff demonstrated competency (having the knowledge and skills to do a job correctly and safely) in the use and management of the CGM. This deficient practice had the potential to result in inaccurate blood glucose readings, inappropriate clinical decision-making, delayed identification of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar), and/or medication errors including inappropriate insulin (a medicine that helps control blood sugar) administration. Findings: Review of Resident 6's admission RECORD, indicated Resident 6 was admitted to the facility with a diagnosis of, but not limited to diabetes mellitus (DM - a condition where the body cannot control blood sugar levels). Review of Resident 6's Medication Order, dated 10/24/24, indicated, . Order Description: Semglee (insulin glargine [a long-acting insulin medicine used to control blood sugar]) at bedtime. Further review of Resident 6's Medication Order, dated 10/22/24, indicated, . Order Description: Novolin R (insulin regular human [a fast-acting insulin medicine used to lower high blood sugar]), per Sliding scale [the amount of medicine depends on the person's blood sugar level]. Frequency: before meals and at bedtime. Special Instructions: for DM - if BG [blood glucose] less than 70 mg/dl [unit of measurement] and alert, hold insulin. if BG less than 70 mg/dl and unresponsive initiate hypoglycemia injection and notify MD [Medical Doctor], and notify MD if BS [blood sugar] greater than 449. Review of Resident 6's General Order, dated 3/3/25, indicated, . Order Description: change out the [Brand Name Continuous Glucose Monitor - a device that continuously checks a person's blood sugar levels throughout the day and night]. Frequency: As Needed. Review of Resident 6's facility provided hospital document titled, [Name of Hospital] Order Details, dated 6/7/23, indicated, . Order Questions. Does the member have a diagnosis of Diabetes Mellitus? Yes. Is the member insulin treated? Yes. Which do you want to order? [Brand Name Continuous Glucose Monitor - a device that continuously checks a person's blood sugar levels throughout the day and night]. Review of Resident 6's clinical record titled, Care Plan, in the section titled Problem, dated 10/23/24, indicated, Resident at risk for complications such as hypo/hyperglycemia related to diagnosis of diabetes mellitus. Further review of the document under the section titled, Goal, indicated, Resident will have absence of signs or symptoms of hypo/hyperglycemia. Review of the document under the section titled, Approach, indicated, . administer medications as ordered. monitor blood glucose as ordered. monitor for signs of hyperglycemia. monitor for signs of hypoglycemia. monitor resident during peak action time for diabetic medication(s). During a concurrent observation and interview on 6/24/26, at 9:44 AM, with Resident 6 in her room, Resident 6 was observed lying in bed. A CGM sensor was observed securely attached to the posterior (back) of Resident 6's left arm. Resident 6 stated she had diabetes mellitus and had been using a CGM sensor for approximately two years. Resident 6 explained that she preferred the CGM because it eliminated the need for frequent finger-stick (a small finger prick to check blood sugar) blood glucose testing. Resident 6 stated that (Name of Hospital) supplied the CGM sensors and related supplies, and that since her admission to the facility, the supplies had continued to be delivered to the facility. Resident 6 further stated the nursing staff replaced the sensor approximately (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every 14 days. Resident 6 stated she had not observed the nursing staff performing finger-stick blood glucose testing to verify the quality, accuracy, or reliability of the CGM readings. Resident 6 further stated that based on her observations, the nursing staff relied on the glucose readings displayed by the CGM receiver when determining her blood glucose level and administering insulin. Resident 6 stated she was unsure whether the nursing staff had reviewed the manufacturer's instructional pamphlet accompanying the CGM sensor. Resident 6 further stated that, according to her physician, the manufacturer's instructions contained important information regarding the proper use, operation, and performance of the device. Resident 6 stated that obtaining accurate blood glucose readings was important because her blood glucose levels fluctuated and inaccurate readings could affect the amount of insulin administered. During a concurrent interview and record review on 6/24/26, at 10:10 AM, with the Resident Assessment Coordinator (RAC), Resident 6's electronic health record (EHR) was reviewed. The RAC stated that the facility's in-house glucometer underwent routine quality control checks (tests to make sure equipment or devices are working correctly) by the night shift licensed nurses. The RAC explained that performing quality control testing was important to ensure the glucometer provided accurate blood glucose readings, as inaccurate results could lead to administration of an incorrect insulin dose and place the resident at risk for hypoglycemia or hyperglycemia. The RAC confirmed there was no physician's order authorizing the use of the CGM. The RAC further confirmed there was no physician's order directing nursing staff to use the CGM glucose readings as the basis for insulin administration, and no physician's order or facility protocol identifying when or how to verify the quality, accuracy, or reliability of the CGM readings, such as comparison with finger-stick blood glucose testing. The RAC stated that it was important to obtain a physician's order addressing the use of the CGM because the order would provide clear clinical direction for nursing staff regarding its use, monitoring requirements, and insulin administration. The RAC further stated that licensed nurses were responsible for notifying the physician of significant clinical findings, obtaining appropriate physician orders, and ensuring those orders were accurately implemented and documented. The RAC stated that complete and specific physician orders promoted consistent nursing practice and were essential to ensuring Resident 6's safety and appropriate diabetes management. During a concurrent interview and record review on 6/25/26, at 9:56 AM, with Licensed Nurse (LN) 4, LN 4, Resident 6's EHR was reviewed. LN 4 confirmed that Resident 6 had physician orders for both short-acting and long-acting insulin. LN 4 further confirmed that Resident 6 currently had a CGM sensor attached to her left arm. LN 4 stated that nursing staff monitored Resident 6's blood glucose levels four times daily by using the glucose readings obtained from the CGM and used those readings as the basis for insulin administration. Upon further review of the EHR, LN 4 confirmed there was no physician's order authorizing the use of the CGM glucose readings for blood glucose monitoring or directing nursing staff to use those readings to determine insulin administration. LN 4 stated that the physician should have been notified to obtain clarification and appropriate physician orders regarding the use of the CGM. LN 4 stated that, based on the prompt displayed on the CGM monitor, the sensor remained in place for approximately 14 days before replacement. LN 4 further stated there was an order dated 3/3/25, to Change out [Brand Name CGM] sensor as needed. LN 4 stated that the order was not sufficiently specific because the sensor was routinely replaced every 14 days rather than on an as needed basis. LN 4 further stated physician orders needed to be clear, complete, and specific to provide consistent direction for all licensed nurses and to ensure uniform implementation of care. LN 4 confirmed that there was no specific physician order identifying the frequency for sensor replacement, parameters for use of the CGM, or instructions for verifying the accuracy of the CGM readings. LN 4 stated that she could not recall (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receiving an in-service or competency training regarding the use and management of the CGM device. During an interview on 6/26/26, at 8 AM, with LN 5, LN 5 stated that she had never received an in-service or competency-based education regarding the manufacturer's instructions for the use and management of the [Brand Name] CGM. LN 5 further stated that she was aware a manufacturer's instructional pamphlet typically accompanied each sensor device; however, she was not familiar with the specific contents or recommendations outlined in the manufacturer's instructions. LN 5 stated that she had not reviewed the manufacturer's guidance and was unaware of the detailed instructions regarding the proper use, operation, monitoring, or recommendations for ensuring the accuracy and reliability of the CGM readings. During an interview on 6/25/26, at 4:32 PM, with the Director of Staff Development (DSD), the DSD stated that a review of the facility's education and training records revealed no documentation showing that licensed nurses had received an in-service or competency-based education specific to the use and management of the Libre CGM. The DSD further stated that education regarding the proper use of the [Brand Name] CGM was necessary to ensure licensed nurses understood the device's intended use, physician order requirements, manufacturer recommendations, methods for verifying the accuracy and reliability of glucose readings, and the appropriate use of CGM results for clinical decision-making, including insulin administration. The DSD further stated that providing education and validating staff competency would help ensure nurses consistently followed appropriate procedures and promote safe, accurate, and effective care for Resident 6. During an interview on 6/26/26, at 8:58 AM, with the Director of Nursing (DON), the DON stated that it was essential for physician orders to be complete, clear, and specific to ensure nursing staff provided care consistent with the physician's treatment plan. The DON further stated that her expectation was that if a physician's order was incomplete, unclear, or lacked specific instructions, the licensed nurse would contact the physician to obtain clarification and secure a complete physician's order before implementing the treatment. The DON explained that clear physician orders provided consistent clinical direction for all licensed nurses and promote safe and appropriate resident care. The DON further stated that Resident 6 should have had a complete physician's order specifically addressing the use of the [Brand Name] CGM, including clear directions regarding its use for blood glucose monitoring, insulin administration, and other necessary clinical parameters. The DON stated that the facility did not have a policy or procedure specifically addressing the use and management of CGM devices. The DON further stated that education and competency validation were important to ensure licensed nurses understood the manufacturer's recommendations, followed consistent nursing practices, and safely implemented physician orders. Review of a facility provided manufacturer's instructions titled, [Brand Name] Glucose Monitoring System, dated 3/19/25, indicated, .Important Safety Information.Before using the App [application], please review the complete product information.Be safe and follow the instructions properly. Using the System incorrectly could cause you to miss a severe low or high glucose event and/or make a harmful treatment decision.Talk to your health care professional about how to use your Sensor.During the first 12 hours of Sensor wear symbol [blood drop with magnifying glass icon] will display and you cannot use the Sensor values to make treatment decisions during this time. Confirm Sensor glucose readings with a blood glucose test before making treatment decisions during the first 12 hours of Sensor wear when you see the symbol . Warnings: Don't ignore low or high glucose symptoms. Use your blood glucose meter to make treatment decisions . Choking hazard: The system has a small parts that may be dangerous.Cautions - Overall System.What to know before using the system.Who should not use the system.When is Sensor glucose different from blood glucose.Cautions - Sensor Use.What to know before you apply the Sensor.What to know about wearing a Sensor.How to store the Sensor Kit.When (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to remove the Sensor.When not to use the Sensor.Using Your Glucose Reading to Make a Treatment Decision. IMPORTANT: Don't take a correction dose within 2 hours of your meal dose. This may result in insulin stacking [taking insulin too close together before the previous dose has finished working] and low glucose.WARNING.Your System can replace blood glucose testing except.Do a blood glucose test if you think your glucose readings are not correct or do not match how you feel.Do a blood glucose test when you see the symbol [blood drop with magnifying glass icon] during the first 12 hours of wearing a Sensor or the Sensor glucose reading does not include a current glucose number.		

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure interventions for pressure ulcer (a sore on the skin caused by staying in one position for too long) prevention and treatment were consistent with professional standards of practice for 1 of 23 sampled residents (Resident 94) using a low air loss mattress (LAL - a special mattress that helps prevent and treat bed sores by blowing gentle air through the mattress), when Resident 94's LAL mattress was not set accurately according to the resident's current weight. This failure had the potential to result in inadequate pressure redistribution (reducing and spreading pressure on the skin to help prevent bedsores), increased pressure over bony prominences (parts of the body where the bones are close to the skin), impaired wound healing, development of new pressure injuries, worsening of existing pressure ulcers, pain, skin breakdown, and risk of infection for Resident 94. Findings: Review of Resident 94's admission RECORD, indicated Resident 94 was admitted to the facility with a diagnosis of, but not limited to age-related physical debility (physical weakness caused by aging), need for assistance with personal care, and abnormalities of gait and mobility (problems with walking and moving). Review of Resident 94's General Order, dated 6/18/26, indicated, .Order Description: LOW AIR LOSS MATTRESS. Frequency: Continuous. A review of Resident 94's clinical record titled, Care Plan, in the section titled, Problem, dated 6/17/26, indicated, .At Risk for Impaired Skin Integrity r/t [related to] Fragile Skin. Further review of the document under the section titled, Goal, indicated, Will Have No New Impaired Skin Integrity Daily x [times] 3 months. Review of the document under the section titled, Approach, indicated, PRESSURE REDUCING MATTRESS. During a concurrent observation and