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	06/08/2026

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 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. Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident 6) received treatment and care in accordance with professional standards of practice, the facility's policy and procedure (P&P), and physician's orders when the facility did not consistently complete Resident 6's ordered skin care and wound management treatments. These failures had the potential to cause Resident 6's skin and wound conditions to worsen and for Resident 6 to not achieve the highest practicable well˜being.Findings:A review of Resident 6's clinical record indicated Resident 6 was admitted in January of 2026 and had diagnoses that included hepatic encephalopathy (decline in brain function caused by severe liver disease), congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), malnutrition (state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly), and muscle weakness.A review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/24/26, indicated Resident 6 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 6 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 6's Skin Conditions, dated 2/24/26, indicated Resident 6 was at risk for developing pressure ulcers/injuries.A review of Resident 6's care plan, revised 1/28/26, indicated, Skin: [Resident 6] has impaired skin integrity present on admission as evidenced by scattered bruising to BUE [bilateral upper extremities- Both arms], surgical incision [cut] to genitals covered with dry dressing. Open areas to sacrum [area on base of the spine, between hip bones], left glute [buttocks] and right glute, Gray scaly skin covering lower BLE [bilateral lower extremities- both legs] with scattered boils [pus-filled bump] .Abdomen is distended, firm, and shiny in appearance .Administer treatments as ordered and monitor for effectiveness .Apply barrier cream as indicated .A review of Resident 6's physician order, dated 1/27/26, indicated, Monitor scattered bruising to B/L [bilateral] upper extremities every shift.A review of Resident 6's treatment administration records (TAR- a daily documentation record used by a licensed nurse to document treatments given to a resident) for February 2026 indicated the care order for Resident 6's bilateral extremity bruises were not done on the following shifts:-Day shift on 2/2/26-Day shift on 2/10/26-Evening shift on 2/12/26-Day shift on 2/19/26A review of Resident 6's physician order, dated 1/29/26, indicated, TX [treatment]: fragile skin to bilateral [both sides] buttock- cleanse with soap and water Pat dry apply house barrier cream daily to prevent skin breakdown every day shift.A review of Resident 6's TAR for February 2026 indicated the treatment order for Resident 6's bilateral buttocks were not done on 2/2/26 and 2/19/26.A review of Resident 6's physician order, dated 1/29/26, indicated, TX: monitor discoloration to abdomen up date np [nurse practitioner] if s/s [signs and symptoms] worsen every day shift.A review of Resident 6's TAR for February 2026 indicated the monitoring order for Resident 6's abdomen discoloration was not done on 2/2/26 and 2/19/26.A review of Resident 6's physician order, dated 1/29/26, indicated, TX: scaly skin to BLE apply house OTC [over-the-counter] ammonium lactate 12% [a medicated lotion] daily to help soften and restore skin every day shift.A review of Resident 6's TAR for February 2026 indicated the treatment order for Resident 6's BLE skin were not done on 2/2/26 and 2/19/26.A review of Resident (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6's physician order, dated 1/29/26, indicated, TX: surgical site to left scrotum - cleanse with NS [Normal saline solution- a mixture of sodium chloride and water commonly used in cleaning wounds] Pat dry pack with plain packing strip moistened with vasche wash pack [a solution used to safely cleanse, irrigate, and debride wounds] apply ABd [abdominal]pad underneath scrotum daily and as needed if dislodged every day shift for surgical.A review of Resident 6's TAR for February 2026 indicated the treatment order for Resident 6's surgical site to left scrotum was not done on 2/2/26.A review of Resident 6's physician order, dated 2/17/26, indicated, TX: surgical site to left scrotum - cleanse with NS Pat dry pack with collagen place ABD pad under scrotum daily every day shift for surgical.A review of Resident 6's TAR for February 2026 indicated the treatment order for Resident 6's surgical site to left scrotum was not done on 2/19/26.During a concurrent interview and record review on 6/8/26 at 5:05 p.m. with the Director of Nursing (DON), Resident 6's medical records were reviewed. The DON confirmed that Resident 6's physician orders for skin care and wound management were not consistently done. The DON stated Resident 6's skin conditions would be at risk for developing complications or getting worse if the treatment and care orders were not followed. During an interview on 6/8/26 at 5:35 p.m. with the DON, the DON stated that she would expect staff to consistently follow skin care and wound treatment frequency for residents as ordered.A review of the facility's P&P titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised 4/2026, indicated, 1. The provider will order pertinent wound treatments, including pressure redistribution surfaces, wound cleansing and debridement approaches, dressings .and application of topical agents .2. The provider will help identify medical interventions related to wound management .A review of the facility's P&P titled, Dressings, Dry/Clean, dated 2001, indicated, 1. Verify that there is a physician's order for this procedure .2. Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs .Documentation .The following information should be recorded in the resident's medical record, treatment sheet or designated wound form: .8. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal .Reporting .1. Notify the supervisor if the resident refuses the dressing change .2. Report other information in accordance with facility policy and professional standards of practice.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to ensure one out of six sampled residents (Resident 6) received care in accordance with professional standards of practice, facility's policy and procedure (P&P), and physician's order when Resident 6's foley catheter (a tube inserted through the urethra into the bladder to drain urine) care, management, and monitoring were not consistently done.These failures had the potential for Resident 6 to develop foley catheter complications such as blockage or infection, and for Resident 6 to not achieve his highest practicable well-being.Findings:A review of Resident 6's clinical record indicated Resident 6 was admitted in January of 2026 and had diagnoses that included hepatic encephalopathy (decline in brain function caused by severe liver disease), benign prostatic hyperplasia (BPH- the prostate gland grows larger than normal potentially causing urinary problems), obstructive and reflux uropathy (occurs when the urine cannot drain through the urinary tract), and muscle weakness.A review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/24/26, indicated Resident 6 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 6 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 6's Bladder and Bowel Status, dated 2/24/26, indicated Resident 6 uses an indwelling urinary catheter (a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time).A review of Resident 6's care plan, revised 1/28/26, indicated, Bladder: [Resident 6] is @ [at] risk for complications with urinary system related to Benign Prostatic Hyperplasia (BPH), Obstructive Reflux Uropathy, indwelling catheter, noted pain level of 10 no relief with prn [as needed] pain medication.Indwelling Catheter: provide catheter care and empty catheter every shift and as needed.A review of Resident 6's physician order, dated 1/27/26, indicated, Indwelling Urinary Catheter: Cleanse Site With Warm Soap & Water & Rinse Then Pat Dry every shift.A review of Resident 6's treatment administration records (TAR- a daily documentation record used by a licensed nurse to document treatments given to a resident) for February 2026 indicated the care order for Resident 6's indwelling urinary catheter was not done on the following shifts:-Day shift on 2/2/26-Evening shift on 2/12/26-Day shift on 2/19/26A review of Resident 6's physician order, dated 1/28/26, indicated, Indwelling Urinary Catheter .For URINARY RETENTION). Check Every Shift Intact/Functioning every shift for for [sic] Obstructive & Reflux Uropathy 2/2 [secondary to] BPH.A review of Resident 6's TAR for February 2026 indicated the monitoring order for Resident 6's indwelling urinary catheter was not done on the following shifts:-Day shift on 2/2/26-Evening shift on 2/12/26-Day shift on 2/19/26A review of Resident 6's physician order, dated 2/4/26, indicated, FLUSH Foley every night 60cc [cubic centimeter- unit of measurement] NS [Normal saline solution- a mixture of sodium chloride and water] PLEASE gently irrigate to encourage UA [urine] to flow freely. at bedtime for prevention of clogging.A review of Resident 6's TAR for February 2026 indicated the flush order for Resident 6's indwelling urinary catheter was not done on bedtime of 2/12/26.A review of Resident 6's physician order, dated 2/7/26, indicated, TX [treatment]: FLush foley cath [catheter] with 60cc gentely [sic] to prevent clogging every morning in the morning.A review of Resident 6's TAR for February 2026 indicated the flush order for Resident 6's indwelling urinary catheter was not done in the morning of 2/19/26.During a concurrent interview and record review on 6/8/26 at 5:05 p.m. with the Director of Nursing (DON), Resident 6's medical records were reviewed. The DON confirmed that Resident 6's foley catheter care, management, and monitoring orders were not consistently done. The DON stated Resident 6 would be at risk for indwelling urinary catheter complications such as infection or clogging if the indwelling catheter care orders were not followed. During an interview on 6/8/26 at 5:35 p.m. with the DON, the DON stated that she would expect staff to consistently follow the indwelling urinary catheter care orders for residents.A review of the facility's P&P titled, Catheter Care, Urinary, revised (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/2022, indicated, 1. Review the resident's care plan to assess for any special needs of the resident .Perineal Care .1. Use soap and water or bathing wipes for routine daily hygiene. Antiseptic wipes for daily cleansing are not recommended. 2. Clean the area under the foreskin in uncircumcised males daily .Maintaining Unobstructed Urine Flow .5. Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction .Complications .1. Observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately .Reporting .1. Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice.