STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saylor Lane Healthcare Center	3500 Folsom Boulevard Sacramento, CA 95816

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 0583 Level of Harm - Potential for minimal harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 46872 Based on observation, interview, and record review the facility failed to ensure residents' rights to personal privacy and confidentiality of his or her personal medical information, when meal tray tickets were found thrown into the general trash. This had the potential to compromise resident privacy and confidentiality for the 38 residents residing in the facility. Findings: During a concurrent observation and interview on 5/14/24, at 9:13 a.m., with Kitchen Aide (KA) 2 in the kitchen, KA 2 was observed throwing away residents' meal tickets into a garbage can. Resident meal tickets listed residents' names, diet, and room number. KA 2 stated meal tickets that are left on meal trays are thrown into the kitchen garbage can and the garbage can is then later emptied into the outside garbage bin. During an observation on 5/14/24, at 10:06 a.m., in the kitchen, KA 1 was observed removing residents' meal tickets from meal trays and throwing them away into the kitchen garbage can. During a concurrent observation and interview on 5/14/24, at 10:13 a.m., with the Dietary Supervisor (DS), the DS confirmed there were residents' meal tickets in the kitchen garbage can and staff was not following policy. The DS stated kitchen staff are expected to collect residents' meal tickets for shredding to protect resident's confidential information. The DS stated, [Residents' meal tickets] Should not be in garbage can . has patient info. During a review of the facility's policy and procedure (P&P) titled, Confidentiality of Information and Personal Privacy, revised 10/17, the P&P indicated, Our facility will strive to ensure privacy in matters related to patient care .Access to resident personal and medical records will be limited to authorized staff .

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Saylor Lane Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 Folsom Boulevard Sacramento, CA 95816	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47197 Based on observation, interview, and record review, the facility failed to ensure two out of 15 sampled residents (Resident 232 and Resident 23) were assisted with nail care as part of their Activities of Daily Living (ADLs- normal daily functions required to meet basic needs) when Resident 232 and Resident 23 had long fingernails with blackish substance underneath the fingernails. This failure had the potential for Resident 232 and Resident 23 to sustain injury and/or for the residents to acquire an infection. Findings: 1. A review of Resident 232's clinical record indicated Resident 232 was admitted April of 2024 and had diagnoses that included chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and need for assistance with personal care. A review of Resident 232's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/29/24, indicated Resident 232 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 11 out of 15 which indicated Resident 232 had a moderate impairment of cognition. A review of Resident 232's MDS Mood Status, dated 4/29/24, indicated Resident 232 had problem like feeling down, depressed, or hopeless for half or more of the days in two weeks. A review of Resident 232's MDS Functional Abilities and Goals, dated 4/29/24, indicated Resident 232 required setup or clean-up assistance with personal hygiene and eating. During a concurrent observation and interview on 5/13/24 at 9:55 a.m. with Resident 232, in Resident 232's room, Resident 232 had fingernails that were long and with blackish substance underneath the fingernails. Resident 232 stated he wanted his fingernails to be cleaned and trimmed. During a concurrent observation and interview on 5/13/24 at 10 a.m. with Certified Nurse Assistant (CNA) 3, in Resident 232's room, CNA 3 confirmed that Resident 232 had long fingernails and with blackish substance underneath the fingernails. CNA 3 stated she would expect that Resident 232's fingernails to be trimmed and cleaned for infection control. During a concurrent interview and record review on 5/14/24 at 3:34 p.m. with Licensed Nurse (LN) 4, Resident 232's clinical records were reviewed. LN 4 confirmed that Resident 232 had no care plan of refusing personal hygiene care and had no documented refusals of nail care. LN 4 stated Resident 232 had no issues like declining the trimming or cleaning of his fingernails. During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated, It is important to keep resident's fingernails clean and short for infection control .to avoid skin cuts or tears. A review of Resident 232's care plan intervention, undated, indicated, Provide assistance with ADLs as indicated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 232's care plan intervention, dated 5/14/24, indicated, The resident [Resident 232] needs their [sic] nails kept short to reduce risk of scratching or injury from picking at skin. A review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), Supporting, revised 3/2018, indicated, .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the plan of care, including appropriate support and assistance with . a. hygiene (.grooming .). 32096 2. Review of Resident 23's Admission Record indicated the resident was a long-term resident in the facility with diagnoses that included muscle weakness and need for assistance with personal care. During the initial pool observation and interview on 5/13/24 at 9:10 a.m., Resident 23 was lying in bed and complained that he had long fingernails and would like them to be trimmed and be cleaned. The resident was observed to have long overgrown fingernails with black substance underneath the distal edges of the fingernails. The resident stated, I don't like long fingernails .I can't cut them by myself, and someone has to help. The resident stated his long fingernails were getting caught in the blankets and clothes and that was inconvenient. In a concurrent observation and interview on 5/13/24 at 9:25 a.m., in the resident's room, LN 1 verified Resident 23 had long overgrown fingernails that were unsanitary. LN 1 stated LNs cut the resident's fingernails every Sunday and Resident 23's fingernails should have been trimmed then.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47197 Based on observation, interview, and record review, the facility failed to ensure two out of 15 sampled residents (Resident 233 and Resident 234) received treatment and care in accordance with professional standards of practice, and facility's policy and procedure (P&P) when: 1. Resident 233's physician's order for stage 3 pressure ulcer/injury (PU/PI- injury to skin and underlying tissue resulting from prolonged pressure which extends through the skin into deeper tissue and fat but do not reach muscle or bone) on the coccyx (area on the lower back where the bottom/base of the spine is) treatment was not followed; and, 2. Resident 233 and Resident 234's wound dressings was not labeled with the nurse initials, and time and date it was applied. These failures had the potential for Resident 's 233's coccyx wound to get worse, and Resident 233 and Resident 234 to not achieve their highest practicable well-being and to not receive appropriate wound care treatment. Findings: 1. A review of Resident 233's clinical record indicated Resident 233 was admitted April of 2024 and had diagnoses that included cutaneous abscess of right lower limb (a localized collection of pus in the skin), cutaneous abscess of head, and stage 3 pressure ulcer (PU/PI- injury to skin and underlying tissue resulting from prolonged pressure which extends through the skin into deeper tissue and fat but do not reach muscle or bone). A review of Resident 233's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/22/24, indicated Resident 233 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 233 had intact cognition. A review of Resident 233's physician's order, dated 4/24/24, indicated, TX [treatment] : STAGE 3 PRESSURE ULCER TO COCCYX, CLEANSE WITH NS [normal saline- a mixture of water and edible salt commonly use in cleaning wounds, help with dry eyes, and used to treat dehydration], PAT DRY, APPLY CALCIUM ALGENATE (used to treat moderate to heavily exuding wounds) FOLLOWED BY DRY DRESSING [a dry piece of gauze used to cover a wound to protect the wound from injury, prevent introduction of bacteria, reduce discomfort, and assist with healing] QD [every day] AND PRN [as needed] IF SOILED/DISLODGED . During a concurrent observation and interview on 5/13/24 at 10:56 a.m. with Licensed Nurse (LN) 4, in Resident 233's room, LN 4 confirmed that Resident 233 had no dry dressing covering his stage 3 PU on the coccyx. LN 4 stated he would expect Resident 233's stage 3 PU on the coccyx to be covered with a dry dressing as per the physician's order to help with wound healing. During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated she would expect the dressing for Resident 233 to be on him because that's the physician's order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Wound Care, revised 10/2010, indicated, 1. Verify that there is a physician's order for this procedure .Dressing material, as indicated (.gauze .) . 2a. A review of Resident 233's physician's order, dated 4/16/24, indicated, TX: .GROIN DRAIN: CLEAN WITH NS, PAT DRY, COVER WITH T-DRAIN SPONGE [a sponge with pre-cut T-slit that provides a snug fit around the drain tubing] FOLLOWED BY CLEAR/TRANSPARENT FILM DRESSING .ONCE A WEEK OR PRN [as needed] IF SOILED OR DISLODGED . A review of Resident 233's physician's order, dated 5/7/24, indicated, TX: OCCIPITAL [back of the head] ABSCESS, CLEANSE WITH NS, PAT DRY, APPLY MEDIHONEY [medical-grade honey intended for wound care] FOLLOWED BY .DRY DRESSING QD AND PRN IF SOILED/DISLODGED . During a concurrent observation and interview on 5/13/24 at 10:56 a.m. with Licensed Nurse (LN) 4, in Resident 233's room, LN 4 confirmed that Resident 233 dry dressing on the back of his head and inner right thigh was not labeled with the initials of the nurse who applied the dressing, and the date and time it was applied. LN 4 stated, It [dry dressing on Resident 233's head and inner right thigh] should be labeled [of the date and time when it was applied] to know when it [dry dressing] was last changed. 2b. A review of Resident 234's clinical record indicated Resident 234 was admitted May of 2024 and had diagnoses that included encounter for other orthopedic aftercare (a care provided after a surgery that involves bones, muscles, and joints), and need for assistance with personal care. A review of Resident 234's ADMISSION-NURSING ASSESSMENT, dated 5/10/24, indicated, .Patient [Resident 234] is A&Ox4 [the patient is alert and oriented to person, place, time, and situation] and has the capacity to make medical decisions . A review of Resident 234's physician's order, dated 5/10/24, indicated, TX: SURGICAL SITE ON LEFT KNEE: CLEANSE WITH NS, PAT DRY, APPLY XEROFORM [a medicated non-adherent primary dressing that promotes wound healing] .AND COVER WITH DRY DRESSING DAILY AND PRN [as needed] IF SOILED OR DISLODGED . During a concurrent observation and interview on 5/13/24 at 1:20 p.m. with Resident 234, in Resident 234's room, Resident 234 was observed to have 2 dry dressing on the left knee; one vertically placed on the left knee, and one placed on the outer side of the left knee. Both dry dressings on the left knee was not labeled with the initials of the nurse who applied the dressing, and the date and time it was applied. Resident 234 confirmed the observation. During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated, .The [dry] dressings should be labelled properly .Label the date and time [on the dry dressing] to keep track if it [dressing change] was done as scheduled and if the [physician's] order is being followed . A review of the facility's P&P titled, Wound Care, revised 10/2010, indicated, .11. Dress wound . [NAME] tape with initials, time, and date and apply to dressing .

