STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40841 Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for one of 26 sampled residents (Resident 141), when the care plan did not address Resident 141's catheter (permanent catheter, a flexible tube inserted into a blood vessel) treatment services and interventions. This failure decreased the facility's potential to address the residents' individualized and specific needs. Findings: A review of an admission record indicated Resident 141 was admitted to the facility in 2024 with a diagnosis of chronic kidney disease (a condition when the kidneys gradually lose its ability to filter blood properly). During a concurrent observation and interview on 11/4/24 at 9:45 a.m. inside Resident 141's room, Resident 141 stated staff did not do any dressing change and monitoring for her right upper chest catheter since she was admitted on e week ago. A review of Resident 141's Order Summary Report, dated 11/5/24, indicated there was no order for catheter care and dressing monitoring on the right upper chest. A review of Resident 141's Admission/Readmission Evaluation/Assessment, dated 10/28/24, indicated a skin assessment was done by the charge nurse and the skin was intact without any vascular access. During a concurrent interview and record review on 11/5/24 at 3:13 p.m. with Licensed Nurse 1 (LN 1), Resident 141's order was reviewed. LN 1 confirmed there was no order for catheter care and dressing monitoring for Resident 141. LN 1 further stated during admission, the nurse should check the resident's skin and assess for any catheter tubing. During an interview on 11/6/24 at 3:03 p.m. with the Director of Nursing (DON), DON confirmed there was no care plan for catheter care since 11/5/24. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Peripheral IV and Midline IV Dressing Changes, dated 4/2006, indicated, Replace gauze dressing every 2 days (48 hours) and transparent dressing every 3-7 days (in accordance with facility policy). A review of the facility's policy and procedure (P&P) titled, Intravenous Therapy: Preventing Catheter-Related Infections, dated 4/2006, indicated the surveillance was to Assess catheter sites visually or by palpation through the intact dressing on a daily basis. The P&P further indicated, Thoroughly examine the catheter site with each routine dressing change. A review of the facility's policy titled, Comprehensive Person-Centered Care Plans, dated 2001, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47465 Based on observation, interview, and record review, the facility failed to provide services according to professional standards for one of 26 sampled residents (Resident 2), when an anticoagulant (medication that prevent or reduce blood clotting) monitoring was not in place for Resident 2. This failure had the potential to put Resident 2 at risk for having complications due to excessive bleeding. Findings: A review of an admission record indicated, Resident 2 was admitted to the facility in October 2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and cerebral infarction (occurs when blood flow to the brain is blocked). A review of Resident 2's Medication Administration Record, dated 11/6/24, indicated Resident 2 was receiving apixaban (medication that decreases the clotting ability of the blood) tablet twice a day. The record did not indicate an order to monitor side effects such as excessive bleeding or bruising. During a concurrent interview and record review on 11/6/24 at 12:10 p.m. with Licensed Nurse 4 (LN 4), Resident 2's orders and care plan were reviewed. LN 4 confirmed there were no orders or care plan for anticoagulant monitoring. LN 4 stated having no order or care plan for anticoagulant monitoring placed Resident 2 at risk for not being monitored for side effects of apixaban. During an interview on 11/6/24 at 1:20 p.m. with the Director of Nursing (DON), DON stated her expectations were residents on anticoagulants should have orders to monitor side effects and an anticoagulant monitoring care plan, otherwise not having them could lead residents to not being monitored for bleeding. A review of the facility's policy titled, Medication Therapy, revised April 2007, indicated, All medication orders will be supported by appropriate care processes and practices. The policy further indicated, . presence of clinical significant adverse consequences . medication should be reduced or discontinued . A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, . care plan includes measurable objectives and . establishing the expected goals and outcomes of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50168 Based on observation, interview, and record review, the facility failed to accurately document and replace emergency medication kits (E-Kit: a kit/box containing medications and supplies for immediate use during a medical emergency) for a census of 95. This failure decreased the facility's potential for having accurate accountability of emergency medications, availability of emergency medications when needed, and meeting the residents' therapeutic needs. Findings: During a concurrent observation and interview on 11/4/24 at 9:35 a.m. with