interview on 6/23/26, at 11:04 AM, with Resident 94 in her room, Resident 94 was observed lying on a LAL mattress. The LAL mattress control unit (the control box that operates a low air loss mattress) was observed to be powered on and functioning. The weight/pressure setting indicator was illuminated (lit up or turned on) at the 180-pound setting. Resident 94 stated that she felt uncomfortable while lying in bed. Resident 94 further stated that she did not know what type of mattress she was using and was unable to state the purpose of the special mattress or why it had been provided. During a concurrent observation, interview and record review on 6/23/26, at 11:14 AM, with Licensed Nurse (LN) 3, in Resident 94's room, Resident 94's electronic health record (EHR) was reviewed. LN 3 confirmed that Resident 94 had a physician's order for a LAL mattress. LN 3 stated that Resident 94 was admitted to the facility on [DATE] and, to her understanding, had been using the LAL mattress since admission. LN 3 further stated that the pressure setting needed to be based on the resident's current body weight. LN 3 stated that Resident 94's most recent documented weight in the EHR was 106.5 pounds, obtained on 6/23/26. LN 3 confirmed Resident 94's LAL mattress was set at 180 pounds. LN 3 further confirmed that the setting did not correspond with the resident's current weight of 106.5 pounds. LN 3 stated that the pressure setting needed to be adjusted accordingly. LN 3 explained that if the mattress was not programmed to the appropriate setting, the pressure redistribution provided by the specialty mattress could be compromised, potentially reducing its therapeutic effectiveness. LN 3 stated that the assigned cart nurses were responsible for ensuring that the resident's specialty mattress was programmed to the correct setting and functioning as ordered. LN 3 further stated that the physician's order should clearly include the clinical indication for the LAL mattress, the prescribed pressure/weight setting, and nursing instructions for ongoing monitoring, including verification of the mattress settings and proper placement each shift. LN 3 explained that without these specific instructions, the order remained a general physician order that (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would not populate on the electronic Medication Administration Record (eMAR - an electronic chart that tracks what medicines a person receives)) for routine nursing follow-up and documentation. During an interview on 6/24/26, at 3:56 PM, with Licensed Nurse (LN) 2, LN 2 stated that nursing staff generally relied on alarm or beep sounds from the LAL mattress control unit to identify whether there was a problem with the mattress. LN 2 further stated that there were no specific physician's orders or eMAR tasks directing nursing staff to routinely assess or document the mattress placement, functionality, pressure/weight settings, or overall operation during resident care. LN 2 stated that when staff identified a problem with the mattress, they typically referred the issue to the Maintenance Department for evaluation and repair. During an interview on 6/26/26, at 2:24 PM, with the Director of Maintenance (DM), the DM stated that the Maintenance Department was responsible for delivering, installing, and setting up the LAL mattress in a resident's room after receiving a request from the nursing department. The DM further stated that obtaining the resident's current weight was an essential part of the initial setup process because the mattress pressure/weight setting should be adjusted according to the resident's body weight. The DM explained that selecting the correct pressure setting was important to ensure the mattress was neither too soft nor too firm. The DM stated that an appropriate pressure setting based on the resident's current weight promoted effective pressure redistribution, enhances resident comfort, and supports wound healing. The DM further stated that once the LAL mattress had been installed and programmed, the nursing staff were responsible for the ongoing daily monitoring of the mattress, including verifying that the appropriate settings remained in place and that the equipment continued to function properly during resident care. The DM stated that it was important for staff to follow the manufacturer's instructions for use when operating and maintaining the LAL mattress. During a concurrent interview with record review on 6/26/26, at 9:05 AM, with the Director of Nursing (DON), Resident 94's EHR was reviewed. The DON confirmed that Resident 94 had multiple skin impairments, including a Stage 3 pressure injury (a deep bedsore with damage below the skin) to the left buttock, an unstageable pressure injury (a severe bedsore that is too covered to tell how deep it is) to the right buttock/sacral area (the lower back near the tailbone, between the hips), a popped blister to the left posterior (back) lower extremity, and redness to the left shin (the front part