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Saylor Lane Healthcare Center	3500 Folsom Boulevard Sacramento, CA 95816

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide enough food/fluids to maintain a resident's health.

32096

Based on interview and record review, the facility failed to assess and evaluate the Intake and Output (I&O, the measurement of fluids entering and leaving the body) weekly summaries for two of 15 sampled residents (Resident 20 and Resident 23) when the residents were on fluid restriction.

This failure placed the residents at risk for unnoted fluid overloads and/or dehydration as well as difficulty to gauge fluid balance of the residents to determine the effects of the treatment and the progress of the disease.

Findings:

Review of Resident 20's Admission Record indicated the resident was a long-term resident in the facility with diagnoses that included hemodialysis (a treatment to filter wastes and fluid from the blood using a dialysis machine, an artificial kidney), heart disease, lung problem with localized swelling issues.

Review of Resident 20's medical record, Order Summary, indicated the resident was on fluid restriction of a total of 2000 ml (milliliter, 2 Liters) per 24 hours with the specification for, Dietary Allotment 1200 ML; Nursing allotment 800 ML/24 Hrs, AM-350 ML, PM-350 ML, NOC [night shift]-100 ML . Record total amount of fluid intake in ML.

Review of Resident 23's Admission Record indicated the resident was a long-term resident in the facility with diagnoses that included chronic kidney disease and was on an anticoagulant (blood thinner) therapy for heart problems.

Review of Resident 23's Medication Administration Record (MAR) indicated the resident had a physician order for 1500 ml daily fluid restriction. The fluid quota specified for dietary allotment of 840 ml and nursing allotment of 660 ml, for AM 300 ml, PM 300 ml, and Noc 60 ml respectively with the start date of 7/5/23.