Licensed Nurse 3 (LN 3) in the medication room on the second floor, it was observed that an intravenous (IV; Injectable medication to be administered into the vein) E-kit was found to be opened on 10/16/24 at 10:25 p.m. LN 3 stated, one liter (L, a unit of measure) of dextrose (a type of sugar solution) was taken out of the E-kit and was not replaced. LN 3 further stated the medication sticker should have been faxed on 10/16/24 to the pharmacy to replace the E-kit and the faxed order should have been documented in a binder in the nursing station. During a concurrent observation and interview on 11/4/24 at 9:40 a.m. with LN 3 in the medication room on the second floor, a refrigerated E-kit was found to be opened on 8/16/24. LN 3 stated a 10 milliliters (ml; a unit of measure) vial of insulin (medication used to lower blood sugar level) was taken out of the E-kit, but pharmacy was not notified, and the E-kit box was not replaced. LN 3 stated if the E-kit was not replaced, then residents will be at risk when emergency medications were needed. During an interview on 11/6/24 at 9:40 a.m. with the Director of Nursing (DON), DON stated her expectation was nurses and pharmacy should have followed the process to replace the E-kits within 72 hours to ensure all emergency medications were available for residents in case of an emergency. A review of the facility's policy and procedure titled, Emergency Pharmacy and Emergency Kits, dated September 2021, indicated, As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the kit by transmitting the entire order for the resident and indicating the first dose was used from the kit . The nurse opening the kit also records use of the kit in the Emergency kit logbook. The nurse records the date, time, resident name, medication name, strength, and dose . If exchanging kits, open kits are replaced within 72 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 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. 50168 Based on observation, interview, and record review, the facility failed to ensure that medications and medical supplies were labeled, stored, and disposed of consistently according to the facility's policies and procedures for a census of 95, when: 1. A medication refrigerator was not properly locked in the medication room, 2. Expired pharmaceutical products were found in a medication refrigerator, medication carts, and treatment carts, 3. Prescription pharmaceutical products did not have resident specific labels, and 4. Open date labels were not used to determine expiration dates. These failures had the potential for residents' medication misuse, drug diversion and medication errors and ineffectiveness. Findings: 1. During an observation on 11/4/24 at 9:35 a.m. in the second-floor medication room, the medication room refrigerator was found to be unlocked. During an interview on 11/4/24 at 9:35 a.m. with Licensed Nurse 3 (LN 3), LN 3 stated the refrigerator was normally locked, and if not, then someone could have taken the medications and therefore became unavailable for residents when needed. During an interview on 11/6/24 at 9:35 a.m. with the Director of Nursing (DON), DON stated her expectation was the medication refrigerator should be locked. A review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated September 2021, indicated, The medication supply is accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 2. During an observation on 11/4/24 at 9:35 a.m. in the second-floor medication room, a bottle of 200 milliliters (ml, a unit of measure) lansoprazole (medication for reducing the amount of acid your stomach makes) was found with an expiration date of 10/20/24. During an interview on 11/4/24 at 9:38 a.m. with LN 3, LN 3 stated the bottle was opened on 9/20/24 with an expiration date of 10/20/24. LN 3 also stated, the bottle of lansoprazole was good for 30 days and should have been thrown away since it was expired. During an observation on 11/5/24 at 9:20 a.m., a 2.5 ml bottle of latanoprost (eye drops used to treat conditions that cause increase pressures inside the eye) was found to be expired on 11/3/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/24 at 9:20 a.m. with LN 4, LN 4 stated expired eye drops could cause an inaccurate strength of eye drops. During an observation on 11/04/24 at 1 p.m., a 473 ml bottle of sodium hypochlorite solution (a type of diluted bleach used as a disinfectant) was found to be expired in August 2024. During an interview on 11/4/24 at 1 p.m. with LN 3, LN 3 acknowledged the bottle was expired and stated expired bottle might not help the residents. During an interview on 11/6/24 at 9:43 a.m. with DON, DON stated her expectation was there should have been no expired medications. DON further stated expired medications should have been removed the month prior. A review of the facility's P&P titled, Medication Storage in the Facility, dated September 2021, indicated, Outdated, contaminated, or deteriorated medications . are immediately removed from stock and disposed of in accordance to procedures for mediation disposal. 