of the leg). The DON further confirmed that Resident 94 had a Braden Scale (a tool that measures a person's risk of getting bedsores) score of 10, indicating Resident 94 was at high risk for pressure injury development and deterioration, and therefore required a LAL mattress as part of Resident 94's pressure injury prevention and treatment plan. The DON stated that the pressure/weight setting of the LAL mattress needed to be based on the resident's current body weight to provide appropriate therapeutic pressure redistribution and maximize the effectiveness of the specialty support surface. The DON acknowledged the importance of ensuring that the mattress was programmed correctly to support wound healing, reduce pressure over bony prominences, and help prevent further skin breakdown. Review of a facility provided manufacturer's instructions for use titled, "[Name of Company/Brand] Alternating Pressure Redistribution System, indicated, ".Please Read The Manual Before Use.Intended Use: This product is intended to help and reduce the incidence of pressure ulcers while optimizing patient comfort.This product can only be operated by personnel who are qualified to perform general nursing procedures and have received adequate training in knowledge of prevention and treatment of pressure ulcer.Pressure Adjust Levels: Pressure adjust levels controls the air pressure output.Higher-pressure output will support the heavier weight patient.Operation.According to the weight and height of the patient, adjust the pressure setting.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure respiratory care provided was consistent with professional standards of practice for 1 of 2 sampled residents (Resident 1), using a Continuous Positive Airway Pressure machine (CPAP- a machine that helps a person breathe by gently blowing air through a mask while sleeping), when Resident 1's CPAP pressure settings (the doctor-ordered air pressure level for the CPAP) were not included in the physician's order. This failure had the potential to result in inconsistent implementation of CPAP therapy, improper setup and administration of the CPAP device, ineffective treatment of 1's respiratory condition, delayed recognition of respiratory needs, and an increased risk for respiratory compromise for Resident 1. Findings: Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with a diagnosis of, but not limited to acute respiratory failure with hypoxia (a sudden, serious breathing problem that causes low oxygen levels in the body), chronic obstructive pulmonary disease (COPD - progressive lung condition that makes it hard to breathe because airflow into and out of the lungs get blocked) with acute exacerbation (a long-term lung diseases that suddenly became worse), pneumonia (an infection in the lungs), and obstructive sleep apnea (a condition where the airway becomes blocked during sleep, causing breathing to stop and start). Review of Resident 1's General Order, dated 6/4/26, indicated, .Order Description: CPAP ON QHS [at bedtime]. Frequency: At bedtime. During a review of Resident 1's clinical record titled, Care Plan, in the section titled, Problem, date revised 6/23/26, indicated, .Resident has ineffective airway clearance using CPAP QHS . Further review of the document under the section titled, Goal, indicated, .Resident will have adequate ventilation [breathing well enough to get enough air into and out of the lungs] and tissue oxygenation [getting enough oxygen to the body's tissues and organs] . Review of the document under the section titled, Approach, indicated, .CPAP AS PER ORDER. During a concurrent observation and interview on 6/23/26, at 3:44 PM, with Resident 1 in her room, Resident 1 was observed lying in bed with the head of the bed elevated. A CPAP machine was noted on top of the bedside drawer located on the right side of Resident 1's bed. The CPAP device was connected to a corrugated air tubing (a flexible ribbed tube that carries air from a machine to a person) leading to a humidifier chamber (a small water container that adds moisture to the air from the breathing machine). The CPAP tubing remained attached to the device and extended across the surface of the bedside drawer. Resident 1 stated that she recently had pneumonia and used the CPAP machine every night while sleeping. Resident 1 further stated, I don't know about its setup. You should ask the nurses, they're supposed to know about that. During a concurrent interview and record review on 6/23/26, at 4:01 PM, with Licensed Nurse (LN) 4, Resident 1's electronic health record (EHR) was reviewed. LN 4 confirmed that the physician order for Resident 1's CPAP machine was incomplete, as it only indicated, CPAP at bedtime and did not include the prescribed pressure settings or other specific parameters necessary for the safe implementation of CPAP therapy. LN 4 stated that the physician order should have also included the clinical indication for CPAP use, pressure settings, instructions for the application