Review of the facility's revised October 2010 policy and procedure, Encouraging and Restricting Fluids, stipulated Licensed Nurse (LN) to Record the amount of fluid consumed on the intake side of the intake and output record. Record fluid intake in mLs [milliliters] for the resident who was on fluid restriction. The policy instructed, The licensed nurses should complete a summary of fluid intake/hydration status at least once per week and notify the doctor if any signs or symptoms of fluid overload or dehydration.

Review of Resident 20's and Resident 23's medical records indicated LNs recorded the residents' fluid intake each shift respectively in the MAR; however, there was no documented evidence that LNs summed up the residents 24-hour fluids intake totals or completed the weekly fluid intake summary for Resident 20 or for Resident 23.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a concurrent interview and medical record review on 5/15/24 at 11:13 a.m. at the nursing station, LN 2 stated LNs on Saturday PM shift were to complete the weekly I&O summary for the residents who were on fluid restrictions. LN 2 verified there was no weekly I&O evaluations for Resident 20 and Resident 23 and stated they should have the weekly I&O summaries as the residents were on fluid restriction. LN 2 acknowledged the weekly I&O summary was important to determine the fluid balance and to evaluate the fluid restriction orders were effective for the residents. In an interview on 5/15/24 at 12:14 p.m., at the nursing station, the Director of Nursing (DON), with the Nurse Consultant (NC) present, stated all residents on fluid restrictions were I&O monitoring. The DON verified there was no weekly I&O evaluation for Resident 20 and Resident 23 and stated without the weekly or monthly I&O evaluations, it was hard to understand the accurate fluid status of the residents.

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

47197

Based on observation, interview, and record review, the facility failed to ensure proper handling and delivery of respiratory care consistent with the facility's policy and procedures (P&P) and the professional standards of practice for one out of 15 sampled residents (Resident 14) when:

1. Resident 14 had no oxygen in use sign placed on the outside of the room entrance door; and,

2. Resident 14's physician's orders for oxygen therapy was not followed.

These failures had the potential to result in unsafe delivery of oxygen to Resident 14 and potential harm to all the residents in the facility.

Findings:

1. A review of Resident 14's clinical record indicated Resident 14 was admitted April of 2024 and had diagnoses that included respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), chronic obstructive pulmonary disease (COPD- a group of diseases that causes airflow blockage and breathing-related problems, heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), and dependence on supplemental oxygen.

A review of Resident 14's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/15/24, indicated Resident 14 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 14 had moderately impaired cognition. A review of Resident 14's MDS Health Conditions, dated 4/15/24, indicated Resident 14 had shortness of breath or trouble breathing with exertion such as when walking, bathing, or transferring and when lying flat, and was a current tobacco user. A review of Resident 14's MDS Special Treatments, Procedures, and Programs, dated 4/15/24, indicated Resident 14 had continuous oxygen therapy on admission and while he is a resident in the facility.

A review of Resident 14's physician's order, dated 4/8/24, indicated, OXYGEN D/T [due to] SOB [shortness of breath]/COPD at _2_L PER MIN [liters per minute/lpm- unit of measurement for oxygen administration] VIA NASAL CANNULA [a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils] CONTINOUS [sic]. every shift.

During a concurrent observation and interview on 5/13/24 at 10:14 a.m. with Licensed Nurse (LN) 4, in Resident 14's room, LN 4 confirmed that there was no oxygen in use sign placed on the outside of Resident 14's room entrance door. LN 4 stated, .I don't put those [oxygen in use sign] signs up .

During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated, .We [facility staff] put the oxygen in use sign so we [facility staff] can prevent potential harm towards patient or staff .It's [oxygen in use sign] a precautionary reminder for everyone .

