STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. The facility census was 49. The sample size was 19. *One (1) complaint #CA00966036, and one (1)* facility reported incident #CA00966958 were investigated during the Recertification Survey. The Department was unable to substantiate a violation of the regulations for facility reported incident #CA00966958. The Department substantiated complaint #CA00966036, and the findings are written under tag #F921.	F 000	POC/EOC acceptable 7/11/25. BIC 6/30/25	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE DON | (X6) DATE 7/1/25

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.

CEDARWOOD
POST-ACUTE

1090 Rio Lane, Sacramento, CA 95822
.TEL 916-446-2506 FAX 916-446-2029

Annual survey

This Plan Of Correction Constitutes our written credible allegation of compliance for the deficiencies noted.

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This Plan of Correction is prepared and or executed solely because it is required by the provisions of the Health and Safety Code Section 1280 and 42 C.F.R 483 et seq.

F550 Resident Rights/ Exercise of Rights

Immediate action(s) taken for the residents found to have been affected include:

Resident 201, 9, 31, 12, 44 were immediately assessed by the provider for s/s of decreased self-esteem. All residents found to have been affected did not have negative outcome of decreased self esteem.

Identification of other areas potentially affected:

DON, IP and DSD conducted facility wide audit of residents with foley catheter privacy bags. Meal time observation of CNA/RNA standing while feeding, and use of clothing protectors: There have been no other residents that have been affected by the deficient practice.

Actions taken/systems put into place to reduce the risk of future occurrence include:

All CNA and LN were in serviced regarding resident rights and exercise of rights. One on One counseling was conducted for RNA 1 and RNA 2 reviewing feeding assistance and resident rights. All clothing protectors were removed from facility.

How the corrective action(s) will be monitored to ensure the practice will not recur:

DSD/IP review of catheter bags coverage, residents being appropriately feed with staff are seated, and no clothing protector being worn every day for 2 weeks then monthly thereafter to identify and address any needed deficient practices and immediately correct any discrepancies.

Plan of Correction completion date: 6.30.25

F558 Reasonable accommodations needs/ preferences

Immediate action(s) taken for the residents found to have been affected include:

Resident 13, 47, 152, 19 were assessed for call light being within reach. Call light was immediately placed within reach and pined to resident gown per request. Resident 4 and 5 ability to use call light was replaced with a call bell for accessibility. Resident 10 call light was replaced with a soft touch call light Plan of care and documentation were updated for each resident.

Identification of other areas potentially affected:

Maintenace director, Administrator and DON conducted a facility wide inspection of all residents and their ability to use call light system. There were no other residents found to have been affected.

Actions taken/systems put into place to reduce the risk of future occurrence include:

All staff members were in-service regarding facility policy of "Call lights: Accessibility and timely Response". Reviewed resident 4 and 5 use of call bell with all residents. Reviewed Resident 10 use of soft touch call light.

How the corrective action(s) will be monitored to ensure the practice will not recur:

IDT review resident every day to review call lights that are within reach, resident are able to use call light. If resident are unable to use call light, the IDT will intervene and implement correct any deficient practice and update the care plan of the resident

Plan of Correction completion date: 6.30.25

F657 Care Plan timing and Revision

Immediate action(s) taken for the residents found to have been affected include:

Resident 255 was immediately assessed for self medication administration for eye drops. Resident was found to be able to self administer medications and orders were placed. MD gave order and stated there is no negative outcome. Resident 10 was assessed and stated wrapping hands is his preference.

Identification of other areas potentially affected:

There were no other residents affected by the deficient practice

Actions taken/systems put into place to reduce the risk of future occurrence include:

An in-service was had regarding policies "Self administration of medications and "Care Plans, Comprehensive person-centered. DON and IDT will review all admissions and quarterly thereafter, in collaboration with pharmacist, medical director, registered dietician to align resident's goals with plan of care.

How the corrective action(s) will be monitored to ensure the practice will not recur:

MDS will conduct weekly audits of all newly ordered medications and treatments to ensure care plan and monitoring interventions are present. Any issues identified will be reported to the Director of Nursing and immediately corrected. This plan of correction has been integrated into the QA program, and the results of these audits will be reviewed quarterly as needed until substantial compliance is achieved.

Plan of Correction completion date: 6.30.25

F759 Free of medication Error rts 5 percent or more

Immediate action(s) taken for the residents found to have been affected include:

Resident 20, 36, 101, 25 were all assessed and found to not have any negative outcome from the deficient practice.

Identification of other areas potentially affected:

No other residents were found to be affected. DON did a facility audit on all medication orders and medications available in the medication carts to make sure that all ordered medications were given as prescribed and with the appropriate amount of food items or water. No other residents were found to be affected. Licensed Nurse 1 was educated on 06/03/2025 on following all special instructions for each medication.

Actions taken/systems put into place to reduce the risk of future occurrence include:

LN 1 and 2 were counseled regarding policy and procedure of "Administering medications." All LN were in-serviced on policy and procedure of "Administering Medications."

How the corrective action(s) will be monitored to ensure the practice will not recur:

DON/Designee will conduct weekly medication administration audits. Any issues identified will be reported to the Director of Nursing and immediately corrected. This plan of correction has been integrated into the QA program, and the results of these audits will be reviewed quarterly as needed until substantial compliance is achieved.

Plan of Correction completion date: 6.30.25

F812 Food Procurement, Store/ Prepare/ Serve-Sanitary

Immediate action(s) taken for the residents found to have been affected include:

The dietary staff members were immediately in-service on 6/10/25 and 6/12/25 regarding Label and dating/Opened Food items, covering food items, General Sanitation Policy and procedure and dishwashing protocol. The Sealed No use by date food item was disposed of on 6/12/25

Identification of other areas potentially affected:

The facility determined that all residents could be affected.

