STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055855	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Park Post Acute	3400 Alta Arden Expressway Sacramento, CA 95825

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681 Based on interview and record review, the facility failed to ensure one resident (Resident 1) was treated with respect and dignity when facility staff was on the phone while providing care, for a census of 145. This failure had the potential for Resident 1 not to receive care based on her needs and preferences. Findings: A review of the clinical record indicated Resident 1 was admitted end of March 2024 with diagnoses including aftercare following joint replacement surgery. The Minimum Data Set (MDS, an assessment tool), dated 4/3/24, indicated Resident 1 was cognitively intact, required partial or moderate assistance with toileting hygiene and frequently incontinent of urine and stool. Further review of Resident 1's care plan dated 3/28/24 indicated, .[Resident 1] has actual for ADL[activities of daily living, tasks related to personal care and includes toilet use]/mobility decline and requires assistance related to recent hospitalization , recent surgery . The inteventions included, Encourage to use call light for assistance. A telephone interview was conducted on 4/23/24 at 5:25 p.m. with Resident 1's Care Coordinator (CC) from [name of the agency]. The CC stated Resident 1 informed her the Certified Nursing Assistant 1 (CNA 1) rolled his eyes and walked out without saying anything when Resident 1 tried to explain her concerns, and CNA 1 was on the phone most of the time when he was giving care. During an interview conducted on 4/24/24 starting at 6:13 a.m., Resident 3 stated there were 4 guys who use their phones a lot of times around mid shift and evening shift. Resident 3 further stated they [staff] dock in the rooms to make phone calls. A review of the clinical record indicated Resident 3 was admitted with diagnoses including osteomyelitis of vertebra, lumbar region (inflammation or swelling of bone tissue in the lower back as a result of infection). Resident 3's MDS, dated [DATE], indicated he was cognitively intact. In an interview on 4/24/24 at 7:41 a.m., Licensed Nurse 1 (LN 1) stated she heard CNA 1 was always disappearing on the PM [afternoon] shift. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent interview and record review on 4/24/24 at 10:43 a.m., the Human Resources Manager (HRM) stated CNA 1 had 2 Employee Counseling Forms on his file dated 3/13/24 and 4/12/24. The counseling form dated 4/12/24 indicated, .This follow-up write-up is a continuation of the previous disciplinary action taken on March 13, 2024 . The following concerns have been identified since the last write-up .Poor customer service . Use of personal cell phone while on the floor, which detracts from your responsibilities and professionalism . Leaving the floor for extended periods of time, resulting in inadequate coverage and potential safety concerns. The HRM explained the poor customer service included staff demeanor (the way a person acts, speaks, expresses themselves). The HRM stated CNA 1 acknowledged the facility's cell phone policy on 11/7/23. The policy indicated, It is the policy of this facility that cell phones will not be used while working, when on the floor or in the resident care area. In an interview on 4/24/24 at 12:01 p.m., the Director of Nursing (DON) stated she received a call from Resident 1's CC when she was out sick. The CC told DON Resident 1 had some concerns with a certified nursing assistant. The DON further stated she called Resident 1 on her cellphone and Resident 1 did not want to discuss her concerns over the phone. The DON called the Administrator (ADM) to talk about Resident 1 regarding her concerns in the facility. In an interview on 4/24/24 at 1:01 p.m., the Administrator (ADM) stated he spoke with Resident 1 and her main concern was her roommate. Resident 1 told the ADM regarding how CNA 1 talked and it was not in the best manners. Resident 1 also made a comment that CNA 1 had a phone call and he stepped out of the room. The ADM further stated Resident 1 was concerned about the way CNA 1 communicated with her. In a telephone interview on 4/26/24 at 4:20 p.m., the DON stated her expectation was for the CNAs to only use their cellphones when there is a family emergency and good customer service included providing explanation to residents during care. A review of the facility's policy revised February 2021 and titled, Dignity indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Staff speak respectfully to residents at all times .Demeaning practices and standards of care that compromises dignity are prohibited. Staff are expected to . promptly responding to a resident's request for toileting assistance

