STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055308	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk Grove Post Acute	9461 Batey Avenue Elk Grove, CA 95624

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to provide Resident 1 with information regarding her medical condition and plan of treatment and failed to notify Resident 1's Family Member (FM) of change in condition, when Resident 1 had an episode of decreased responsiveness due to hypoglycemia (low blood sugar). This failure resulted in Resident 1 and Resident 1's FM being unaware of Resident 1's medical condition and treatment plan with the potential for worsening medical condition. Findings: A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in October 2024 with multiple diagnoses including left acetabulum fracture (hip fracture), right pelvic fracture, osteoporosis (condition in which bones become weak and brittle), diabetes (high blood sugar levels), and obstructive sleep apnea (sleep disorder characterized by breathing pauses causing decreased oxygen levels). A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 10/24/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 1 was cognitively intact. A review of Resident 1's eINTERACT Change in Condition Evaluation, dated 11/1/24, indicated .Name of family/representative notified .self . A review of Resident 1's Progress Notes, dated 11/1/24 at 4:42 a.m., indicated .Situation: The Change in Condition/s .At 0345 [3:45 a.m.] CNA [Certified Nursing Assistant] reported to charge nurse pt [patient] is not responding. Upon assessment resident noted very lethargic, hard to arouse, unable to follow verbal commands, resident was shaking, moaning. Breathing heavily with eyes close BS [blood sugar] 41 mg [milligrams]/dl [deciliter]. try to give pt sugar, but unable to open mouth, resident kept on moving upper and lower Ext [extremities] with eyes close. Around 0400 [4:00 a.m.] call 911. Arrived around 0420 [4:20 a.m.] IV [Intravenous] Dextrose [simple sugar chemically identical to glucose or blood sugar] given by paramedics and BS went up to 132. Pt start to respond back to her baseline . (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/19/25 at 2:16 p.m. with the Assistant Director of Nursing (ADON), the ADON stated on 11/1/24, the CNA reported to the Licensed Nurse (LN) that Resident 1 was not responding. The ADON stated the LN checked Resident 1's BS and it was 41 mg/dl and tried to administer sugar orally, but was unable and called 911. The paramedics arrived and administered IV Dextrose and Resident 1's BS went up to 132 mg/dl and Resident 1 was aroused and back to baseline. When asked what the facility policy regarding notifying family of change in condition, the ADON stated if Resident 1 had been transferred to the acute hospital, Resident 1's FM would have been notified. The ADON stated because Resident 1 was not transferred, was awake and alert after treatment, the FM was not contacted regarding change in condition. Reviewed Resident 1's progress notes for 11/1/24 with the ADON. When asked what the expectation is for providing education and information to the resident after a change in condition, the ADON stated, Should have let her know that sugar was low and she was showing symptoms of hypoglycemia. Should have reoriented her. Should have explained any medication or treatment changes. Did not see any documentation that patient was notified of what happened or new plan. My expectation for nurses is information should have been reviewed with the patient and documented information was given . There is nothing that stated patient was given any education or information . During an interview on 6/19/25 at 3:24 p.m. with LN 1, LN 1 stated after an incident of hypoglycemia, would educate patient, let the resident know what happened, and update resident of any new changes in medications. During an interview on 6/19/25 at 3:28 p.m. with LN 2, LN 2 stated would notify the resident's representative of any change in condition or any new medication and would educate resident once back to baseline. LN 2 stated she would document any education given in the progress notes. During a subsequent interview and facility policy review on 6/19/25 at 3:49 p.m. with the ADON, reviewed policies Nursing Documentation, Change in Notification: Notification of, and Resident Rights. The ADON acknowledged that these policies indicated residents are to be informed of any changes to their medical condition and nursing documentation is to include resident's status, interventions, and outcomes. The ADON acknowledged that facility policies were not followed regarding communication to Resident 1 following change of condition on 11/1/24. During a telephone interview on 6/20/25 at 2:40 p.m. with LN 3, LN 3 stated she recalled incident when Resident 1 was found unresponsive in the early morning. LN 3 stated Resident 1 had low BS, paramedics were called, and resident was given IV dextrose. LN 3 stated Resident 1 returned to her baseline after treatment. LN 3 stated she called Resident 1's FM to let him know of low BS. LN 3 stated that Resident 1 was awake and alert, but still called FM due to change of condition and charted that she contacted FM. Reviewed with LN 3 that there was not documentation on 11/1/24 that Resident 1's FM was notified. LN 3 stated, Maybe not charted that son was notified, but I did call that day. LN 3 stated she talked with Resident 1, told her what was going on and explained everything that day. Reviewed with LN 3 that there was no documentation that indicated Resident 1 was provided information about change of condition. LN 3 stated, Not sure if I documented .Should have charted that I explained to her. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure (P&P) titled Resident Rights, revised 12/21, indicated .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .be notified of his or her medical condition and any changes in his or her condition .be informed of, and participate in, his or her care planning and treatment . A review of the facility's P&P titled Change in Condition: Notification of, dated 8/25/21, indicated .To ensure residents, family, legal representatives, and physicians are informed of changes to the resident's condition .A Facility must immediately inform the resident, consult with the Resident's physician .notify, consistent with his/her authority, Resident Representative when there is: .A significant change in the Resident's physical, mental, or psychosocial status (that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications) . A review of the facility's P&P titled Nursing Documentation, dated 8/27/22, indicated .To communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided .Documentation includes information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patient's outcomes and responses to nursing care .The patient's record specifies what nursing interventions were performed by whom, when, and where .