Actions taken/systems put into place to reduce the risk of future occurrence include:

The dietary staff members were immediately in-service on 6/10/25 and 6/12/25 regarding Label and dating/Opened Food items, covering food items, General Sanitation Policy and procedure and dishwashing protocol. The Sealed No use by date food item was disposed of on 6/12/25. The Glasses with white film have all be disposed of and new glasses ordered, Thermometer were changes and replaced back in freezer, Lids were ordered for food distribution during meal tray

How the corrective action(s) will be monitored to ensure the practice will not recur:

Weekly Dietary Checklist will be conducted as needed by FND to maintain compliance weekly x 4 weeks and monthly PRN Which will be collected analyzed monthly via QAPI

Plan of Correction completion date: 6.30.25

F814 Dispose Garbage and refuse properly

Immediate action(s) taken for the residents found to have been affected include:

A new lid for the garbage was order for the garbage on 6/12/25

Identification of other areas potentially affected:

The facility determined that all residents could be affected.

Actions taken/systems put into place to reduce the risk of future occurrence include:

The New lid for the garbage was order and Put in place on 6/12/25

How the corrective action(s) will be monitored to ensure the practice will not recur:

Maintain new lid for garbage can to be compliance with CMS and state regulation

Plan of Correction completion date: 6.30.25

F880 Infection Prevention & Control

Immediate action(s) taken for the residents found to have been affected include:

Resident 36, Resident 101, and resident 20 were immediately assessed, and provider determined there was no adverse effect of the deficient practice.

Identification of other areas potentially affected:

The facility determined that all residents have the potential to be affected

Actions taken/systems put into place to reduce the risk of future occurrence include:

DON and IP in-service LN 1 and LN 2 on facility policy on "Cleaning and Disinfection of Resident-Care items and Equipment. An all staff in-service was held for staff members to be educated on facility policy of "Cleaning and Disinfection of Resident-Care items and Equipment."

How the corrective action(s) will be monitored to ensure the practice will not recur:

The Infection Preventionist or Designee will conduct twice weekly round to verify adherence to infection control practices. Any issues identified during these audits will be immediately corrected. This plan of correction has been integrated into the facility's Quality Assurance program, and the results of these audits will be reviewed quarterly until substantial compliance is achieved.

Plan of Correction completion date: 6.30.25

F921 Safe/ Function/ Sanitary/ Comfortable Environ

Immediate action(s) taken for the residents found to have been affected include:

The facility was immediately assessed for emergency exits to ensure exits are clear from any items

Identification of other areas potentially affected:

The facility determined that all residents have the potential to be affected

Actions taken/systems put into place to reduce the risk of future occurrence include:

An all staff in-service was held for facility staff members regarding facility policy "Equipment and Device Storage"

How the corrective action(s) will be monitored to ensure the practice will not recur:

Maintenance director and Administrator will conduct daily for 2 weeks then weekly round to verify adherence to policy of Equipment and device storage. Any issues identified during these audits will be immediately corrected. This plan of correction has been integrated into the facility's Quality Assurance program, and the results of these audits will be reviewed quarterly until substantial compliance is achieved.

Plan of Correction completion date: 6.30.25

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure five residents out of a census of 49 (Resident 201, Resident 29, Resident 31, Resident 12, and Resident 44) were treated with dignity and respect when: 1) Resident 201's urinary catheter bag was not covered by a dignity bag; and, 2) RNA 1 and RNA 2 were standing up when assisting to feed Resident 29 and Resident 31; and, 3) Resident 12 and Resident 44 were not asked if they had a preference on using clothing	F 550		

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F 550	Continued From page 2	F 550		

protectors during their meals.

These failures placed Resident 201, Resident 29, Resident 31, Resident 12 and Resident 44 at potential risk of diminished self-esteem and feelings of self-worth.

Findings:

1.During a review of Resident 201's Admission Record, indicated Resident 201 was admitted May 2025 with a diagnosis of metabolic encephalopathy (a condition characterized by altered brain function) and bacteremia (bloodstream infection).

During a review of Resident 201's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/27/25, the MDS indicated Resident 201 was "rarely/never understood." The MDS further indicated Resident 201 had a foley catheter (a hollow tube inserted into the bladder to drain or collect urine).

During a concurrent observation and interview on 6/10/25 at 10:36 a.m., in Resident 201's doorway, Resident 201 was in bed and a urinary catheter bag half-filled with urine, hung beside the bed without a dignity bag cover. A blue dignity bag was hanging on Resident 201's wheelchair. Registered Nurse (RN) 1 came into the room and confirmed that the catheter bag was not covered. RN 1 stated, Resident 201's catheter bag should have been covered with the dignity bag. The RN 1 acknowledged that it was a dignity issue.

During an interview on 6/13/25 at 10 a.m., the Director of Nursing (DON) stated, licensed

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F 550	Continued From page 3	F 550		

nurses and certified nursing assistants were responsible for checking that urinary catheter bags were covered with dignity bags. The DON acknowledged that Resident 201's catheter bag should have been covered because it was a dignity issue.

During a review of the facility's policy and procedure (P&P), titled, "Quality of life-Dignity," revised February 2020, indicated, "Staff are expected to promote dignity and assist residents. For example: Helping the resident to keep urinary catheter bags covered ..."

2. During a review of Resident 31's Admission Record, indicated Resident 31 was admitted to the facility in April 2025 with multiple diagnoses which included cerebral infarction (loss of blood flow to a part of the brain), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).

During a review of Resident 31's MDS, dated 5/10/25, indicated Resident 31 was "rarely/never understood." The MDS further indicated Resident 31 was independent in eating.