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 2) was provided with adequate supervision and safe environment, for a census of 145. This failure resulted in Resident 2's fall and transfer to the acute care hospital for further evaluation. Resident 2 sustained multiple fractures (break) of the bones of the neck requiring surgical intervention. Findings: A review of the clinical record indicated Resident 2 was admitted with diagnoses including hemiplegia and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (disruption of blood flow to the brain) affecting right dominant side, schizoaffective disorder, bipolar type (episode of mood swings ranging from depression [loss of interest in activities] to mania [extreme changes in mood or emotions]). The Minimum Data Set (MDS, an assessment tool) indicated Resident 2 was cognitively impaired and required moderate assistance once in a wheelchair to wheel at least 50 feet and make 2 turns. Further review of Resident 2's clinical records indicated the following: - Fall Risk Assessment, dated 2/27/24,, indicated Resident 2 was a high risk for falls with a score of 26; -Care plan, dated 5/6/23, indicated Resident 2 was at risk for alteration in Activities of Daily Living related to hemiplegia, history of CVA (stroke) and cognitive impairment. The interventions included staff supervision with mobility, self propels in wheelchair; -Care plan, dated 5/6/23, indicated Resident 2 was at risk for repeat falls related to history of falls, hemiplegia and cognitive impairment. The intervention included to provide resident with safe environment such as even floors; and -Care plan, dated 4/13/23, indicated Resident 2 was at risk for fall or injury due to poor fall safety awareness. The interventions included during activities keep close observation to minimize potential for falls and to keep environment free of hazards. A review of Resident 2's 'Nurse's Note,' dated 4/20/2024 at 14:30 [2:30 p.m.] indicated, I was told the [Resident 2] fell outside on the smoking area at 1345 p.m., she was in her wheelchair heading to the smoking area and she fell because the wheelchair was pulled to the edge of the slightly uneven surface. we [sic] assisted her back to the wheelchair. on [sic] assessment I noticed the bruise and minimal bleeding on her right side of the head. i [sic] asked her if she hit her head and she said yes. she [sic] said it hurts my head and my back .paramedics .picked her [up] . and left the facility . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's physician note from the Emergency Department (ED) on 4/20/24 indicated, [brought in by ambulance] to the ED [status post] witnessed mechanical GLF [ground level fall] today at SNF [Skilled Nursing Facility]. A review of Resident 2's 'TRAUMA ADMISSION HISTORY AND PHYSICAL NOTE,' dated 4/20/24, indicated Resident 2 was admitted to Surgical ICU (Intensive Care Unit, provides critical care and life support for the acutely ill or injured). The assessment and plan included, NSG consulted due to multiple cervical fractures (break in the bones of the neck) including C6 (controls the muscles of the wrist and the large muscle on the front of the upper arm between the shoulder and elbow) left floating lateral (side) mass fracture and C5 to C7 (C5- controls the large muscles of the shoulders and front of the upper arm, C7- controls the large muscle on the back part of the upper arm and wrist muscles) left lateral mass fractures. A review of Resident 2's 'DEPARTMENT OF NEUROLOGICAL SURGERY SPINE CONSULTATION,' dated 4/20/24, indicated, .fell at SNF and was found to have multiple cervical injuries .consider trauma consultation for full trauma workup given significance of cervical injuries. A review of Resident 2' s 'INPATIENT OPERATION RECORD' indicated an operation date of 4/22/24. Resident 2 had pre and post operative diagnosis of closed fracture of cervical vertebra, unspecified cervical vertebral level (there are 7 bones of the neck, from C1 to C7). The procedure performed included: Anterior interbody fusion (a major surgery performed through the abdominal cavity to fuse 2 or more bones to restore stability), with discectomy (surgical removal of abnormal disc material that presses on a nerve root) and decompression (helps return bulging discs to their correct locations), of the C5 to C7. During an observation conducted on 4/24/24 at 8:05 a.m., there was an uneven curved pavement on the right side of the building leading to the smoking area. The dirt area had a yellow plastic caution sign around it supported by 5 sticks and 4 cones along the side. An interview was conducted on 4/24/24 at 8:09 a.m. with Resident 6 in the smoking area. Resident 6 stated he knew Resident 2 and she was in the hospital. Resident 6 stated, 5 to 6 days ago at the scheduled smoke break at 1:30 p.m., Resident 2 was impatient and she went out without assistance. Resident 2 pushed herself out and started rolling. Resident 2's wheelchair tipped sideways and she hit her head on the wall. The CNA told Resident 2 to stay there [inside], she let herself out and she fell . Resident 6 stated the caution sign was there at the time of fall and the cones were put up 2 days after Resident 2 fell . In a concurrent observation and interview on 4/24/24 at 8:23 a.m., Resident 6 pointed to the area where Resident 2 fell . Resident 6 stated Resident 2 fell in the middle of the dirt area. Upon further inspection of the location of the fall, the unpaved area on the side of the building had approximately 4-5 inches of elevation from the ground to the cemented area. A review of the clinical records indicated Resident 6 