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	03/19/2026

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to meet professional standards of quality for four of 35 sampled residents (Resident 164, Resident 6, Resident 36, and Resident114) when:1. Staff did not notify the physician of abnormal high lab values for Resident 164;2. Staff did not notify the physician of abnormal low lab values for Resident 6;3. Resident 36 was administered 3LPM (liters per minute, flow rate of the oxygen) of oxygen instead of the ordered 2LPM; and 4. Resident 114 was given 2.5 LPM of oxygen instead of the ordered 3 LPM.These failures placed Resident 164 and Resident 6 at risk for unmet care needs and delayed treatment, and placed Resident 36 and Resident 114 at risk for not receiving appropriate oxygenation.Findings: 1.Resident 164 was admitted to the facility in early 2026 with diagnoses which included kidney disease. During a review of Resident 164's Order Summary Report [OSR], order date 2/20/26, the OSR indicated an order for a complete metabolic panel (CMP, a lab that provides information on the body's chemistry, metabolism and electrolytes, including potassium: essential for nerve function, muscle contraction and maintaining a healthy heartbeat) to be completed on 2/23/26. During a review of Resident 164's Lab Results Report, reported 2/24/26, the report showed an H [high] potassium level of 5.6 mEq/l (unit of measurement normal range 3.5 -5.1). During a review of the facility provided document, All Inclusive Medical Services, Inc. [AIMS], undated, the AIMS indicted, REPORT ALL CRITICAL/PANIC VALUES.These parameters must be called to the on-call provider.No faxes or voice mail.Lab results for K+ [potassium].if greater than 5.5. During a review of Resident 164's electronic health record (EHR) no documentation was found indicating the physician was notified of the high potassium level. During a concurrent interview and record review on 3/17/26 at 3:26 p.m. with Licensed Nurse (LN 8), LN 8 confirmed Resident 164's potassium level on 2/23/26 was high and stated the physician should have been notified. LN 8 confirmed the lab was not marked reviewed in the EHR and stated she was unable to find any documentation the physician had been notified. During an interview on 3/17/26 at 3:34 p.m. with the Director of Nursing (DON), the DON confirmed there was no documentation of the physician being notified of Resident 164's elevated potassium. The DON stated it was important to notify the physician of elevated potassium, because potassium was an electrolyte that affects the heart. During an interview on 3/19/26 at 11:34 with the Medical Director (MD 2), the MD 2 confirmed a (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potassium level of 5.6 mEq/l met the AIMS criteria for provider notification and confirmed the facility did not call the physician. 2.Resident 6 was admitted to the facility in early 2026 with diagnoses that included anemia (a blood condition that did not have enough healthy red blood cells to carry sufficient oxygen to the body's tissues). During a review of Resident 6's Lab Result Report, report date 2/28/26, the report showed an L [low] hemoglobin level of 7.6 g/Dl (unit of measurement, normal range 11.2-15.7). During a review of Resident 6's EHR, no documentation was found indicating the physician was notified of the low hemoglobin level. During a concurrent interview and record review on 3/19/26 at 8:25 a.m. with LN 10, of Resident 6's EHR, LN 10 confirmed Resident 6's hemoglobin value of 7.6 g/dL was low. LN 10 confirmed the lab was not marked reviewed in the EHR and stated she was unable to find any documentation the physician had been notified. LN 10 stated if there was no documentation that it had been sent to the physician, staff would not know if any of the labs had been addressed or if anything had been done to help the resident, no continuity of care. During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results-Clinical Protocol, dated 11/18, the P&P indicated, The physician will identify and order diagnostic and lab testing based on the resident's diagnosis and monitoring needs.When test results are reported to the facility, an nurse will first review the labs.A physician can be notified by phone, fax, voicemail.Facility staff would document information about when, how and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record. 3. A review of an admission record indicated Resident 36 was admitted to the facility in May 2023 with diagnoses that included congestive heart failure and respiratory failure. During a concurrent observation and interview on 3/16/26 at 8:52 a.m. with Resident 36, the resident's oxygen concentrator was observed to be set at 3 LPM. Resident 36 stated, My oxygen should be at 2. A review of Resident 36's Order Summary Report (OSR), dated 11/20/22, the OSR indicated an order for continuous oxygen at 2 LPM via nasal cannula (a thin tube connecting the oxygen source to the resident's nose for administration). During an interview on 3/16/26 at 8:55 a.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated the oxygen was set at 3 LPM. During an interview on 3/16/26 at 9:05 a.m. with LN 8, LN 8 stated that the oxygen should be at 2LPM. LN 8 further stated that staff must follow the doctor's orders. A review of Resident 36's care plan, dated 1/18/24, indicated the resident required the use of continuous oxygen at 2 LPM via nasal cannula related to congestive heart failure and shortness of breath. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A review of an admission record indicated Resident 114 was readmitted to the facility in January 2025 with diagnoses that included congestive heart failure and respiratory disorder. During an observation on 3/16/26 at 10:23 a.m. in Resident 114's room, the resident's oxygen concentrator was observed to be set at 2.5 LPM. During an interview on 3/16/26 at 10:26 a.m. with CNA 8, CNA 8 stated the oxygen was set at 2.5 LPM. During an interview on 3/16/26 at 10:32 a.m. with LN 1, LN 1 stated the oxygen was on 2.5LPM and should have been at 3 LPM. LN 1 further explained that staff must follow the doctor's order, otherwise it could affect Resident 114's oxygen saturation. A review of Resident 114's OSR, dated 1/28/25, the OSR indicated an order for continuous oxygen at 3LPM via nasal cannula for respiratory failure and shortness of breath. A review of Resident 114's care plan, dated 3/14/25, indicated the resident required continuous oxygen at 3 LPM via nasal cannula related to congestive heart failure and respiratory illness with chronic respiratory failure. During an interview on 3/19/26 at 10:53 a.m. with the DON, the DON stated that staff were expected to adhere to physicians' orders to ensure residents received appropriate oxygenation.