During a review of Resident 29's Admission Record, indicated Resident 29 was admitted to the facility in August 2024 with multiple diagnoses which included cerebral infarction and hemiplegia.

During a review of Resident 29's MDS, dated 5/23/25, the MDS indicated Resident 29 had intact cognition. The MDS further indicated Resident 29 needed set up or clean up assistance for eating.

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F 550	Continued From page 4 During a concurrent observation and interview on 6/10/25, at 11:59 a.m., Resident 29 and Resident 31 were sitting in their respective wheelchairs in the dining room with other residents. Restorative Nurse Assistant (RNA) 1 and RNA 2 stood over Resident 29 while she was eating. RNA 2 standing went behind Resident 31's wheelchair and reached over to take a cup from his tray to prompt him to drink. RNA 2 still standing went to Resident 29 and took her spoon and assisted Resident 29 while reaching around from behind the wheelchair. RNA 1 and RNA 2 acknowledged that they remained standing during lunch. RNA 1 and RNA 2 could not explain why it was important sitting down while assisting residents with feeding. During a review of facility's "In service attendance record-Nutrition & Hydration/Feeding," the training indicated that RNA 1 and RNA 2 received training on dignity and feeding on Monday 6/9/25. During an interview on 6/13/25, at 10:10 a.m., the DON stated it was expected for RNAs to be seated at eye level and not standing over the residents when assisting to feed. The DON acknowledged it was a dignity issue. During a review of the facility's policy and procedure (P&P) titled, "Quality of Life-Dignity," revised November 2020, indicated, " ...Each resident shall be cared for in a manner that promotes and enhances his or her sense of well being, level of satisfaction with life, feeling of self worth and self esteem..."	F 550		

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F 550	Continued From page 5 3. During a review of Resident 12's Admission Record, indicated Resident 12 was admitted to the facility in March 2025 with a diagnosis of compression fracture of ...vertebra (broken bone in the spine). Resident 12's MDS indicated that he had intact cognition. During a review of Resident 44's "Admission Record," indicated Resident 44 was admitted to the facility in March 2025 with a diagnosis of cerebral infarction. Resident 44's MDS indicated that he had intact cognition. During an observation on 6/10/25, at 11:59 a.m. in the dining room, six of the eight residents had clothes protectors on. Resident 12 and Resident 44 were observed with clothes protectors on and fastened to their neck. During an observation on 6/11/25 at 11:54 a.m., in the dining room, Resident 12 and Resident 44 were observed with clothes protector on and fastened to their neck. Staff did not ask residents if they prefer to wear clothes protectors during their lunch. During an interview on 6/11/25 at 3 p.m. with Resident 12, Resident 12 stated, "The staff do not ask me if I want to wear a bib..." During an interview on 6/12/25 at 11 a.m. with Resident 44, Resident 44 stated, he is depressed, and he does not like using the clothes protector. Resident 44 further stated " ...It makes me feel like a baby..." Resident 44 confirmed that he was not asked at mealtime. During a review of Resident 12's and Resident	F 550		

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F 550	Continued From page 6 44's care plans, no documented evidence that Resident 12 and Resident 44 had a choice or preference to wear the clothes protector during mealtimes. During a review of the facility's P&P, titled "Quality of Life-Dignity", revised November 2020, indicated, "The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences ..."	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure resident needs were accommodated for seven out of 19 sampled Residents (Resident 13, Resident 47, Resident 152, Resident 19, Resident 4, Resident 5, and Resident 10), when 1. The call light was not within reach for Resident 13, Resident 47, Resident 152 and Resident 19; 2. Resident 4 and Resident 5 did not have interventions regarding inability to use call lights in their care plans; and, 3. Resident 10 did not have a call light that accommodated his special needs	F 558		

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F 558	Continued From page 7 These failures had the potential to result in the residents not attaining their highest practicable physical, psychosocial and emotional well-being. Findings: 1. Review of Resident 13's Admission Record indicated Resident 13 was admitted April 2025 with diagnoses including rhabdomyolysis (a condition which damaged skeletal muscle breaks down rapidly), muscle weakness, other abnormalities of gait (a person's manner of walking) and mobility, and need for assistance with personal care. Review of Resident 13's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 4/17/25, indicated Resident 13 had moderately impaired cognition. The MDS also indicated that Resident 13 was dependent to required partial/moderate assistance (helper does less than half of the effort) for activities of daily living (ADL's-routine tasks such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 6/10/25 at 9:38 a.m. in Resident 13's room, Resident 13 was lying in bed and stated he could not reach his call light. Certified Nurse's Assistant (CNA) 2 confirmed the call light was out of reach of Resident 13 and stated the call light should be within reach. Review of Resident 13's Care plan dated 4/12/25, indicated Resident 13 was "at risk for skin breakdown related to Actual skin breakdown ...related to Rhabdomyolysis ...interventions ...	F 558		

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F 558	Continued From page 8	F 558		

keep the call light within reach and encourage resident to call for assistance."

Review of Resident 47's Admission Record indicated Resident 47 was admitted May 2025 with diagnoses including muscle weakness, difficulty in walking, and need for assistance with personal care.

Review of Resident's 47's MDS dated 5/21/25, indicated Resident 47 had intact cognition. The MDS also indicated Resident 47 was dependent to needed setup or clean up assistance for ADL's.

During a concurrent observation and interview on 6/10/25 at 9:18 a.m., in Resident 47's room, Resident 47 was lying in bed, and the call light was hanging against the wall out of reach of Resident 47. Resident 47 stated he did not know where his call light was. CNA 3 confirmed Resident 47's call light was out of reach and stated the call light should be within reach.

Review of Resident 47's care plan dated 5/15/25, indicated Resident 47 was "at risk for skin breakdown related to impaired mobility...interventions ... Keep call light within reach and encourage resident to call for assistance."

