STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055855	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024

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 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. 38834 Based on interviews and record review, the facility failed to ensure professional standards of quality were followed for one of three sampled residents (Resident 1), when the fluid restriction physician order was not followed. This failure had the potential to increase Resident 1's difficulties in breathing resulting in hospitalization . Findings: A review of the admission record indicated the facility admitted Resident 1 in 2022 with multiple diagnoses including chronic lung disorders. A review of Resident 1's clinical records contained a chest x-ray result dated 6/27/24 which indicated that the resident had pulmonary edema (a condition caused by too much fluid in the lungs making it difficult to breathe). A review of Resident 1's Order Summary Report, dated 6/28/24, indicated a physician order for fluid restriction of 1500 milliliters (ml, unit of measurement) a day. The physician directed nurses to total all fluids that the resident received every shift and added, Should not exceed 1500 total 24 hr [hour] fluid restriction. A review of the physician's progress notes, dated 7/2/24, indicated that Resident 1 was prescribed a diuretic medication that helps to reduce the amount of excess fluid from the lungs by increasing the amount of urine produced and was placed on strict fluid restriction. A review of Resident 1's fluid intake flow sheet from 6/28/24 to 7/6/24, indicated that the amount of fluid given daily to the resident exceeded the amount ordered by the physician. Resident 1's eMAR (electronic medication administration record) for July 2024, indicated that in addition to fluid documented in the fluid intake flowsheet, the nurses administered additional fluids when administering medications to the resident. Per fluid intake flowsheet, Resident 1 received extra fluids on the following dates: On 6/28/24 - 1800 ml, (300 ml more than ordered by physician); (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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	6/30/24 - 1680 ml, (180 ml more than ordered); 7/1/24 - 1920 ml, plus 300 ml with medications (720 ml more than ordered); 7/2/24 - 1920 ml, plus 260 ml with medications (680 ml more than ordered); 7/4/24 - 2240 ml, plus 280 ml with medications (1020 ml more than ordered by the physician). A review of Resident 1's annual Nutritional Risk Assessment, dated 7/1/24 at 2:11 p.m., did not contain information that the resident was on fluid restriction. A review of Resident 1's clinical records contained nursing progress note, dated 7/6/24 at 11:03 p.m., which indicated Resident 1's blood pressure (BP) reading was low at 101/59 (normal BP is 120/80), resident's oxygen saturation was 93% on 2 liters of supplemental oxygen (normal is 99-100% at room air), respiratory rate was 22 (elevated; normal is 14 -16), and the resident was lethargic. Resident 1's clinical records indicated the resident had a change in condition and was transferred to the hospital. In a concurrent interview and record review on 7/18/24 at 4:40 p.m., with a Registered Dietician (RD), the RD stated she was familiar with Resident 1 and did her annual nutritional assessment recently. The RD reviewed the fluid restriction order and stated the kitchen staff was not aware of Resident 1's order for fluid restriction. The RD reviewed Resident 1's meal card and confirmed that the fluid restriction of 1500 ml/day was not on the meal card and acknowledged that the resident was receiving unrestricted amount of fluids. The RD stated there was no care plan initiated to reflect resident's need for fluid restriction. In a concurrent interview and record review on 7/18/24 at 3:35 p.m., with the Corporative Consultant (CC), who was covering for the Director of Nursing, Resident 1's fluid intake flow sheet and eMAR were reviewed. The CC confirmed the amount of fluid offered and given to Resident 1 on multiple days exceeded the amount of fluid restriction ordered by the physician. The CC confirmed that the physician's order was not followed and the resident who already had fluid overload, continued receiving more fluids than her doctor prescribed. The CC stated the nursing staff should have monitored Resident 1's fluid intake and documented it accurately to help improve her fluid overload condition, but it was not done. The CC further added that a care plan for fluid restriction should have been developed but there was none. A review of the facility's policy and procedure titled, Encouraging and Restricting Fluids, dated 2001, indicated that the purpose of the policy was to provide the resident with the amount of fluids necessary to maintain optimum health . This may include restricting fluids. The policy indicated, Verify that there is a physician ' s order .Review the resident ' s care plan .Follow specific instructions concerning fluid intake or restriction .Be accurate when recording fluid intake .Encourage the resident to follow specific instructions . encourage to stay within the limits of his or her intake. The policy directed nursing staff to document the amount of fluids consumed by the resident and report other information in accordance with facility policy and professional standards of practice.