A review of the facility's P&P titled, Oxygen Administration, revised 10/2010, indicated, Steps in the Procedure .2. Place an Oxygen in Use sign on the outside of the room entrance door.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview on 5/14/24 at 8:50 a.m. with Resident 14, in Resident 14's room, Resident 14 was observed lying on bed and was using an oxygen delivered using a nasal cannula with oxygen concentrator set at 3 LPM. Resident 14 stated, .No, it should be at 2 [liters per min] . During a concurrent observation and interview on 5/14/24 at 8:51 a.m. with Certified Nurse Assistant (CNA) 3, in Resident 14's room, CNA 3 confirmed that Resident 14 was using an oxygen delivered using a nasal cannula with oxygen concentrator set at 3 lpm. During a concurrent interview and record review on 5/14/24 at 3:34 p.m. with LN 4, Resident 14's clinical records were reviewed. LN 4 confirmed that Resident 14 had no documented notes that he needed more than 2 lpm of oxygen. LN 4 stated, .He's not asking for more than 2 [lpm of oxygen] .He should be at 2 lpm . LN 4 further stated facility staff should follow the physician's order when providing oxygen therapy. During an interview on 5/15/24 at 1:51 p.m. with the DON, the DON stated she would expect the staff to follow the physician's order when administering oxygen therapy to a resident. The DON further stated, . That's [administering 3 lpm instead of 2 lpm of oxygen] too much .there should be monitoring .It [administering 3 lpm instead of 2 lpm of oxygen] could cause hyperoxygenation [a condition in which the body is exposed to an unusual amount of oxygen causing respiratory and/or neurological problems]. A review of Resident 14's care plan intervention, undated, indicated, OXYGEN SETTINGS: O2 [oxygen] via nasal cannula at 2L [liters] continuously . A review of the facility's P&P titled, Oxygen Administration, revised 10/2010, indicated, 1 .Review the physician's orders or facility protocol for oxygen administration .Steps in the Procedure .6. Adjust the oxygen delivery device so that .the proper flow of oxygen is being administered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 47197 Based on interview and record review, the facility failed to ensure one out of 15 sampled residents (Resident 14) received dialysis care services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's order when: 1. Resident 14's post-dialysis weight was not consistently documented in the resident's chart; and, 2. Resident 14's the dialysis communication sheet was not consistently completed. These failures had the potential for Resident 14 to not achieve the highest practicable well-being and to not receive appropriate dialysis care treatment and services. Findings: 1. A review of Resident 14's clinical record indicated Resident 14 was admitted April of 2024 and had diagnoses that included diabetes mellitus (a chronic condition causing too much sugar in the blood that can affect kidney function and breathing), stage 5 chronic kidney disease (a condition in which the kidneys are severely damaged and have stopped doing their job to filter waste from the blood), and dependence on renal dialysis (the process of removing excess water, particles, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). A review of Resident 14's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/15/24, indicated Resident 14 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 14 had moderately impaired cognition. A review of Resident 14's MDS Special Treatments, Procedures, and Programs, dated 4/15/24, indicated Resident 14 was on hemodialysis (a treatment to filter wastes and water from the blood) on admission and while he is a resident in the facility. A review of Resident 14's physician's order, dated 4/8/24, indicated, Document Post [after] dialysis weight in the evening every Mon [Monday], Wed [Wednesday], Fri [Friday]. PM SHIFT MUST COMPLETE . During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated, We [facility staff] refer it [post-dialysis weight] from the dialysis sheet .If they [dialysis center] don't write down anything we [facility staff] call them [dialysis center]. The DON further stated, I expect nurses to document the post-dialysis weight always .so we [facility staff] can check if there's a significant weight change .That's the [physician's] order. During a concurrent interview and record review on 5/15/24 at 3:23 p.m. with Licensed Nurse (LN) 4, Resident 14's clinical records were reviewed. LN 4 confirmed that there were no documented weights of Resident 14 on his electronic medical record on Wednesday, 5/1/24; Friday, 5/3/24; Monday, 5/6/24; Wednesday 5/8/24, and Friday 5/10/24. LN 4 stated the post-dialysis weight should always be documented in resident's chart. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 14's physician's order, dated 4/8/24, indicated, Complete Dialysis Communication Sheet BEFORE and Upon Return from Dialysis two times a day every Mon [Monday], Wed [Wednesday], Fri [Friday]. PM SHIFT MUST COMPLETE FORM UPON RETURN . During an interview on 5/15/24 at 1:51 p.m. with the DON, the DON stated, It [Dialysis Communication Sheet] should always be completed .if not, the nurse should call the dialysis center . During a concurrent interview and record review on 5/15/24 at 3:23 p.m. with LN 4, Resident 14's Dialysis Communication Sheet, dated 5/6/24, was reviewed. LN 4 confirmed that Resident 14's dialysis communication sheet, dated 5/6/24, was not complete and did not indicate Resident 14's pre [before] and post [after] dialysis weights. During a concurrent interview and record review on 5/15/24 at 3:23 p.m. with LN 4, Resident 14's Dialysis Communication Sheet binder was reviewed. LN 4 confirmed that Resident 14's dialysis communication sheet on 5/10/24 was not in the binder. LN 4 stated, The [Dialysis Communication Sheet] binder sometimes gets lost .All dialysis sheet is in there [Dialysis Communication Sheet binder] .If it's not there .I don't know . A review of Resident 14's care plan intervention, dated 5/13/24, indicated, Complete Dialysis communication form pre and post dialysis, which includes VS [vital signs], changes in condition, nutritional status, access site . A review of the facility's P&P titled, Hemodialysis Access Care, revised 09/2010, indicated, Documentation. The General medical nurse should document in the resident's medical record pre/post-dialysis as follows: .4. Any part of report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis.

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NAME OF PROVIDER OR SUPPLIER Saylor Lane Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 Folsom Boulevard Sacramento, CA 95816	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 32096 Based on interview and record review, the facility failed to provide thorough drug regimen reviews (DRR) for one of 15 sampled residents (Resident 23) when the facility did not act on the facility pharmacist (FP) report on irregularities and the expired medications were mixed with other medications available for use in the medication storage room refrigerator. These failures resulted in unresolved irregularities of antipsychotic (to treat symptoms of psychosis) medication therapy for Resident 23 and increased the potential for medication errors. Findings: Review of Resident 23's medical record, Admission Record, indicated the resident was a long term resident in the facility with diagnoses that included unspecified memory problems with behavioral disturbance. Review of Resident 23's medication administration record (MAR) for March, April, and May 2024 indicated the resident was on antipsychotic medication monitoring every shift as follows: 1. Monitor side effect of Antispychotic medication (Risperidone) episodes of facial/tongue movement, decreased mental status, inability to sit still, tremors, drooling, rigidity every shift with the order date of 8/8/23. 2. Monitor behavior for Antipsychotic (Risperidone) episodes of verbally aggressive outbursts every shift, order date of 8/8/23. 3. Monitor behavior for Antipsychotic (Risperidone) episodes of threats self harm every shift, order date of 8/8/23. Review of Resident 23's medical record, Order Listing Report, indicated the residents had two physician orders for Risperidone that were discontinued on 3/25/24 as follows: 1. Risperidone 0.25 mg (milligram) 1 tablet by mouth once a day for dementia with psychotic features until 3/28/24 as evidenced by threats self harm and verbally aggressive outburst with the order date of 2/29/24 2. Risperidone 0.25 mg 1 tablet by mouth twice a day for dementia with psychotic features until 3/14/24 as evidenced by threats self harm and verbally aggressive outburst with the order date of 2/29/24 Review of Resident 23 monthly DRR for 3/1/24 through 3/27/24 included the FP's report on the irregularities of the Risperidone therapy monitoring and recommended, Since this patient [Resident 23] was DC [discontinued] off of Risperidone, you may remove any SE [Side Effect] or behavior monitoring associated with the order if no longer needed. (continued on next page)

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F 0756

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of Resident 23's medical record included no documented evidence that the facility did act upon the FP's March DRR recommendation, either discontinued the monitoring or documented the rationale for continuation of the monitoring pertinent to the Risperidone even though the medication was discontinued.

Review of Resident 23's monthly DRR for 4/1/24 through 4/21/24 included a FP's note, The following is a list of residents [Resident 23 included] which were reviewed during the consultant pharmacist's visit, but did not require any recommendations while the facility had not resolved the FP's recommendation in March and the irregularities continued in the absence of Risperidone administration.