3. During a concurrent observation and interview on 11/4/24 at 1 p.m. with LN 3, 50 grams (g; a unit of measure) silver sulfadiazine (used to treat and prevent infections for people with burns to the skin) and two 50 g containers of lidocaine (cream used to treat pain) ointment were found without resident specific labels. LN 3 stated without the label, it could have been used for multiple residents with potential for cross contamination. During an interview on 11/6/24 at 9:35 a.m. with DON, DON stated if the medications did not have a resident specific label, then there could be potential for medication error or cross contamination and an issue of infection control. A review of the facility's P&P titled, Administering Medications, dated April 2019, indicated, Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the director of nursing services. 4. During an inspection on 11/4/24 at 9:35 a.m. of medication cart B on the second floor, a 3 ml of semaglutide (a medication used to lower high blood sugar levels) was found without an open date. During an interview on 11/4/24 at 9:36 a.m. with LN 3, LN3 stated the semaglutide was expired. During an interview on 11/6/24 at 9:40 a.m. with DON, DON agreed that if the manufacturer packaging stated there should be an open date, then the staff should put an open date on the medication to calculate the expiration date. DON also stated with no open date it was impossible to know if the medications were expired or not. A review of the manufacturer instructions for semaglutide package label printed on the box indicated, to discard 56 days after opening. During an inspection on 11/5/24 at 9:20 a.m. of medication cart for station 2, a bottle of blood glucose test strips (small disposable plastic strips used to measure blood sugar levels) was found without an open date to determine its expiration date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/24 at 9:20 a.m. with LN 4, LN 4 stated expired test strips could give inaccurate test results. During an interview on 11/6/24 at 9:49 a.m. with DON, DON stated her expectation was there should have been an open date for the test strips. A review of the manufacturer instructions of the blood glucose test strips package label printed on the outside of bottle indicated, to use within six months of opening. During an inspection on 11/4/24 at 12:20 p.m. of medication cart 3-B, a package of umeclidinum and vilanterol (combination of two medications used to control wheezing, shortness of breath, coughing, and chest tightness) had no open date. The manufacturer packaging indicated to discard six weeks after opening. During an interview on 11/4/24 at 12:25 p.m. with LN 3, LN 3 stated if the product had no open date then it could be expired and did not give the right strength of medication to the resident. During an interview on 11/6/24 at 9:50 a.m. with DON, DON acknowledged that if the manufacturer packaging stated there should be an open date, then staff should put an open date. A review of the facility's P&P titled, Administering Medications, dated April 2019, indicated, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multidose container the date opened is recorded on the container.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49821 Based on observation, interview, and record review, the facility failed to ensure the menu was followed during lunch for a therapeutic diet (a modification of a regular diet to fit a person's particular nutritional needs, which could be related to a medical condition - usually prescribed by a physician), when 10 residents on a pureed diet for a census of 95 were served food that was not consistent with the recipe. This failure had the potential to compromise the residents' nutritional status. Findings: During a concurrent observation and interview on 11/6/24 at 10:45 a.m. with Dietary [NAME] 1 (DC 1), DC 1 started preparing the pureed diet for 10 residents for a total of 12 servings, with the two extra servings for double portions and a test tray. After boiling the diced carrots, DC 1 confirmed she added 1 1/2 cups of chicken broth to the carrots for 12 half-cup servings, which were pureed in a blender. DC 1 acknowledged the consistency of the pureed carrots was runny and stated the mixture would thicken when heated on the steam tray and the consistency of the pureed carrots would be similar to that of mashed potatoes. DC 1 put the carrots on the steamer tray at 10:50 a.m. and nothing was added to them after that. During an observation on 11/6/24 from 11:32 a.m. to 12:48 p.m., it was noted during tray line (food service assembly line where workers plate food) that the carrot mixture oozed into other plated food. During a concurrent observation and interview on 11/6/24 at 12:59 p.m. with the Dietary Services Supervisor (DSS), a pureed diet test tray tasting indicated the carrots had a runny consistency. DSS stated the extra liquid in the carrots could have contributed to a pureed mixture that was too thin. During an interview on 11/7/24 at 10 a.m. with the Registered Dietician (RD), RD stated she wanted to check with DC 1 why the pureed vegetable recipe was altered. RD also stated DC 1 could have added food thickener to the carrots. A review of a facility document titled, Recipe: (Pureed International Dysphagia Diet Standardization Initiative (IDDSI) Level 4) Vegetables, dated 2024, indicated, Vegetables per recipe . Serves 12 . 