and removal of the device, and directions for the cleaning, maintenance, and replacement of the CPAP equipment, including the mask, tubing, and humidifier chamber. LN 4 further stated that complete physician orders were important to provide clear guidance to nursing staff, promote consistent implementation of respiratory care, ensure proper maintenance of the equipment, and maintain Resident 1's safety and comfort. LN 4 stated that with the current order stating only CPAP at bedtime, it was unclear who was responsible for removing the CPAP device after use or whether additional respiratory care instructions had been prescribed by the (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician.During an interview on 6/26/26, at 8:15 AM, with LN 5, LN 5 stated that she was aware the evening shift routinely applied the CPAP at bedtime; however, she did not know the prescribed pressure settings or other device parameters. During an interview on 6/26/26, at 9:37 AM, with the Director of Nursing (DON), the DON stated that physician orders needed to be complete, clear, and specific to ensure licensed nursing staff provided respiratory care consistent with the physician's prescribed treatment plan and accepted standards of nursing practice. The DON further stated that if a physician's order was incomplete, unclear, or lacked essential treatment parameters, such as the prescribed CPAP settings, the licensed nurse was expected to promptly contact the physician to obtain clarification and a complete physician order before implementing the treatment. The DON explained that complete physician orders provided clear clinical direction, promote consistency among nursing staff, reduce the risk of misinterpretation, and help ensure safe and effective resident care. The DON stated that Resident 1 should have had a complete physician order that included the prescribed CPAP pressure settings and any additional instructions necessary for the safe implementation of CPAP therapy. Review of a facility provided manufacturer's instructions for use titled, [Name of Company/Brand] CPAP System, dated 2001, indicated, .At low CPAP pressures, some exhaled gas (CO2 - carbon dioxide, a waste gas that the body breathes out) may remain in the mask and be rebreathed.Do not use the device if the room temperature is warmer than 95 degrees Fahrenheit.this could cause irritation to your airway.Contact your doctor if symptoms of sleep apnea recur.If you notice any unexplained changes in the performance of this device, if it is making unusual or harsh sounds, if it has been dropped or mishandled, if the enclosure is broken, or if water has entered the unit, discontinue use and contact your provider.First time Setup.DO NOT use.until an appropriate professional adjusts the settings.		

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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 that timely medication reordering and adequate medication supply management to ensure medications were available and administered as ordered for 2 of 67 residents (Resident 65 and 8) when: A. Resident 65 did not receive the ordered Lidocaine patch on 6/24/26 due to the medication being unavailable. The resident experienced a pain level of 5 on a scale of 1-10 on her right hip the following day. B. Resident 8 did not receive two of the three ordered doses of Calcium Acetate due to the medication being unavailable. Resident 8 receives dialysis for whom consistent administration of Calcium Acetate is necessary to maintain therapeutic levels. These failures resulted in Resident 65 experiencing pain and placed Resident 8 at risk for reduced medication effectiveness due to missed doses. FINDINGS: A. During a concurrent observation and interview on 06/24/2026 at 8:41 AM with Licensed Nurse (LN) 1 and LN 2 in the Sequoia Hallway during medication pass, LN 1 reported that the Lidocaine patch (a sticky patch containing medicine that is placed on skin to numb pain in that area) for Resident 65 was unavailable. LN 2 stated that Resident 65 had been informed the Lidocaine patch would be re-ordered and noted that the resident was understanding and denied pain at the time of observation. During an interview on 06/24/2026 at 4:32 PM with LN 2, LN 2 reported that the lidocaine patch had not yet been received from the pharmacy. During a concurrent interview and record review on 6/26/26 at 9:14 AM with LN 7, LN 7 stated that when medications are supplied in bubble packs, a blue/last column indicates it is time to re-order the medication. However, when a medication is supplied in a different form, (for example, a patch or a bottle), it is at the nurse's discretion to check the contents and reorder when the supply is getting low. LN 7 reviewed the electronic medication administration record (eMAR, system used in the facility) for Resident 65 and confirmed the Lidocaine patch was not administered on 6/24/26 because the patch was unavailable. LN 7 further stated that the Lidocaine patch was delivered on 6/24/26 