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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055296 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                           | (X3) DATE SURVEY COMPLETED<br><br>11/15/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Cedarwood Post Acute |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1090 Rio Lane<br>Sacramento, CA 95822 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>43247</p> <p>Based on observation, interview, and record review, the facility failed to ensure hemodialysis (HD- treatment that filters waste from the blood when kidneys are not working) services were provided per facility policy for one of three sampled residents (Resident 1), when Resident 1 missed four outpatient hemodialysis appointments due to lack of transportation services and the physician was not notified of missed HD appointments.</p> <p>This failure resulted in Resident 1 going to the hospital for potential fluid retention increasing the risk for respiratory decline.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was initially admitted to the facility in September 2024 with multiple diagnoses including cerebral infarction (stroke- disrupted blood flow to the brain causing brain tissue death), chronic obstructive pulmonary disease (lung disease that blocks airflow causing breathing difficulties), and end stage renal disease (kidneys stop functioning and no longer filter waste from the blood).</p> <p>A review of Resident 1's Minimum Data Set (MDS-a federally mandated assessment tool), Cognitive Patterns, dated 10/29/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS-tool to assess cognition) score of 14 out of 15 that indicated Resident 1 was cognitively intact. A review of Resident 1's MDS, Functional Abilities, dated 10/29/24, indicated Resident 1 was dependent for transfers. A review of Resident 1's MDS, Special Treatments, Procedures, and Programs, dated 10/29/24, indicated Resident 1 was receiving hemodialysis on admission to the facility and as a resident.</p> <p>A review of Resident 1's Order Summary Report indicated Document the dialysis days: T [Tuesday], TH [Thursday], S [Saturday] .Transportation: .Pick up Time: 1:45pm-5:15pm Chair Time: 2:30 pm-5:00 pm, .</p> <p>A review of Resident 1's Change in Condition Evaluation, dated 10/30/24, indicated .Signs and Symptoms Identified .fluid retention .patient has missed dialysis multiple times this week d/t [due to] issues with transport. This nurse was unable to get in contact with transport services to get more information. Patient was requesting to be sent to [acute hospital] to get dialysis. This nurse called MD [Medical Doctor] .and he stated to send patient out. This nurse contacted [ambulance company] to get transport to [acute hospital] at around 0700 [7:00 a.m.] .patient was transported via gurney .</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>A review of Resident 1's Progress Notes, dated 10/26/24 at 4:59 a.m., indicated .called transportation confirmed dialysis pickup at 1:40 pm .</p> <p>A review of Resident 1's Progress Notes. dated 10/26/24 at 6:27 p.m., Indicated .called [HD clinic] to reschedule HD . RN [Registered Nurse] rescheduled pt [patient] dialysis Monday 10/28/24 chair time 5:15am and be there at 5:00am . This LN [licensed Nurse] called [transport hub] to arrange transportation. pick up time will be between 4:15am -4:45am .</p> <p>A review of Resident 1's Progress Notes, dated 10/28/24 at 2:40 p.m., indicated .SS [Social Services] called [transport hub] to confirm standing order for resident .</p> <p>A review of Resident 1's Progress Notes dated 10/29/24 at 2:00 p.m., indicated .Patient missed dialysis. MD notified and NNO [no new orders] received .</p> <p>A review of Resident 1's Progress Notes, dated 10/29/24 at 2:19 p.m., indicated .The driver waited for resident for 20 minutes. Res [resident] did not show up and left. Could not find another driver .Res needs to be in dialysis today. The driver needs to come into the facility to get the resident because resident is not mobile .</p> <p>A review of Resident 1's Progress Notes, dated 10/29/24 at 3:02 p.m., indicated . Spoke w/ [with] [transport hub] . SSD [Social Services Director] received an ETA [estimated time of arrival] that stated 2:45 PM picked. She replied that there is no ETA. Res did not show up with the driver arrived . Informed .that resident could not wheel himself to the door. The driver needed to come inside the facility to let staff aware of the arrival Spoke with .supervisor .He placed SSD [Social Services Director] on hold to call the dialysis .The latest is at 3:30 PM today. It is now 3:19 PM . resident will not make .:</p> <p>A review of Resident 1's Progress Notes, dated 10/30/24 at 5:44 a.m., indicated .call to [transport hub] .no transport available for now .</p> <p>A review of Resident 1's Progress Notes, dated 10/30/24 at 8:12 a.m., indicated .Received a message .Res has not been picked up for dialysis .SSD made a conference call to [transport hub] and [HD clinic] .Driver needs to come into the facility to let the staff arrive .Pick up time: 1:55 PM . Return time: 5:45 PM .</p> <p>A review of Resident 1's Progress Notes, dated 10/30/24 at 10:52 a.m., indicated .patient has missed dialysis multiple time this week d/t issues with transport. This nurse was unable to get in contact with transport services to get more information. Patient was requesting to be sent to [acute hospital] to get dialysis .Sent patient to ED [Emergency Department] for further eval [evaluation] .</p> <p>A review of Resident 1's Progress Notes, dated 10/30/24 at 6:09 p.m., indicated Writer received call .stating resident finished dialysis and will need transportation. Writer call [transport hub] and spoke with customer service .stated resident will be picked up at [HD clinic] by 1900 [7:00 p.m.] .</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>A review of Resident 1's Progress Notes, dated 10/30/24 at 8:35 p.m., indicated .Writer received call from [HD clinic] around 1915 [ 7:15 p.m.], nurse .stated Transport arrived but left d/t gurney bound .Writer called [transport hub] for via gurney pick up and was able to set up transportation. Customer service .stated will take about 3-4 hours d/t late scheduling .Writer called [ambulance company] to pick up resident from [HD clinic] .