was admitted with diagnoses including acute and chronic respiratory failure (lungs have a hard time loading the blood with oxygen). Resident 6's MDS, dated [DATE], indicated he was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/24/24 at 8:24 a.m., the Activities Director (AD) stated there was a big palm tree that was removed on the side of the building. The AD further stated she heard about Resident 2's fall. In an interview on 4/24/24 at 8:30 a.m., the Director of Nursing (DON) stated she received a text message from the Social Services Director (SSD) on 4/20/24 regarding Resident 2. The DON further stated Resident 2 had a fall, one wheel got caught on the uneven pavement. In an interview on 4/24/24 starting at 11:07 a.m., the SSD stated she was the Manager of the Day on 4/20/24, when Resident 2 fell . The SSD was in the hallway, CNA 2 was outside by the patio door, Resident 2 was going slowly, she used her hand to propel her wheelchair, the wheelchair got close to the cement and the front wheel on the right tipped over, The SSD saw Resident 2 lying on her side and her head was against the wall. The SSD stated the area was curved and Resident 2 went straight. The SSD further stated before the CNA 2 could turn around, Resident 2's wheelchair tipped off the ledge. The yellow tape was there with the sticks, no cones. Resident 2 was picked by nurses from the ground back to her wheelchair. The SSD stated the fall could have been prevented if CNA 2 pushed the residents in their wheelchairs one at a time. The SSD described there was approximately 5 inches difference from the cemented area to the ground. The SSD stated a tree was taken out and the elevation from the cemented area to the ground was something new. In a follow-up interview on 4/24/24 starting at 12:01 p.m., the DON stated she could not tell if Resident 2's fall was preventable or not. In an interview on 4/24/24 at 1:17 p.m., the Administrator (ADM) stated a huge palm tree was taken out since the roots were going underneath the foundation of the building. The ADM added the facility put the caution sign when the tree was taken out. The ADM was unable to state if Resident 2's fall was preventable or not. A telephone interview was conducted with the Licensed Nurse 2 (LN 2) on 4/24/24 starting at 2:51 p.m. The LN 2 stated the SSD was the one who informed him of Resident 2's fall. When LN 2 went to check on Resident 2, she was in the soil area, lying on her right side and her wheelchair was tipped. The LN 2 saw a little bruise on the right side of her head. The LN 2 stated they did a manual transfer because resident was in the soil and there was an uneven surface between the cement and the soil. The LN 2 stated the safest way should be to leave Resident 2 on the ground. The RN further stated Resident 2 was transferred manually with 3 people (including LN 2) from the ground back to her wheelchair because resident was screaming and she insisted on getting up. The LN 2 stated Resident 2 complained of pain on her head and on her back after she was transferred. LN 2 further stated, the fall was preventable, and the surface should be even. In a telephone interview on 4/25/24 at 12:15 p.m., the AD stated the safest way to assist Resident 2 while going outside to the the patio was for another staff to push her wheelchair when she was not agitated. If Resident 2 was agitated she will immediately notify the nurse or certified nursing assistant to assist her and make them aware on her behavior. The AD described there was a huge palm tree with the roots that had lifted up. The AD added there was no way a wheelchair would flip due to the area being pretty high. In a telephone interview on 4/25/24 at 12:38 p.m., the Maintenance Supervisor (MS) stated there was 4 inches of elevation between the concrete and the dirt. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on 4/25/24 starting at 3:12 p.m., CNA 2 stated she was assigned to supervise the residents for the smoking break on 4/20/24. The CNA 2 further stated Resident 2 was in the wheelchair and she was going out with other residents to the smoking area. CNA 2 was in the middle of helping a male resident when Resident 2 had a fall. CNA 2 further stated her back was facing Resident 2 and she was not able to see how she fell . CNA 2 saw Resident 2 on the ground lying on her right side in the wheelchair and her head was touching the wall. CNA 2 stated she could have prevented the fall if she had the chance but it was too late. CNA 2 further stated Resident 2 fell on the dirt and she could not have fallen if the area was all cemented. CNA 2 stated the yellow sign did not prevent Resident 2's wheelchair from tipping over the side. In a follow-up telephone interview on 4/26/24 at 10:06 a.m., the MS stated the 30 foot palm tree was taken out on 4/16/24. The MS further stated the contractor worked on the site for 2 days, they removed 150 foot of gravel and it was 4 inches deep. The MS agreed the area was unpaved when the tree and the stump was removed. A review of the facility's policy revised July 2017 and titled, Safety and Supervision of Residents indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment . The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) .