at 8:55 PM and that Resident 65 had a pain level of 5 on a scale of 1-10 on her right hip when the Lidocaine patch was administered at 8:32 AM on 6/25/26. No PRN (as needed) medication was administered. LN 7 stated the Lidocaine patch was not re-ordered on time, possibly because it was overlooked when the nurses were busy or the nurse forgot. B. During a concurrent observation and interview on 06/24/2026 at 8:48 AM with Licensed Nurse (LN) 1 and LN 2 in the Sequoia Hallway during medication pass, LN 1 reported that the Calcium Acetate of Resident 8 was unavailable. LN 2 stated that they would inform the physician. During a concurrent interview and record review on 6/26/26 at 9:14 AM with LN 7, LN 7 stated that Resident 8 did not receive two out of three ordered doses of the Calcium Acetate as documented in the eMAR. The reason documented was that the medication had to be re-ordered. LN 7 further stated that missing Calcium Acetate for a dialysis resident such as Resident 8 may reduce the medication effectiveness or therapeutic dose. During an interview with the Director of Nursing (DON) on 6/26/26 at 10:36 AM, the DON stated that the unavailability of medications during medication pass did not meet her expectations because licensed nurses need to track residents' medication supply and re-order in a timely manner so as not to delay treatments. During a review of the facility's policy and procedure titled, SPECIFIC MEDICATION ADMINISTRATION PROCEDURES - IIB2: ORAL MEDICATION ADMINISTRATION revised on 1/2018, indicated, .To administer oral medications in a safe, accurate and effective manner. B. Review and confirm medication orders for each individual residents on the medication Administration Record PRIOR to administering medications to each resident. A review of the facility's policy and procedure titled, PREPARATION AND GENERAL GUIDELINES - IIA1: EQUIPMENT AND SUPPLIES FOR (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADMINISTERING MEDICATIONS revised on 1/2018, indicated, .The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents.D. the charge nurse is notified if supplies are inadequate.The charge nurse reports.supply deficiencies to the director of nursing.A review of the facility's policy and procedure titled, PREPARATION AND GENERAL GUIDELINES - IIA2: MEDICATION ADMINISTRATION-GENERAL GUIDELINES revised on 12/2019, indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices.The facility has sufficient staff and a medication distribution system to ensure safe medications without unnecessary interruptions.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications, medication-related supplies, and controlled substances were stored, labeled, and maintained in accordance with manufacturer instructions and facility policy for a census of 67 residents when:1. Three sterile packing strips were maintained in opened containers that were not labeled with the date and time opened;2. Multi-resident use of opened 100 mL Normal Saline (NS, salt water) bottles occurred despite the manufacturer's label/instruction, DO NOT REUSE;3. The vault used to store controlled substances awaiting destruction was not permanently affixed to the wall or floor. These failures had the potential to increase the risk of contamination and infection, contribute to resident identification errors during the administration of resident-specific nutritional supplements, and compromise the security of controlled substances awaiting destruction. FINDINGS:1. During a concurrent observation and interview on 6/24/26 at 10:11 AM with the Treatment Nurse (TN), an inspection of the treatment cart located in the Sequoia hallway was conducted. Three opened bottles of sterile packing strips were observed inside the treatment cart. None of the bottles were labeled with the date or time they had been opened. The TN stated that the sterile packing strips are used by admission nurses and that she did not know why the opened bottles were inside the treatment cart. The TN further stated that she would discard the bottles due to the risk of infection. During a follow-up interview on 6/25/26 at 4:35 PM with the IP, the IP stated that the facility does not use sterile packing strips frequently because they are only used when a resident has a tunneled wound or a small wound requiring packing. The IP further stated that the opened, undated bottles of sterile packing strips were not maintained in accordance with the facility's policy and posed a risk for cross-contamination and infection. A review of the facility's policy titled, Wound Dressings revised on 1/23/25, indicated, .All wound dressings will be handled in a safe and sanitary manner.to avoid contamination.A review of the facility's policy and procedure titled, PREPARATION AND GENERAL GUIDELINES - IIA1: EQUIPMENT AND SUPPLIES FOR ADMINISTERING MEDICATIONS revised on 1/2018 revealed that the facility must maintain supplies for proper storage, preparation, and administration of medications to residents, including .labels for date opened/date expires, discontinued and other applicable procedures. 