Review of the facility's May 2019 policy and procedure, Medication Regimen Reviews, stipulated, the medication regimen reviews involved, a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems .other irregularities .

In an interview on 5/15/24 at 11:52 a.m. at the nursing station, the Director of Nursing (DON) stated the facility practice was to monitor residents for 72 hours after the discontinuation of antipsychotic medications and drop the monitoring if no issues noted and acknowledged Resident 23 had no issues post Risperidone monitoring period. The DON verified the FP's March DRR recommendation for Resident 23 and stated the facility should have acted on it to complete the DRR process. The DON verified there was no FP's recommendation in April DRR for Resident 23.

In a telephone interview on 5/15/24 at 2:15 p.m., the FP explained the monthly DDR process was for the FP reviewing each resident's medications and making recommendations if indicated and the facility was to act upon the FP's recommendation. The FP acknowledged the March 2024 recommendation for Resident 23 was not resolved and had the potential for confusion and miscommunication among the healthcare providers regarding the antipsychotic therapy for the resident. The FP stated the pharmacist who conducted the April DRR should have identified the irregularities for Resident 23 and made a re-recommendation for the facility to act on.

During the medication storage room observation on 5/13/24 starting at 2:45 p.m. with Licensed Nurse (LN 3), there were multiple identical boxes of pre-filled flu syringes stored in the medication refrigerator drawer available for use. Some of the boxes were open and some were not; two open boxes were 5 milliliter pre-filled Influenza Vaccine afuria(R) Quadrivalent for 2022-2023 and each box contained six and three syringes apiece, nine total, with the expiration date of 6/30/23. The expired syringes were mixed with Influenza Vaccine afuria(R) Quadrivalent 2023-22024 flu vaccines in the drawer.

In a concurrent interview on 5/13/224 starting at 2:45 p.m., LN 3 verified the name, quantity and the expiration date of the flu vaccines.

In a telephone interview on 5/15/24 at 2:15 p.m., the FP stated checking the medication storage room was a part of monthly DRR process and the expired medications should have been found during the DRR monthly visits.

Based on interview and record review, the facility failed to provide thorough drug regimen reviews (DRR) for one of 15 sampled residents (Resident 23) when the facility did not act on the facility pharmacist's (FP) report on irregularities.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This failure resulted in unresolved irregularities of antipsychotic (to treat symptoms of psychosis) medication therapy for Resident 23. Findings: Review of Resident 23's medical record, Admission Record, indicated the resident was a long-term resident in the facility with diagnoses that included unspecified memory problem with behavioral disturbance. Review of Resident 23's medication administration record (MAR) for March, April, and May 2024 indicated the resident was on antipsychotic medication monitoring every shift as follows: a. Monitor side effect of Antipsychotic medication (Risperidone) episodes of facial/tongue movement, decreased mental status, inability to sit still, tremors, drooling, rigidity every shift with the order date of 8/8/23. b. Monitor behavior for Antipsychotic (Risperidone) episodes of verbally aggressive outbursts every shift, order date of 8/8/23 c. Monitor behavior for Antipsychotic (Risperidone) episodes of threats self harm every shift, order date of 8/8/23 Review of Resident 23's medical record, Order Listing Report, indicated the resident had two physician orders for Risperidone that were discontinued on 3/25/24 as follows: 1. Risperidone 0.25 mg (milligram) 1 tablet by mouth once a day for dementia with psychotic features until 3/28/24 as evidenced by threats self harm and verbally aggressive outburst with the order date of 2/29/24 2. Risperidone 0.25 mg 1 tablet by mouth twice a day for dementia with psychotic features until 3/14/24 as evidenced by threats self harm and verbally aggressive outburst with the order date of 2/29/24 Review of Resident 23 monthly DRR for 3/1/24 through 3/27/24 included the FP's report on the irregularities of the Risperidone therapy monitoring and recommended, Since this patient [Resident 23] was DC [discontinued] off of Risperidone, you may remove any SE [Side Effect] or behavior monitoring associated with the order if no longer needed. Review of Resident 23's medical record included no documented evidence that the facility did act upon the FP's March DRR recommendation, either discontinued the monitoring or documented the rationale for continuation of the monitoring pertinent to the Risperidone even though the medication was discontinued. Review of Resident 23's monthly DRR for 4/1/24 through 4/21/24 included a FP's note, The following is a list of residents [Resident 23 included] which were reviewed during the consultant pharmacist's visit but did not require any recommendations while the facility had not resolved the FP's recommendation in March and the irregularities continued in the absence of Risperidone administration. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's May 2019 policy and procedure, Medication Regimen Reviews, stipulated, the medication regimen reviews involved, a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems .other irregularities . In an interview on 5/15/24 at 11:52 a.m. at the nursing station, the Director of Nursing (DON) stated the facility practice was to monitor residents for 72 hours after the discontinuation of antipsychotic medications and drop the monitoring if no issues noted and acknowledged Resident 23 had no issues post Risperidone monitoring period. The DON verified the FP's March DRR recommendation for Resident 23 and stated the facility should have acted on it to complete the DRR process. The DON verified there was no FP's recommendation in April DRR for Resident 23. In a telephone interview on 5/15/24 at 2:15 p.m., the FP explained the monthly DDR process was for the FP reviewing each resident's medications and making recommendations if indicated and the facility was to act upon the FP's recommendation. The FP acknowledged the March 2024 recommendation for Resident 23 was not resolved and had the potential for confusion and miscommunication among the healthcare providers regarding the antipsychotic therapy for the resident. The FP stated the pharmacist who conducted the April DRR should have identified the irregularities for Resident 23 and made a re-recommendation for the facility to act on.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32096 Based on observation, interview and documentation review, the facility failed to discard expired medications for a census of 38 when the expired flu vaccines were mixed with non-expired flu vaccines in the medication refrigerator, available for use. This failure increased the potential for medication errors and placed the residents at risk for drug safety. Findings: During the medication storage room observation on 5/13/24 starting at 2:45 p.m. with Licensed Nurse (LN 3), there were multiple identical boxes of flu vaccines stored in the medication refrigerator drawer in the room. There were 5 milliliter pre-filled Influenza Vaccine afuria(R) Quadrivalent for 2022-2023 mixed with 2023-2024 flu vaccines; two boxes of 2022-2023 vaccines were open and each contained six and three pre-filled syringes apiece, a total of nine syringes, with the expiration date of 6/30/23. Review of the facility's March 2018 policy and procedure, Medication Storage in the Facility, stipulated, Outdated .are immediately removed from stock, disposed of according to procedures for medication disposal . In a concurrent interview on 5/13/224 starting at 2:45 p.m., LN 3 verified the name, quantity and the expiration date of the flu vaccines and stated night shift nurses were to discard the expired medication in the medication storage room and stated the expired flu vaccines should have been disposed. LN 3 acknowledged storing expired medications with non-expired medications, especially when they were identical, increased the potential for medication errors.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