1/4 to 3/4 cup (of) . broth, denoted the recommended amount of added liquid to make the appropriate pureed texture per total number of vegetable servings. A review of a facility document titled, Recipe: Pureed (IDDSI Level 4) Vegetables, dated 2024, indicated, . instant potatoes or commercial instant food thickener, as options for a vegetable thickener.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49821 Based on observation, interview, and record review, the facility failed to serve pureed food (cooked food that has been processed in a blender) that was suitable to consume, when the kitchen prepared food items with inadequate textures for 10 residents on a pureed diet for a census of 95. This failure had the potential to compromise the residents' medical and nutritional status. Findings: During a concurrent observation and interview on 11/6/24 at 10:45 a.m. with the Dietary [NAME] 1 (DC 1), DC 1 confirmed she added 1 1/2 cups of chicken broth for 12 1/2 cup servings (with two extra servings for double portion requests and test tray) of cooked carrots and ran the ingredients through a blender. DC 1 stated the carrot mixture was runny because she expected it to thicken up while placed on the hot steam tray and the consistency would be like mashed potatoes. The carrot mixture was put in a metal serving pan on the steamer tray at 10:50 a.m. and no further ingredients were added before serving. During a concurrent observation and interview on 11/6/24 at 11:11 a.m. with DC 1, DC 1 pureed 12 baked wheat rolls by adding one cup of heated milk and butter for every five rolls she blended. The consistency was thick after the initial blending and DC 1 added another 2/3 cup of heated milk and butter. DC 1 stated the thinner consistency of the rolls was what she aimed for, and the rolls would continue to thicken while they were placed on the hot steam tray line. DC 1 stated she wanted the pureed rolls to be in a consistency that molded to the inside of the serving scoop. DC 1 compared the texture at serving time to creamy mashed potatoes. The pureed bread was placed in a metal serving pan on the steam tray at 11:17 a.m. During an observation on 11/6/24 at 11:39 a.m. during tray line (food service assembly line where workers plate food), the following pureed items were served from the steam table for 10 residents: stiff bread roll puree and watery carrot mixture which seeped into the other plated food items. During a concurrent observation and interview on 11/6/24 at 12:59 p.m. with the Dietary Services Supervisor (DSS), in the main dining room, DSS noted the carrots had a watery texture which could have been caused from extra liquid during cooking and stated she could taste lumps in the thick bread puree. During an interview on 11/6/24 at 2:14 p.m. with DSS, DSS confirmed that the thin pureed carrot texture and the firm bread puree with lumps could make it hard for residents on pureed diet to consume the food. DSS further stated runny carrots could lead to less nutrients consumed and thick bread puree with lumps could be difficult for residents to swallow. During an interview on 11/7/24 at 10 a.m. with the Registered Dietitian (RD), RD stated DC 1 could have added an approved thickener to the pureed carrots to make them more palatable. RD also stated the stiff lumpy pureed bread posed an aspiration risk (when a person accidentally inhales food into their lungs through their airway) for the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility document titled, Healthcare Menus Direct, LLC. International Dysphasia Diet Standardization Initiative (IDDSI) Transition, dated 2024, indicated, Pureed/IDDSI Level 4: This diet has been designed for residents who have difficulty swallowing or chewing. The texture of the prepared pureed food items . should be smooth and free of lumps, hold their shape, while not being too firm or sticky, and should not weep.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49821 Based on observation, interview, and record review, the facility failed to store food and maintain proper sanitizing procedures in accordance with professional standards for food service safety for a total of 95 residents, when: 1. Expired food was found in dry storage, 2. Metal serving containers were stacked wet in storage, 3. [NAME] sticky residue was found on the bottom surface of a metal serving container, and 4. Two of three sanitizer buckets contained sanitizers not within required disinfecting ranges. These failures had the potential to lead to contamination and food borne illness among residents. Findings: 1. During a concurrent observation and interview on [DATE] at 9 a.m. with the Dietary Services Supervisor (DSS), one opened package and two unopened packages of hamburger buns were found expired on the bread rack. The opened bread had an open date of [DATE] (the date the bread was taken out of the freezer) with no expiration date written on the label (bread was in dry storage for 20 days). Two unopened hamburger bun packages had open dates of [DATE] and expiration dates of [DATE] written on the label (bread was in dry storage for eight days). DSS stated bread was expired and should have not been kept on the bread rack past five to seven days from the opening date, whether the bread was opened or not. A review of a facility document titled, Dry Goods Storage Guidelines, dated 2023, indicated, bread should be stored no longer than ,d+[DATE] days, unopened . or opened on shelf. 2. During a concurrent observation and interview on [DATE] at 9:22 a.m. with DSS, eight steam table pans were found stacked wet. DSS stated the pans were stored wet. They should be air dried before storing. A review of the facility's undated policy and procedure (P&P) titled, Dishwashing, indicated, Dishes are to be air dried in racks before stacking and storing. A review of the United States Food and Drug Administration (FDA) Food Code 2022, Section ,d+[DATE].11, titled, Equipment and Utensils, Air Drying Required, dated [DATE], indicated, After cleaning and sanitizing, equipment and utensils shall be air dried . Items must be allowed to . air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview on [DATE] at 9:29 a.m. with DSS, one metal serving container was found to have a brown sticky residue on the outside bottom surface. DSS touched the bottom surface and stated it was sticky. DSS further stated the pan was not appropriately sanitized for use on the kitchen's steam tray line. A review of the facility's undated P&P titled, Dishwashing, indicated, All dishes will be properly sanitized through the dishwasher . Gross food particles shall be removed by careful scraping and pre-rinsing in running water. 4. During a concurrent observation and interview on [DATE] at 10:29 a.m. with the Dietary Aide (DA), two of three sanitizer buckets containing quaternary ammonia sanitizer were tested at 100 parts per million (ppm; a unit of measure). DA stated Dietary [NAME] 2 (DC 2) filled the sanitizing buckets at 6 a.m. and the sanitizer buckets were sitting too long before being replenished and had lost their cleaning strength. DA also stated they should be emptied and replaced with new sanitizer approximately every two hours or when the solution becomes noticeably dirty. During an interview on [DATE] at 10:37 a.m. with DC 2, DC 2 stated she first filled the sanitizer buckets with fresh water and quaternary ammonia at around 5:40 a.m. and did not have time to refresh them. During an interview on [DATE] at 10:41 a.m. with DSS, DSS stated the red sanitizing buckets' solution should read 200 ppm on the quaternary ammonium test strips. DSS also stated 100 ppm would not be an acceptable strength to clean contaminated kitchen surface areas. During an interview on [DATE] at 10:24 a.m. with the Registered Dietician (RD), RD stated that 100 ppm quaternary ammonium sanitizer was too weak for adequate decontamination of surfaces or equipment. A review of a facility document titled, Quaternary Ammonium Log, dated 2018, indicated, Ammonium reading should be at least 200 ppm . A review of the facility's policy titled, Quaternary Ammonium Log Policy, dated 2023, indicated, The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution . The solution will be replaced when the reading is below 200 ppm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40841 Based on observation, interview, and record review, the facility failed to maintain infection control for a census of 95 residents, when: 1. Staff members did not use gowns in rooms with enhanced barrier precautions (EBP, an infection control method that involves wearing gowns and gloves during high-contact interactions); 2. Certified Nursing Assistant 5 (CNA 5) did not use personal protective equipment (PPE) while providing care to Resident 21 in an EBP room; and 3. A clean-linen cart was stored uncovered in the basement. These failures had the potential for the spread and transmission of a communicable disease among residents. Findings: 1. During a concurrent observation and interview on 11/4/24 at 9:45 a.m. and 9:55 a.m. with a physical therapist (PT) inside an EBP room, the PT was assisting a resident to transfer from bed to wheelchair without wearing a gown. The PT confirmed he should have used a gown and gloves while in the EBP room. During a concurrent observation and interview on 11/4/24 at 9:58 a.m. and 10:01 a.m. with CNA 2 inside an EBP room, CNA 2 was changing the old linen with new linen using the same gloves. CNA 2 did not use a gown while changing linen. CNA 2 confirmed she should have used a gown and gloves while changing the linen inside an EBP room. During a concurrent observation and interview on 11/4/24 at 10:29 a.m. and 10:35 a.m. with CNA 3 inside an EBP room, CNA 3 was checking a resident's weight using a mechanical lift (a device to lift-up resident). CNA 3 confirmed he should have used a gown and gloves in an EBP room. During a concurrent observation and interview on 11/4/24 at 11:47 a.m. with a hospice nurse (HN) in an EBP room, the HN did not use a gown while assessing a resident at the bedside. HN confirmed he should have used a gown in an EBP room. During an interview on 11/6/24 at 12:25 p.m. with the Infection Preventionist (IP), IP expected staff to follow the EBP signage for the PPE requirement of a gown and gloves while assisting care for the resident in an EBP room. A review of the facility's policy titled, Enhanced Barrier Precautions, dated October 2018, indicated, the staff to use gown and gloves while assisting resident with dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care and/or wound care. The policy further stipulated, PPE is available outside of the resident rooms. 