Review of Resident 152's Admission Record, indicated Resident 152 was admitted May 2025 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by muscle rigidity, tremors and slow imprecise movements), multiple fractures of ribs unspecified side, dementia (a progressive state

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F 558	Continued From page 9	F 558		

of decline in mental abilities), other reduced mobility, and need for assistance with personal care.

Review of Resident 152's MDS dated 6/3/25, indicated Resident 152 had severely impaired cognition. The MDS also indicated that Resident 152 was dependent to required partial/moderate assistance for ADLs.

During a concurrent observation and interview on 6/10/25 at 8:49 a.m., Resident 152 was sitting in her wheelchair in the middle of her room and her call light was hanging from the wall out of reach of Resident 152. Licensed Nurse (LN) 1 confirmed the call light was out of reach of Resident 152 and stated the call light should be attached to where it is within reach.

During a review of Resident 152's Care plan dated 5/28/25, indicated Resident 152 was " ...at risk for skin breakdown related to Parkinson's disease ... intervention ... keep call light within reach and encourage resident to call for assistance ..."

During an interview on 6/12/25 at 1:05 p.m. with the Director of Nursing (DON), the DON stated it was unacceptable to have the call light out of a resident's reach. The DON further stated it could be a problem meeting a resident's needs, they could not call for help and the staff would not be able to help the resident.

Review of the facility's Policy and Procedures (P&P) titled, "Call Lights: Accessibility and Timely Response," undated, indicated, " ...staff will ensure the call light is in reach of resident and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 10 secured as needed ..." During a review of Resident 19's Admission Record, indicated, Resident 19 was admitted on January 2021 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) affecting left non-dominant side, contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) left hand and need for assistance with personal care. During a review of Resident 19's MDS, dated 3/18/25, the MDS indicated, Resident 19 had severe memory problems. During a concurrent observation and interview on 6/10/25 at 10:37 a.m. in Resident 19's room, Resident 19's call light was clipped to the gown at the top backside of the left shoulder. Resident 19's left arm was contracted. When asked to activate the call light, Resident 19 used the right hand to reach over to the left side. Upon pulling the call light the call light was not activated. Resident 19 attempted to pull the string again, his arms were shaking, and Resident 19 was unable to pull the call light. Resident 19 stated, " ...It's hard for me to pull this (call light string); I use my right hand, and it is placed on my left side ..." During a concurrent observation and interview on 6/10/25 at 10:42 a.m. with LN 5 in Resident 19's room, Resident 19's call light string was observed still clipped on the gown on the left side. LN 5 stated call lights should be accessible, and operable by the resident. LN 5 further stated that	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 11	F 558		

Resident 19's call light should have been positioned on his right side and that he should have been using a touchpad call light.

During an interview on 6/12/25 at 9:19 a.m. with DON, the DON stated, the call light served as a form of communication for residents when they needed assistance. The DON stated that a resident's ability to use the call light was an essential component of the call system.

During a review of the facility's policy and procedure (P&P) titled "Call Lights: Accessibility and Timely Response," undated, the P&P indicated, " ...special accommodations will be identified and provided accordingly ...examples include touch pads ...staff will ensure the call light was within reach of resident ..."

2. During a review of Resident 4's Admission Record, dated 12/23, indicated Resident 4 was admitted to the facility with diagnoses including schizophrenia (a long-term mental health condition that causes a range of psychological symptoms) and epilepsy (a disorder causing seizures).

During a review of Resident 4's MDS, dated 3/21/25, indicated Resident 4 had severe memory problems.

During concurrent observation and interview on 6/10/25 at 9:10 a.m. in Resident 4's room, Resident 4 was sitting in bed and was unable to retrieve food on the back corner of her meal tray with her utensil. Resident 4 stated that she could not locate where her call light was.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 12	F 558		

During an interview on 6/11/25 at 12:14 p.m. with LN 1, stated Resident 4's inability to use call lights can result in resident being in constant pain and neglect of care.

During a review of Resident 5's Admission Record, dated 7/22, indicated Resident 5 was admitted to the facility with diagnoses of Type II Diabetes Mellitus (a condition that impairs the body's ability to use sugar for energy) and schizophrenia.

During a review of Resident 5's MDS, dated 5/11/25, indicated Resident 5 had severe memory problems.

During a concurrent observation and interview on 6/11/25 at 11:46 a.m. in Resident 5's room, Resident 5 was in bed calling out for assistance with pain. Resident 5 stated she did not know where her call light was or how to call the nurse.

During a concurrent interview and record review on 6/12/25 at 11:35 a.m. with DON, Resident 4's and Resident 5's Care Plans, undated, were reviewed. The Care Plan for Resident 4 indicated, "...keep the call light within reach and encourage resident to use it for assistance, as needed ...Provide use of call light ..." The Care Plan for Resident 5 indicated, "...place call light within reach and encourage to use it ...Resident needs prompt response to all requests for assistance ...." There was no documented evidence of Resident 4's and Resident 5's care plans were updated to address both residents' inability to use the call light. The DON acknowledged interventions should be specific to the resident and should include an intervention

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

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F 558	Continued From page 13	F 558		

stating staff to perform frequent checks on the safety and needs of Resident 4 and Resident 5.

During a review of the facility's P&P titled, "Care Plans, Comprehensive Person-Centered," dated 3/22, indicated, "...care plans are revised as information about the resident and resident's conditions change ..."

3. During a review of Resident 10's Admission Record, the face sheet indicated, Resident 10 was admitted to the facility July 2021 with multiple diagnoses which included Sequelae of Cerebral Infarction (stroke, loss of blood flow to a part of the brain).