46872

Based on observation, interview, and record review, the facility failed to ensure food safety when food storage temperature logs and sanitization solution logs were not being consistently documented.

This failure had the potential to lead to food borne illnesses for 38 residents eating facility prepared meals.

Findings:

During a concurrent observation and interview on 5/13/24, at 8:21 a.m., with Cook (CK1), the Dry Food Storage Temperature Control Log was reviewed. CK1 stated the temperature for the dry foods' storage room was taken and documented twice daily, once on morning shift and once on evening shift. CK1 confirmed 4 entries were missing for the month of May 2024. CK1 stated it was not acceptable for entries to be missing and not monitoring the temperature could lead to food safety concerns.

During a concurrent observation and interview on 5/13/24, at 8:24 a.m., with Kitchen Aid (KA) 2, the red bucket sanitizing solution was observed near the dishwashing sink. KA 2 tested the solution and stated the sanitizing solution is tested twice daily and results are written on a log. KA 2 showed the Quaternary Ammonium Log and confirmed there were 7 missing entries for the month of May 2024.

During a concurrent observation and interview on 5/13/24, at 8:33 a.m., with CK1, the Cold Storage Temperature Control Log was reviewed. CK1 stated the temperature for the refrigerator and freezer are taken and documented twice daily, once on morning shift and once on evening shift. CK1 confirmed 14 entries were missing for the month of May 2024. CK1 stated not monitoring the temperature can potentially lead to spoiled food and was a safety concern for residents.

During a concurrent observation and interview on 5/13/24, at 8:43 a.m., with the Dietary Supervisor (DS), the food storage temperature logs and sanitation solution log were reviewed. The DS confirmed entries were missing on the Dry Food Storage Log, Cold Storage Temperature Log and Quaternary Ammonium Log. The DS stated kitchen staff were expected to complete the logs twice daily and not doing so could potentially lead to resident harm.

During a review of the facility's policy and procedure (P&P) titled, Preventing Foodborne Illness-Food Handling, revised 7/14, the P&P indicated, Food will be stored .so that the risk of foodborne illness is minimized .refrigeration and food temperatures will be monitored at designated intervals throughout the day and documented .

During a review of the facility's policy and procedure (P&P) titled, Quaternary Ammonium Log Policy, dated 2023, the P&P indicated, The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution .concentration will be tested at least every shift .staff will record the readings twice a day .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 32096 Based on interview and record review, the facility failed to maintain accurate, consistent, and complete medical records for three of 15 sampled residents (Resident 23, Resident 4 and Resident 20) and one randomly selected resident (Resident 3) for a census of 38. These failures resulted in the residents' health and care status to be inaccurately reflected in the medical records and placed the residents at risk for inadequate care due to the potential miscommunication among the healthcare providers. Findings: 1. a) Review of Resident 23's medical record, Admission Record, indicated the resident was a long-term resident in the facility with diagnoses that included unspecified memory problem with behavioral disturbance. Resident 23 was on fluid restriction due to a heart problem. Review of Resident 23's medication administration record (MAR) for March, April, and May 2024 indicated the resident was on antipsychotic medication monitoring every shift for Risperidone (to treat symptoms of psychosis). The antipsychotic monitoring included the side effect of Risperidone and for the behavior manifestation of verbal aggression and threats to self-harm. Review of Resident 23's medical record, Order Listing Report, indicated Risperidone therapy was discontinued as of 3/25/24. In an interview on 5/15/24 at 11:52 a.m. at the nursing station, the Director of Nursing (DON) verified the MARs were inconsistent with Resident 23's antipsychotic medication therapy and acknowledged the inaccurate documentation did not reflect the resident's mental status correctly and stated it could create confusion among the healthcare providers. b) Review of Resident 23's MAR indicated the resident was on a 1500 ml (milliliter) daily fluid restriction therapy with the specific fluid daily allotments for dietary 840 ml and nursing 660 ml respectively. Review of the facility's revised October 2010 policy and procedure, Encouraging and Restricting Fluids, stipulated residents who were on fluid restriction therapy: The nurse should record the 24hr fluid intake at least once per day .the licensed nurse should complete a summary of fluid intake/hydrations status at least once per week . Review of Resident 23's medical record had no weekly I&O evaluation. (continued on next page)

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

In a concurrent interview and record review on 5/15/24 at 11:13 a.m. at the nursing station, Licensed Nurse (LN 2) explained Resident 23 had no weekly I&O evaluation because LNs inaccurately checked no in the I&O section in the LN weekly summary chart. LN 2 stated, otherwise the LN weekly summary would open the task screen where LNs to enter the summary of the resident's I&O weekly total. The most recent four LN weekly summaries, dated 5/11/24, 5/4.24, 4/27/24 and 4/20/24, were reviewed and noted all four summaries check marked that the resident was not on I&O monitoring.

In an interview on 5/15/24 at 12:14 p.m., the DON, with the Nurse Consultant present, verified Resident 23's LN weekly summaries were inaccurate. The DON stated the resident should have been evaluated for weekly I&O and acknowledge the resident's medical record was incomplete.