</p> <p>A review of Resident 1's Progress Notes, dated 10/30/24 at 10:40 p.m., indicated . Resident came back from Dialysis via gurney transport from [ambulance company] around 2215 [10:15 p.m.] .</p> <p>A review of Resident 1's RD [Registered Dietitian] Progress Note, dated 11/1/24, indicated .res is HD dependent wt [weight] fluctuation fluid shifts anticipated. Res has recent hx [history] of multiple hospitalization and missed HD appointments. Leading to excessive fluid shifts /wt gain followed by excessive fluid shifts /wt loss. Res is anticipated to have wt gain as 2 HD visits were missed .</p> <p>During a telephone interview on 11/14/24 at 4:14 p.m. with Social Worker (SW) at HD clinic, SW stated Resident 1 missed HD appointments on 10/26/24, 10/28/24, 10/29/24 and 10/30/24 due to transportation issues. The SW stated Resident 1 was sent to the emergency department on 10/30/24 after several missed visits. The emergency department determined Resident 1 needed to be dialyzed and was sent to the HD clinic for dialysis. The SW stated Resident 1 was not picked up from the HD clinic until 10:00 p.m. When asked what the consequences of missed HD appointments are, the SW stated, It is a lifesaving procedure. If missed can experience shortness of breath. Worst case fluid overload and death.</p> <p>During an interview on 11/15/24 at 10:49 a.m. with the Director of Nursing (DON), the DON stated Resident 1 missed several HD appointments due to many issues with transportation. The facility attempted to reschedule HD appointments after transport did not show up at the scheduled times. The DON stated, on 10/30/24, Resident 1 was sent to emergency department, per Resident 1's FM concern, after Resident 1 had missed a few days of HD. The DON stated Resident 1 was picked up late from the HD clinic on 10/30/24 due to difficulty finding gurney van transport late in the day. The DON stated he finally arranged for an ambulance transport on 10/30/24. The DON stated the physician was notified of Resident 1's missed HD appointments by phone call or in person.</p> <p>During an interview on 11/15/24 at 11:08 a.m. with the SSD, the SSD stated Resident 1 had missed HD appointments on 10/26/24, 10/28/24, 10/29/24, and 10/30/24 due to transport company not picking up even after HD appointments had been rescheduled. On 10/30/24 Resident 1's family member requested Resident 1 go to the emergency department after several missed HD appointments. The SSD stated if transport did not arrive, the nurse was to call the transport company and notify the MD.</p> <p>During an interview on 11/15/24 at 11:43 a.m. with Resident 1, Resident 1 stated his HD days are Tuesday, Thursday, and Saturday. Resident 1 stated on 10/30/24 he was feeling short of breath and his wife wanted him to go to the emergency room . Resident 1 stated he waited a long time at the HD clinic after treatment to be picked up.</p> <p>During an interview on 11/15/24 at 11:50 a.m. with LN 1, LN 1 stated Resident 1 usually is picked at 1:00 p.m. to 1:30 p.m. on Tuesday, Thursday, Saturday for HD appointment. LN 1 stated if Resident 1 missed HD, MD should be notified and should chart that the MD was notified. LN 1 stated if HD is missed labs should be done.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During an interview on 11/15/24 at 11:59 a.m. with LN 2, LN 2 stated Resident 1 missed a few days of HD due to miscommunication with the transport company. LN 2 stated if Resident 1 missed HD, LNs should notify MD and have labs done.</p> <p>During a subsequent interview on 11/15/24 at 12:04 p.m. with the SSD, the SSD stated Resident 1's HD transport was ordered for door to door and the driver was supposed to come into the facility to pick up resident. The SSD stated on 10/26/24 and 10/29/24 the driver did not come into the facility and left without transporting the resident. The SSD stated on 10/28/24 and 10/30/24 the transport company did not have a driver.</p> <p>During an interview on 11/15/24 at 2:16 p.m. with the DON, reviewed Resident 1's progress notes for 10/26/24 and 10/28/24. The DON acknowledged that there was no documentation that the MD had been notified of missed HD appointments on 10/26/24 and 10/28/24. The DON stated LNs, Should chart that MD was notified. If [LNs] let MD know [MD] would have asked for labs.</p> <p>During an interview on 11/15/24 at 2:38 p.m. with LN 3, LN 3 stated Resident 1 was sent to the emergency department on 10/30/24 after missed HD appointments on 10/26/24, 10/28/24, 10/29/24, and 10/30/24. SS had scheduled the transports. LN 3 stated if resident missed HD appointment MD is notified and orders are received including possible labs. When asked what were the consequences of a missed HD appointment, LN 3 stated, Fluid retention, shortness of breath. Critical if you miss dialysis.</p> <p>A review of the facility's Policy and Procedure (P&amp;P) titled Hemodialysis Policy, dated 7/1/23, indicated .The facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders . The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice .The facility will ensure that arrangements are made for safe transportation to and from the dialysis facility .The facility will communicate with the attending physician, dialysis facility, .of any canceled or postponed dialysis treatments and document any responses to the changes in treatment in the medical record. The facility will coordinate with the dialysis facility for rescheduling of the resident's dialysis treatment if indicated .</p> <p>A review of the facility's P&amp;P titled Notification of Changes, dated 3/1/23, indicated .The purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician .The facility must inform the resident, consult with the resident's physician .when there is a change requiring such notification . Circumstances requiring notification include .Circumstances that require a need to alter treatment .</p> |  |  |