During a review of Resident 10's MDS, dated 4/25/25, the MDS indicated Resident 255 needed supervision with ADLs including self-care.

During an observation on 6/11/25 at 12:00 p.m. in Resident 10's room, Resident 10 was lying down comfortably. Resident 10's hands were completely wrapped with a self-adhering elastic bandage.

During a concurrent observation and interview on 6/11/25 at 12:13 p.m. in Resident 10's room, with CAN 1 confirmed Resident 10's hands were wrapped with a self-adhering elastic bandage. Resident 10 attempted to activate the call light. Resident 10 had difficulty pulling on the call light string. Resident 10 wrapped the string around his arm several times before the call light could be activated. CAN 1 acknowledged the delay in Resident 10 activating the call light due to Resident 10 having difficulty in pulling the call light string.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

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F 558	Continued From page 14 During an interview on 6/13/25 at 9:05 a.m. with DON, DON acknowledged not providing Resident 10 with a call light that accommodated Resident 10's needs could cause a delay in care and injury. During a review of the facility's P&P titled "Call Lights: Accessibility and Timely Response," undated, the P&P indicated, " ...Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system ...Special accommodations will be identified and provided accordingly. (Examples include touch pads, larger buttons ...) ..."	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 15 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to review and revise the comprehensive care plan for two of 49 sampled residents (Resident 255 and Resident 10) reflecting the residents' current health status and needs when: 1. Resident 255 's care plan was not updated for self-administration of medications; and, 2. Resident 10's care plan was not updated for wound dressings on his hands. These failures had the potential to result in Resident 255 and Resident 10 receiving outdated and not person-centered care placing the residents at risk for not meeting their highest practicable well-being. Findings: 1.During a review of Resident 255's Admission Record indicated, Resident 255 was admitted to the facility May 2025 with multiple diagnoses which included Sjögren's syndrome (a chronic autoimmune disease where the body's immune system mistakenly attacks moisture-producing glands, particularly those in the eyes and mouth).	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 16	F 657		

During a review of Resident 255's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/20/25, the MDS indicated Resident 255 needed supervision with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) including self-care.

During a concurrent observation and interview on 6/10/25 at 9:25 a.m. in Resident 255's room, Resident 255 had Carboxymethylcellulose Sodium Ophthalmic Solution (medication used to treat dry eyes and associated symptoms like burning, irritation, and discomfort) eyedrops on her bedside table. Resident 255 stated she used the eye drops for dry eyes. Resident 255 further stated she self-administered the eye drops daily since her admission to the facility.

During a review of Resident 255's active orders dated 5/23/25, the orders indicated " ...Carboxymethylcellulose Sodium Ophthalmic Solution ...Instill 1drop in both eyes every 1 hours as needed for dry eyes ..." The order indicated no documented evidence that Resident 255 will self-administer the eye drops.

During a review of Resident 255's care plan, the care plan indicated no documented evidence with goals or interventions indicating Resident 255 was assessed for self-administration of medications or could self-administer medications.

During an interview on 6/13/25 at 9:05 a.m. with Director of Nursing (DON), DON confirmed Resident 255 had Carboxymethylcellulose Sodium Ophthalmic Solution at bedside. DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 17	F 657		

stated the expectation was Resident 255 should be assessed for self-administration of medications and care planned before the resident could safely self-administer medications. DON confirmed Resident 255 did not have an assessment, physician orders, or care plan that indicated Resident 255 could self-administer medication. DON further stated there was a risk for medications being administered incorrectly when self-administration of medication did not care planned.

During a review of the facility's policy and procedure (P&P) titled, " Self-Administration of Medications," revised February 2021, the P&P indicated, " ...Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so ...If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and care plan ..."

2.During a review of Resident 10's Admission Record, indicated, Resident 10 was admitted to the facility July 2021 with multiple diagnoses which included Sequelae of Cerebral Infarction (stroke, loss of blood flow to a part of the brain).

During a review of Resident 10's MDS, dated 4/25/25, the MDS indicated Resident 255 needed supervision with ADLs including self-care.

During an observation on 6/11/25 at 12 p.m. in Resident 10's room, Resident 10 was lying down in bed, his hands were completely wrapped with a self-adhering elastic bandage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 18 During a concurrent interview and record review on 6/11/25 at 12:05 p.m. with Treatment Nurse (TN), TN stated Resident 10's hands were wrapped with self-adhering bandages because Resident 10 wanted to cover his hand amputations. TN confirmed Resident 10 did not have a care plan with goals or interventions addressing the bandages. During a concurrent observation and interview on 6/11/25 at 12:13 p.m. in Resident 10's room, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 10 needed assistance with care due to the bandages including eating his meals. During an interview on 6/13/25 at 9:05 a.m. with DON, DON acknowledged that Resident 10's care plan should have been updated to reflect use of the self-adhering bandages on Resident 10's hands. DON stated there was risk for appropriate care not being provided including an issue with accessibility, decrease of circulation to extremities, and feeding of meals when care plan was not updated for Resident 10. During a review of the facility's P&P titled "Care Plans, Comprehensive Person-Centered," revised March 2022, the P&P indicated, " ...A comprehensive, person-centered care plan that includes ...the resident's physical ...functional needs ...is developed and implemented ...assessment of residents are ongoing and care plans are revised as information about the residents ...conditions change ...."	F 657		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 19 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medication error rate was below 5% or greater when the error rate was 25.81% based on eight medication errors out of 31 opportunities observed during a medication administration observation for four out of six residents (Resident 20, Resident 36, Resident 101, and Resident 25). This failure resulted in medications not given in accordance with the prescriber's orders or manufacturer's specifications and had the potential to affect the residents' clinical conditions. Findings: 1.During a medication administration observation on 6/11/25 at 7:55 a.m. with Licensed Nurse (LN) 1, outside of Resident 20's room, LN 1 was observed preparing 6 medications for Resident 20, including chewable aspirin (ASA-medication for pain that can be used as prevention for heart disease) and omeprazole delayed-release tablet (medication used to treat excess stomach acid and help control heartburn). At 8:01 a.m., LN 1 went inside the room with a 5 oz (ounces-unit of measurement) cup of water to give the medications to Resident 20. No food or other drinks were observed on the bedside table. When LN 1 told Resident 20 ASA was one of the	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 20	F 759		

medications he was administering, Resident 20 stated, "Oh, I need to chew it." LN 1 responded, "You can swallow it." No further instructions were provided. Resident 20 swallowed the ASA, and the other medications LN 1 brought with the 5 oz cup of water.

During an observation on 6/11/25 at 8:08 a.m., outside Resident 20's room, observed label on bottle for Resident 20's chewable aspirin, bottle indicated, "Adult Low Dose Chewable Aspirin".

During an interview on 6/11/25 at 8:26 a.m. with Resident 20, Resident 20 stated she had breakfast a little after 7 a.m. that morning.

During a review of Resident 20's Order Summary Report (OSR), dated 6/11/25, the OSR indicated Resident 20 had an order for ASA 81mg (milligram-unit of measurement) oral tablet (tab) chewable to be given, indicated, "1 tablet by mouth one time a day for blood clot prophylaxis (action taken to prevent disease) Chew and swallow the tablet. Give with food or a full glass (240ml [8oz]) of water or milk to minimize gastric irritation."

During a review of omeprazole delayed-release manufacturer's packaging, the directions indicated, "swallow 1 tablet with a glass of water before eating in the morning."

During a telephone interview on 6/12/25 at 11:04 a.m. with Facility Pharmacy Consultant (PC), stated, "A full glass of water is 8 oz... It's good to have that amount of water to coat the stomach." PC further stated it was important to take aspirin with food or full glass of water to prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 21	F 759		

gastrointestinal (related to the stomach and intestines) discomfort and chew aspirin first before swallowing for better absorption.

During a telephone interview on 6/13/25 at 9:48 a.m. with PC, stated, "Omeprazole should be taken 3 minutes to an hour before breakfast because it is important for better absorption ...more readily absorbed on empty stomach."

2.During a medication administration observation on 6/11/25 at 8:07 a.m., LN 1 was observed preparing 10 medications for Resident 36, including chewable aspirin, metoprolol (medication affecting the heart used to treat chest pain and high blood pressure), and potassium chloride (medication used to prevent or treat low blood levels of potassium-mineral needed for body functions).

During a concurrent observation and interview on 6/11/25 at 8:17 a.m., LN 1 entered Resident 36's room with the prepared medications and a 5 oz cup of water. LN 1 informed Resident 36 of the medications he was administering. No food or other drinks were observed on the bedside table. No further instructions were given to resident. Resident 36 drank twice from the 5 oz cup of water when taking the pills. Observed 1/3 of the water remained in the 5 oz cup. LN 1 stated Resident 36 ate breakfast at 7am. LN 1 was observed throwing the cup with the remaining water into the trash. LN 1 confirmed he threw the 5 oz cup with water remaining into the trash.

During a review of Resident 36's OSR, dated 6/11/25, the OSR indicated, "Aspirin Tablet Chewable 81 MG. Give 1 tablet by mouth one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 22	F 759		

time a day for CVA (Cerebrovascular accident-stroke, loss of blood flow to a part of the brain) Give with food or a full glass (240ml[8 oz]) of water or milk to minimize gastric (of or relating to the stomach) irritation ...Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth two times a day for hypertension (high blood pressure) ...Administer with food ...Potassium Chloride ER Oral Tablet Extended Release 8 MEQ (milliequivalent-unit of measurement) ...Give with full glass of water [8 oz] and food."

During a telephone interview on 6/12/25 at 11:04 am with PC, PC stated it was important to take metoprolol with a snack or a meal because metoprolol is better absorbed with food, and it was important to take potassium chloride tablet with a full glass of water and food to prevent irritation of the stomach. PC further stated a full glass of water is 8 oz.

3.During an observation on 6/11/25 at 8:35 a.m. with LN 2 in Resident 101's room, LN 2 asked Resident 101 his pain level and Resident 101 responded his pain level was 9 out of 10 (severe pain).

During a medication administration observation on 6/11/25 at 8:36 a.m., in the hallway outside of Resident 101's room, LN 2 was observed preparing tramadol hcl (hydrochloride; medication used to treat pain) 50mg for Resident 101. At 8:39 a.m., LN 2 administered the tramadol to Resident 101.

During a concurrent medication observation and interview on 6/11/25 at 8:52 a.m. with LN 2, LN 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 23	F 759		

was observed preparing 5 medications, including carvedilol 3.125mg (medication used to treat heart failure and high blood pressure).

During an observation on 6/11/25 at 8:53 a.m. outside of Resident 101's room, the pharmacy label on the bubble pack (packaging oral medication is dispensed from) for Resident 101's carvedilol medication indicated, "carvedilol 3.125 MG TAB Take 1 tablet by mouth 2 times a day with breakfast and dinner."

During a concurrent medication administration observation and interview on 6/11/25 at 8:59 a.m., LN 2 entered the room and administered Resident 101's medications without food. Resident 101 stated he had breakfast at 7:15 a.m.

During a review of Resident 101's OSR, dated 6/11/25, the OSR indicated, "TraMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours as needed for Moderate back pain (4-7)."