2. Review of Resident 4's Admission Record indicated the resident admitted to the facility recently for aftercare of neck surgery.

During the medication administration observation on 5/14/24 starting at 8:59 a.m., Licensed Nurse (LN 4) administered Resident 4's morning medications including a 30-milliliter cup of 15-gram liquid protein supplement. Resident 4 took all her morning medications but refused the liquid protein and didn't take it.

Review of Resident 4's 5/14/24 AM medications was reconciled with the MAR. The MAR reflected that the liquid protein was administered to the resident with other morning medications. There was no documented evidence LN 4 noted the resident refused the liquid protein in the progress note or notified the DON or the RD (Registered Dietician).

In a concurrent interview and record review on 5/15/24 at 10:50 a.m., LN 4 stated it was a typo that the protein liquid was administered to Resident 4 the previous morning and stated it should have been coded 2 for the medication refusal and progress note should have been created for the resident's refusal. LN 4 explained it was the facility practice to let DON know when the resident refused prescription medications two to three times and to document in the progress notes for the reason of the resident's refusal. LN 4 stated when resident refused other supplements or over-the-counter medications, LNs do not notify the DON or the physician.

In an interview on 5/15/24 at 12:06 p.m., the DON stated it was her expectation LNs to notify the RD (Registered Dietician) when residents refused supplements and notify the DON for all medication refusal not only prescription medications, but vitamins and over-the-counter medications as well.

3. a) Review of Resident 20's Admission Record indicated the resident was a long-term resident in the facility with diagnoses that included hemodialysis (a treatment to filter wastes and fluid from the blood using a dialysis machine, an artificial kidney) and had an above knee amputation recently. Resident 20 was on fluid restriction due to hemodialysis treatment.