48694 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 21's Admission Record, indicated Resident 21 was admitted to the facility in April 2017 with a diagnosis of quadriplegia (weakness below neck including both arms and legs). During a concurrent observation and interview on 11/4/24 at 10:37 a.m. with CNA 5, CNA 5 was providing care to Resident 21 in an EBP room without wearing a protective gown. CNA 5 agreed she did not use PPE as per instructions posted at the room entrance and stated she was dressing Resident 21 and getting him ready to transfer from bed to wheelchair. CNA 5 further stated Resident 21 was on EBP due to pressure ulcer stage four (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on right hip and she should have used PPEs to protect Resident 21 from infection. During a concurrent interview and record review on 11/6/24 at 10:36 a.m. with Treatment Nurse (TN), Resident 21's wound record was reviewed. Resident 21 had a pressure ulcer stage 4 on right hip and heeling slowly without any complications. TN stated CNA 5 should have used PPEs to protect Resident 21 from infection. During an interview on 11/7/24 at 11:41 a.m. with Director of Nursing (DON), DON stated CNA 5 should have used PPEs as per facility's policy and instructions posted at the room entrance to protect Resident 21 from infection. A review of the facility's policy titled, Enhanced Barrier Precautions, dated October 2018, indicated, . Enhanced barrier precautions are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms to residents . gloves and gown are applied prior to performing the high contact resident care activity including . dressing . transferring . for the residents with wounds . 3. During a concurrent observation and interview on 11/7/24 at 10:19 a.m. with Laundry Supervisor (LS), a clean-linen cart was observed in the basement. The cart was full of clean linen and there was no cover on it. LS agreed a clean-linen cart was stored uncovered. During an interview on 11/7/24 at 10:25 a.m. with IP, IP stated the clean-linen carts should never be stored uncovered. IP also stated the linen inside the uncovered cart was contaminated. During an interview on 11/7/24 at 11:44 a.m. with DON, DON stated the clean-linen carts stored in the basement should be covered all the time and the uncovered clean linen was a source of infection. A review of the facility's policy titled, Laundry and Linen, dated January 2014, indicated, . Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055493	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Town Oaks Post-Acute	2600 L Street 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 48694 Based on observation, interview, and record review, the facility failed to ensure the call light was functioning for one of 26 sampled residents (Resident 37), when Resident 37 pushed the button for assistance and the call light did not turn on. This failure decreased the facility's potential to assist Resident 37 when needed. Findings: A review of Resident 37's admission record indicated Resident 37 was admitted to the facility in April 2024 with diagnoses including malignant breast neoplasm (a cancerous breast tumor likely to spread to other body parts) and generalized muscle weakness. A review of Resident 37's Minimum Data Set (MDS-an assessment tool), dated 10/15/24, indicated Resident 37 needed partial to moderate assistance to roll from side to side in the bed. During a concurrent observation and interview on 11/4/24 at 10:51 a.m. with Resident 37, Resident 37 was lying on her back at the left edge of the bed and pressing the call light button. Resident 37 stated she had been pressing the call button for few minutes and did not get any response. Resident 37 further stated being afraid to slide off the bed and fall. During a concurrent observation and interview on 11/4/24 at 10:53 a.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 checked the call light securely plugged, pressed the call light button, and checked the light outside the room. The light did not turn on indicating Resident 37 needed assistance. CNA 4 confirmed Resident 37's call light was not working and stated Resident 37 needed urgent assistance for repositioning in the bed to prevent fall and injuries. During an interview on 11/7/24 at 11:36 a.m. with the Director of Nursing (DON), DON stated Resident 37's call light should be working at all times and nurses should have checked on Resident 37 every two hours or more frequently and made sure the call light was functioning. DON further stated Resident 37 would have missed the assistance needed and an unwanted incident might have happened. A review of the facility's policy titled, Residents' Call System, dated September 2022, indicated, . The resident call system remains functional at all times .