During a telephone interview on 6/11/25 at 11:04 a.m. with PC, PC stated if tramadol is ordered "just for moderate, it is not appropriate to be administered for severe pain. If a medication is indicated for moderate pain, it should only be given for moderate pain." PC further stated if there was no pain scale indicated in the medication order to cover severe pain, a doctor's order was needed to administer the medication for severe pain. PC stated carvedilol should be given with breakfast or dinner for better absorption. PC further stated the meal is needed to reduce the rate of absorption of the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

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F 759	Continued From page 24	F 759		

and carvedilol gets absorbed too rapidly when the stomach is empty.

During a review of the facility's document titled, "Integrated Patient Education-Medication Leaflets" (IPE-MedLeaf) for carvedilol printed from the facility's electronic health record (EHR) by Treatment Nurse (TN) on 6/12/25 at 8:54 a.m., the IPE-MedLeaf indicated, "Take this drug with food."

During a review of the carvedilol manufacturer's label from the FDA (package insert that includes approved uses and dosage administration information: Food and Drug Administration), indicated, under "Dosage and Administration, [brand name for the medication carvedilol] should be taken with food to slow the rate of absorption and reduce the incidence of orthostatic (low blood pressure when standing up) effects."

4.During a medication administration observation on 6/11/25 at 9:19 a.m. in the hallway outside of Resident 25's room, LN 2 was observed preparing five medications for Resident 25, including allopurinol 100mg (medication used to treat gout, a type of arthritis).

During a concurrent observation and interview on 6/11/25 at 9:25 a.m., LN 2 was observed administering Resident 25's medications. No food or snacks were observed on Resident 25's bedside table or given. Resident 25 stated he ate breakfast at 7 a.m.

During a review of Resident 25's OSR, dated 6/11/25, OSR indicated, "Allopurinol Oral Tablet 100 MG (Allopurinol) Give 1 tablet by mouth two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

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F 759	Continued From page 25 times a day for gout. Administer with food and water." During a telephone interview on 6/11/25 at 11:04 a.m. with PC, PC stated it is important to take allopurinol with food and water because the medication can be associated with gastrointestinal (related to the stomach and intestines) issues and can cause dehydration (condition caused by the loss of too much fluid from the body). PC further stated allopurinol should be taken with 8 oz of water. During an interview on 6/12/25 at 9:31 a.m. with Director of Nursing (DON), DON stated, "There is an expectation that nurses follow doctor's orders when administering medications." During a concurrent observation and interview on 6/12/25 at 9:38 a.m., DON took a cup from a medication cart and confirmed cups were 5 oz when filled to the rim. During a review of the facility's Policy and Procedure (P&P) titled, "Administering Medications", revised April 2019, indicated, "Medications are administered in a safe and timely manner, and as prescribed ...Administer medication as ordered in accordance with manufacturer's specifications. Provide appropriate amount of food and fluid."	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	**1090 RIO LANE SACRAMENTO, CA 95822**

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F 812	Continued From page 26 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food properly in accordance with professional standards for food service safety for a census of 49 when: 1) Two metal bowls and 9 plate cover lids stored wet and stacked, 2) Two plastic cups had white film build up inside the cups, 3) Two thermometers missing inside freezers, 4) Open food items were not labeled with use by date, and, 5) Food items were not covered during resident food distribution of meal trays These failures increased the potential for food borne illness. Findings:	F 812		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	**1090 RIO LANE SACRAMENTO, CA 95822**

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F 812	Continued From page 27 1.During a concurrent initial tour observation and interview on 6/10/25 at 8:20 a.m. with the Dietary Manager (DM), nine plate cover lids and two small bowls were stored upright with water collected at the bottom of the bowl. The DM stated that the plate cover lids and bowls should be on a drying rack to air dry completely before storing. During an interview on 6/12/25 at 1:10 p.m. with the Registered Dietician (RD), RD stated lids and bowls should always be air dried and confirmed that if not dried it could grow bacteria. During a review of the Food and Drug Administration (FDA) Food Code 2022, Section 4-901.11 Equipment and Utensils, Air Drying Required, "After cleaning and sanitizing, equipment and utensils; shall be air dried ..." During a review of the Food and Drug Administration (FDA) Food Code 2022, Section 4-903 Storing, indicated "Clean EQUIPMENT and UTENSILS shall be stored ...In a self-draining position ..." 2. During a concurrent initial tour observation and interview in the kitchen tour on 6/10/25 at 8:32 a.m. with the DM, there were two plastic cups observed stored on the shelf that had white film build up inside the cups. DM confirmed that the cups had residual inside the cups. During an interview on 6/12/25 at 1:15 p.m. with the RD, the RD confirmed that the cups did not look clean, and the resident's perceptions is that the kitchen has served dirty cups.	F 812		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	**1090 RIO LANE SACRAMENTO, CA 95822**