Review of Resident 20's weight variance from 1/12/24 through 5/13/24 indicated the resident had a 12.2 lb. (pound) weight loss for less than half a month period from 131.6 lbs. (2/23/24) down to 119.4 lb. (3/12/24). Since March 2024, the resident continued exhibited insidious weight loss and on 4/24/24 the resident weight was down to 50.7 lb.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a concurrent interview and record review on 5/15/24 at 10:11 a.m. at the nursing station, the RD explained Resident 20 was on hemodialysis and frequently exhibited weight fluctuation up to 10 lbs. in a short period of time. The RD stated 50.7 lb. on 4/24/24 was inaccurate and explained it was a typo that must have been kilograms and not pounds. b) Review of Resident 20's MAR indicated the resident was on a 2000 ml daily fluid restriction therapy with the specific fluid daily quota for 1200 ml dietary and 800 ml nursing respectively. Review of the facility's revised October 2010 policy and procedure, Encouraging and Restricting Fluids, stipulated residents who were on fluid restriction therapy were to be evaluated for the resident's intake hydration status every week (weekly I&O summary). Review of Resident 20's medical record included no documented evidence of the weekly I&O summary evaluation. In a concurrent interview and record review on 5/15/24 at 11:32 a.m. at the nursing station, LN 2 stated Resident 20 had no daily I&O total summary or weekly I&O evaluation summary. LN 2 reviewed the most recent four weeks of nursing weekly summaries and stated they were inaccurate in that LNs documented Resident 20 was not on I&O monitoring. LN 2 stated without the weekly I&O summary, LNs were not able to know whether the resident's intakes were met with the doctor's order and had the potential for unnoted fluid overload, dehydration or skin integrity. In an interview on 5/15/24 at 12:14 p.m., the DON, with the Nurse Consultant present, verified Resident 20 was on fluid restriction and therefore should have been evaluated weekly for the intake/hydration status. The DON acknowledge the resident's medical record was inaccurate and incomplete. 4. Review of Resident 3's Admission Record indicated he was a long-term resident in the facility with diagnoses that included a mood disorder. Review of Resident 3's April and May 2024 MAR indicated LNs monitored the resident for the side effect of an antipsychotic medication, Abilify, for facial/tongue movement, drooling, rigidity, decreased mental status, tremors, and inability to sit still. In addition, the resident was being monitored for his behaviors in relation to Abilify therapy, for verbal aggressive outburst in the absence of Abilify administration which was discontinued on 4/19/24. Review of the facility's policy and procedure, revised July 2017, Charting and Documentation, stipulated, The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .Documentation in the medical record will be .complete, and accurate. In an interview on 5/15/24 at 11:52 a.m., the DON verified the Abilify therapy monitoring had been continued in the absence of the Abilify administration for Resident 3. The DON acknowledged the resident's medical record was inaccurate and inconsistent with the care provided and it could mislead the healthcare providers on the resident's health status.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47197 Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 38 residents when: 1. A facility staff did not wear required personal protective equipment (PPE) when assisting Resident 233 and Resident 234 with mobility exercises who were both on enhanced standard precaution (ESP- also known as enhanced barrier precaution/EBP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use); and, 2. Resident 14's nasal cannula (a medical device with two prongs connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils) was left uncovered and hanging on the resident's bedside rail when not in use. These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure of Resident 233, Resident 234, and Resident 14 to germs, and may cause infection among residents, staff, and visitors. Findings: 1a. A review of Resident 233's clinical record indicated Resident 233 was admitted April of 2024 and had diagnoses that included cutaneous abscess (a localized collection of pus in the skin) of right lower limb, cutaneous abscess of head, and stage 3 pressure ulcer (PU/PI- injury to skin and underlying tissue resulting from prolonged pressure which extends through the skin into deeper tissue and fat but do not reach muscle or bone). A review of Resident 233's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/22/24, indicated Resident 233 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 233 had an intact cognition. A review of Resident 233's physician's order, dated 5/13/24, indicated, Enhanced Based [sic] Precaution (EBP) d/t [due to] stage 3 pressure ulcer (PU- also known pressure injury/PI, injury to skin and underlying tissue resulting from prolonged pressure which extends through the skin into deeper tissue and fat but do not reach muscle or bone) and occipital [back of the head] abscess. every shift. During an observation on 5/13/24 at 10:29 a.m., of Resident 233's room had a sign posted on the door which indicated, Enhanced Standard Precaution .ANYONE PARTICIPATING IN ANY OF THESE SIX MOMENTS MUST ALSO: Don [put on] gown and gloves .Mobility assistance . During an observation on 5/13/24 at 10:36 a.m. in the therapy gym, Physical Therapy Assistant (PTA) was observed not wearing a gown or gloves while assisting Resident 233 with his mobility exercises in using the stairs. PTA went in contact with Resident 233's clothing multiple times and touched Resident 233's shoulder. PTA was also observed assisting Resident 233 to sit on his walker and proceeded on checking Resident 233's oxygen level using a pulse oximeter (an electronic device that clips onto a resident's finger to measure the oxygen level in the blood) without using gown or gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Saylor Lane Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 Folsom Boulevard Sacramento, CA 95816	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/13/24 at 10:37 a.m. with PTA, PTA confirmed she did not wear a gown or gloves while assisting Resident 233 in his mobility exercises and when checking Resident 233's oxygen level using a pulse oximeter. PTA stated, .We [therapy staff] don't wear those in therapy [gym] because his [Resident 233] wound is covered .Our practice is not to wear them [gown and gloves] in the therapy gym. PTA further stated the importance of following ESP is for infection control and prevention of bacterial transmission. During a concurrent observation and interview on 5/13/24 at 10:56 a.m. with Licensed Nurse (LN) 4, in Resident 233's room, LN 4 confirmed that Resident 233 had no dry dressing covering his stage 3 PU on the coccyx (area on the lower back where the bottom/base of the spine is). LN 4 stated he would expect Resident 233's stage 3 PU on the coccyx to be covered with a dry dressing. A review of Resident 233's care plan, undated, indicated, [name of Resident 233] is on enhanced based [sic] precautions d/t stage 3 pressure injury to coccyx and occipital abscess. A review of Resident 233's care plan intervention, undated, indicated, Don .PPE as indicated when doing one of the following: .mobility assistance . 1b. A review of Resident 234's clinical record indicated Resident 234 was admitted May of 2024 and had diagnoses that included encounter for other orthopedic aftercare (a care provided after a surgery that involves bones, muscles, and joints), and need for assistance with personal care. A review of Resident 234's ADMISSION-NURSING ASSESSMENT, dated 5/10/24, indicated, .Patient [Resident 234] is A&Ox4 [the patient is alert and oriented to person, place, time, and situation] and has the capacity to make medical decisions . A review of Resident 234's physician's order, dated 5/13/24, indicated, Enhanced Based [sic] Precaution (EBP) d/t surgical site to L [left] knee. every shift. During an observation on 5/13/24 at 11:25 a.m., in Resident 234's room there was a sign posted on the door which indicated, Enhanced Standard Precaution .ANYONE PARTICIPATING IN ANY OF THESE SIX MOMENTS MUST ALSO: Don [put on] gown and gloves .Mobility assistance . During an observation on 5/13/24 at 11:27 a.m. in the therapy gym, PTA was observed not wearing a gown or gloves while assisting Resident 234 with his sit-to-stand mobility exercises. PTA went in contact with Resident 234's clothing multiple times while standing closely to Resident 234 during the mobility exercises. A review of Resident 234's care plan, undated, indicated, [name of Resident 234] is on enhanced based [sic] precautions d/t stage surgical site to L knee. A review of Resident 233's care plan intervention, undated, indicated, Don .PPE as indicated when doing one of the following: .mobility assistance . During an interview on 5/13/24 at 1:11 p.m. with the Chief Clinical Officer (CCO), the CCO stated they are aware about the new QSO (policy, memos, and guidance from the Centers for Medicare & Medicaid Services [CMS]) regarding ESP and the facility follows it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated facility staff should be observing ESP if a resident is placed under ESP to avoid potential spread of diseases, if there's any. A review of the facility's policy and procedure (P&P) titled, Enhanced Standard Precautions, revised 8/2022, indicated, 1. Enhanced standard precautions (ESPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents. A review of the QSO-24-08-NH memorandum from CMS with the subject, Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated, .Outside the resident's room, EBP should be followed .when working with residents in the therapy gym . 2. A review of Resident 14's clinical record indicated Resident 14 was admitted April of 2024 and had diagnoses that included respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), chronic obstructive pulmonary disease (COPD- a group of diseases that causes airflow blockage and breathing-related problems, heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), and dependence on supplemental oxygen. A review of Resident 14's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/15/24, indicated Resident 14 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 14 had a moderately impaired cognition. A review of Resident 14's MDS Health Conditions, dated 4/15/24, indicated Resident 14 had shortness of breath or trouble breathing with exertion such as when walking, bathing, or transferring and when lying flat, and was a current tobacco user. A review of Resident 14's MDS Special Treatments, Procedures, and Programs, dated 4/15/24, indicated Resident 14 had continuous oxygen therapy on admission and while he is a resident in the facility. A review of Resident 14's physician's order, dated 4/8/24, indicated, OXYGEN D/T SOB [shortness of breath]/COPD at _2_L PER MIN [liters per minute/lpm- unit of measurement for oxygen administration] VIA NASAL CANNULA CONTINOUS [sic]. every shift. During a concurrent observation and interview on 5/13/24 at 10:14 a.m. with LN 4, in Resident 14's room, LN 4 confirmed that Resident 14's nasal cannula was left wrapped around and hanging on resident's bedside rail when not in use. LN 4 stated Resident 14 went to his dialysis (the process of removing excess water, particles, and toxins from the blood in people whose kidneys can no longer perform these functions naturally) treatment and was picked up before 9 a.m. today. LN 4 further stated he would expect the nasal cannula to be placed inside a bag when not in used, for infection control. During an interview on 5/15/24 at 1:51 p.m. with the DON, the DON stated, .It [nasal cannula] should be bagged when not in use . for infection control . A review of the facility's P&P titled, Departmental (Respiratory Therapy)- Prevention of Infection, revised 11/2011, indicated, Steps in the Procedure .8. Keep the oxygen cannula and tubing .in a plastic bag when not in use.