2. During a concurrent observation and interview on 6/24/26 at 10:29 AM with Licensed Nurse (LN) 10, an inspection of the treatment cart located in the Redwood hallway was conducted. An opened bottle of Normal Saline (NS, saltwater) was observed inside the treatment cart. The top of the bottle cap was labeled with the date 6/24/26. LN 10 stated that she uses the opened NS bottle during her shift and that the bottle is not taken into any resident rooms. During an interview on 6/24/26 at 11:48 AM with the Infection Preventionist (IP), the IP stated an opened bottle of NS that was labeled with the date and time it was opened may be used for up to 24 hours as per the facility's policy. During an interview on 6/25/26 at 10:16 AM with LN 2, LN 2 stated that when she opens a small bottle of NS, she reused it for up to 24 hours before discarding it. LN 2 was shown the manufacturer's label on the front of the NS bottle, which indicated, DO NOT REUSE. LN 2 stated that the manufacturer's instruction was likely intended to prevent the risk of infection. During an interview on 6/25/26 at 3:11 PM with LN 4, LN 4 stated that NS is used for treatments and that, most of the time, one bottle is used throughout the duration of the shift. LN 4 further stated that the same bottle was used for multiple residents and, if not emptied, may also be used by the next shift. LN 4 was shown the manufacturer's label on the NS bottle, which indicated DO (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NOT REUSE. LN 4 stated that she did not believe there was a risk because staff label the bottle with the date it was opened, saturate a cotton with NS before entering a resident's room, and do not take the opened bottle into the resident rooms as part of standard precautions. During a follow up interview on 6/25/26 at 4:28 PM with LN 4, LN 4 stated that after speaking with the IP, staff were informed that the facility would begin using a NS ampules instead of the current 100 ml NS bottles because the 100 ml bottles are intended for single use. LN 4 further stated that the manufacturer's label, DO NOT REUSE, means that once the bottle is opened, it should not be used again due to the risk of contamination and infection. During a follow up interview on 6/25/26 at 4:35 PM with the IP, the IP stated that the staff had been educated that NS bottles were not to be reused in accordance with the manufacturer's label. The IP acknowledged that although the facility's policy allowed opened NS bottles with date and time to be used for up to 24 hours, the facility would instead follow the manufacturer's instruction, DO NOT REUSE, meaning the bottle is intended for one-time use only because of the potential risk of contamination. The IP further stated that the facility would begin purchasing NS ampules. During an interview on 6/26/26 at 10:36 AM with the Director of Nursing (DON), the DON stated that the facility was changing from 100 ml NS bottles to smaller NS vials. The DON further stated that the manufacturer's label, DO NOT REUSE, means the bottle is intended for one-time use only and must be discarded after opening. During a review of the facility's policy and procedure titled, PREPARATION AND GENERAL GUIDELINES - IIA8: IRRIGATION SOLUTIONS revised ON 1/2018, indicated, .Irrigation solutions, whether provided by the pharmacy for an individual resident or available as facility house supply may be stored until the manufacturer's expiration date until opened. Opening the container triggers a new expiration date. The use period after opening is usually found on the manufacturer's label. The nurse opening the container labels the container with the date and time immediately upon opening. 3. During a concurrent observation and interview on 6/24/26 at 1:35 PM with the DON in the DON's office, a SentrySafe vault identified by the DON as the storage location for narcotics awaiting destruction was observed. When asked whether the vault was permanently affixed to the wall or floor, the DON stated she did not know. During interview, the DON telephoned the facility Administrator, who confirmed that the vault was not permanently affixed to the wall or floor. During a follow up interview on 6/26/26 at 10:36 AM with the DON, the DON stated that she was not aware the vault was required to be permanently affixed. The DON stated that the facility's Maintenance Director would permanently affix the vault to the floor as soon as possible. The DON further stated that permanently affixed meant the vault could not be picked up and removed because it was bolted to the floor. During a review of the facility's policy and procedures titled, MEDICATION STORAGE IN THE FACILITY - ID2: CONTROLLED SUBSTANCE STORAGE revised on 1/2018 indicated, .Schedule [II-V] medications and other medications subject to abuse or diversion are stored in a permanently affixed, [double-locked] compartment separate from all other medications.		