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F 812	Continued From page 28 During a review of the Food and Drug Administration (FDA) Food Code 2022, Section 4-601.11 Cleaning of Equipment and Utensils, indicated "EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch." 3. During a concurrent observation and interview on 6/10/25 at 8:40 a.m. in the kitchen, DM verified there were no thermometers inside both freezers. Food items were observed in both freezers. DM stated there should be a thermometer in every fridge and freezer and confirmed that kitchen staff would not know what the appropriate safe temperature for food to be stored. During a review of the facility's policy and procedure (P&P) titled, "Food Receiving and Storage " revised November 2022, the P&P indicated " ...must have working thermometers and are monitored for temperature according to state guidelines." 4. During a concurrent observation and interview on 6/10/25 at 8:58 a.m.in the kitchen, DM verified there were frozen opened waffle, opened corn, opened spices, a box of cream of wheat that had no used by dates. During an interview on 6/12/25 at 1:20 p.m. with the RD, the RD confirmed that no use by dates had a risk of kitchen staff not knowing if food items were sitting and stored for a long period of time. During a review of the facility P&P titled "Food	F 812		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 29 Receiving and Storage" revised November 2022, indicated, "All foods stored in the refrigerator or freezer are covered, labeled and dated ("use by" date). 5. During an observation on 6/10/25 at 12:04 p.m. in Wing C, the meal trays with dessert were not covered while being transported from the kitchen to residents' rooms. The delivery cart had plastic bags covering only three sides of the cart, but the staff rolled the plastic coverings up to the top exposing the desserts that were not covered. During an interview on 6/12/25 at 1:25 p.m. with the RD, the RD was shown a picture of the uncovered dessert and confirmed that they should be covered. The RD confirmed and agreed that items should be covered to prevent contamination and maintain cleanliness and sanitation and prevent foodborne illness. During a review of the FDA Food Code 2022, Section 8-203.10 Preoperational Inspections, indicated "Food is managed so that the safety and integrity of the food from the time of delivery to the establishment throughout its storage, preparation, and transportation."	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a clean environment for the residents and visitors when two of two garbage dumpsters, located outside	F 814		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

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F 814	Continued From page 30 the facility, were not secure with closed lids, for a census of 49. This failure had the potential for pest infestation providing an unsafe environment for the residents and visitors. Findings: During a concurrent observation and interview on 6/10/25 at 8:22 a.m., the facility's outside garbage dumpster lids had two openings built in. There were bags of garbage in the dumpster bin, a bad odor and flies were coming out from the opening of the lids. The Dietary Manager (DM) confirmed that the lids were not securely closed. During a concurrent observation and interview on 6/11/25 at 11:23 a.m., the Maintenance Director (MD) stated the lids should have been closed with tight fitting covers per facility policy and that lids with openings could not prevent pest and rodent activity. During a review of the facility's policy and procedure (P&P) titled, "Food-Related Garbage and Refuse Disposal," revised October 2017, the P&P indicated, "All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored ...garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests."	F 814		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

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CEDARWOOD POST ACUTE	**1090 RIO LANE SACRAMENTO, CA 95822**

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F 880	Continued From page 31 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 880	Continued From page 32 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement and maintain an effective infection prevention and control program for a census of 49 residents when a shared blood pressure (BP) cuff was not cleaned and sanitized properly in between resident use. This failure resulted in increased risk for cross-contamination (transfer of bacteria from one person, object, or place to another) and may	F 880		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 33 cause infections among residents. Findings: During an observation on 6/11/25 at 7:48 a.m., Licensed Nurse (LN) 1 took the blood pressure (BP) of Resident 20 using a BP cuff from the medication cart without sanitizing it. LN 1 placed the BP cuff on Resident 20's right arm. After completing the task, LN 1 exited the room and placed the BP cuff in the medication cart without sanitizing it. At 8:04 a.m., LN 1 used the same BP cuff on Resident 36 without sanitizing it prior to use. LN 1 did not sanitize the BP cuff in between resident use before placing it back into the medication cart. During an observation on 6/11/25 at 8:51 a.m., LN 2 was observed taking the blood pressure of Resident 101 using a BP cuff from the medication cart. LN 2 placed the BP cuff on Resident 101's right arm. After exiting the room, LN 2 cleaned the BP cuff using a single alcohol prep wipe (tiny size) and then placed it back into the medication cart. During an interview on 6/11/25 at 9:37 a.m. with LN 1, LN 1 confirmed that he did not clean the BP cuff between residents and stated that he was not aware if the facility had a policy for cleaning BP cuffs between resident uses. During an interview on 6/12/25 at 8:08 a.m. with Infection Preventionist (IP), IP stated the expectation was to disinfect BP cuffs between resident use with disinfectant wipes from the canister with a purple top [brand name; germicidal disposable wipe) to prevent	F 880		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	1090 RIO LANE SACRAMENTO, CA 95822

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F 880	Continued From page 34 cross-contamination. The IP stated, "This tiny little thing (alcohol prep pad)-how can it clean the whole blood pressure cuff?" The IP further stated that it was not acceptable and not effective to use an alcohol prep wipe to clean a bp cuff. During a review of the facility policy and procedure (P&P) titled, "Cleaning and Disinfection of Resident-Care Items and Equipment," revised 9/22, the P&P indicated, " ...reusable items are cleaned and disinfected or sterilized between residents ..."	F 880		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a safe environment for a census of 49 when: 1) A wheelchair and standing fan were partially blocking the emergency exit in Wing A, and; 2) Two Hoyer lifts were stored with unlocked wheels in Wing A. These failures had the potential for delayed exit of residents during an emergency and resident injury from unsecured medical equipment. Findings: During an observation on 6/10/25 at 9:32 a.m. in	F 921		

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	055296	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARWOOD POST ACUTE	**1090 RIO LANE SACRAMENTO, CA 95822**

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F 921	Continued From page 35 Wing A, a resident wheelchair and a standing fan were stored in front of the emergency exit, partially blocking access. There were two hoyer lifs stored on the right side of the hallway facing the emergency exit with unlocked wheels. During an interview on 6/12/25 at 9:35 a.m. with the Administrator (ADM), ADM confirmed that there was a wheelchair and standing fan stored in front of the emergency exit in Wing A. ADM confirmed there were two hoyer lifts that were stored unlocked in Wing A. ADM stated the expectation is for the emergency exits to remain clear and for medical equipment to stored safely. ADM acknowledged the risk of delayed resident emergency exit and resident injury. During a review of the facility's policy and procedure (P&P), titled "Equipment and Device Storage" undated, the P&P indicated, " ...It is the policy of this facility to ensure that all equipment and clinical devices ...are stored in a ...safe ...manner ..."	F 921		