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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. Based on observation, interview, and record review, the facility failed to implement its Emergency Medications policy and procedure for a census of 152 residents when the Emergency Kit (EˆKit), a storage box containing emergency medications, was not replaced upon the next routine medication delivery after being used.This failure increased the potential risk of not having essential emergency medications available when needed and increased the risk of drug diversion.During a medication storage inspection in the facility's east station medication room on 3/16/26 at 9:20 a.m. with Licensed Nurse 1 (LN 1), EˆKit #082 was observed secured with a red plastic zip tie, indicating that the EˆKit had been previously opened by the facility. In a concurrent interview and record review, LN 1 confirmed that the EˆKit contained documentation showing it was used on nine occasions, with 3/8/25 noted as the first documented use by licensed nursing staff.During an interview on 3/18/26 at 3:20 p.m. with the Director of Nursing (DON), the DON stated the used EˆKit should have been replaced with a new EˆKit. The DON further stated emergency medications should be available for resident use and that having a used EˆKit with many medications removed places resident safety at risk.A review of the facility's policy titled Emergency Medications, dated 4/2021, indicated: Medications and supplies used from the emergency medication kit must be replaced upon the next routine drug order.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored properly according to the facility's Policy and Procedure (P&P), when:1. An opened inhaler (used to administer medication by breathing in) in the medication cart was not correctly dated with an expiration date, and2. A labeled pharmaceutical bag was found behind the drawers in the back of a medication cart These failures placed the residents at risk for receiving expired or outdated medication and had the potential for medication error and drug diversion for the census of 152. Findings:1. During an inspection of medication cart 2 east station on [DATE] at 9:08 a.m., an open budesonide and formoterol inhaler (used to control and prevent symptoms of asthma and improve lung functions) had an open date (date the medication was removed from the protective foil pouch) of [DATE]. The instructions on the inhaler carton indicated, Discard within three months after removing from the foil pouch.During an interview on [DATE] at 9:09 a.m. with Licensed Nurse (LN) 1. LN 1 verified the inhaler had an incorrect expiration date of [DATE] on the label instead of [DATE].During an interview on [DATE] at 3:11 p.m. with the Director of Nursing (DON), the DON stated the multidose inhaler's efficacy could be compromised when the inhaler did not have a correct expiration date. A review of the facility P&P titled, Medication Labeling and Storage, dated 2/2023, indicated, labeling of medication and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: d. expiration date.if medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.2. During an inspection of the west station Medication Cart 2 on [DATE] at 9:42 a.m., a bag of pharmaceutical product was found behind the drawers at the back of the medication cart.During an interview on [DATE] at 9:45 a.m. with LN 2, LN 2 confirmed that a medication bag was found at the back of the medication cart behind the drawers. LN 2 stated the medication bag belonged to a resident who had been discharged three weeks ago, and that the cart should have been checked daily to ensure medications did not fall behind the drawers.During an interview on [DATE] at 3:15 p.m. with the DON, the DON stated all medications should be stored inside the medication cart and the staff should have noticed and retrieved the medication bag that had fallen behind the drawers.A review of the facility's policy and procedure titled Medication Labeling and Storage, dated 2/2023, indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

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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. Based on observation, interview and record review, the facility failed to ensure food was prepared and served under sanitary conditions for 149 residents who received meals from the kitchen in a census of 152 when:1. Multiple dishes were stored upright, exposed to dust and splatter, and 2. Two of five roasts were thawed improperly.These findings increased the potential for food born illness.Findings:1.During an initial tour observation and concurrent interview on 3/16/26 at 8:08 a.m. with the Dietary Director (DD), eight stacks of multiple bowls, 11 decanter lids, 10 thermal lids available for food service were stored upright on the kitchen counter. The DD verified the observation and said, They should be stored face down to be protected from dust.A review of the FDA Food Code 2022, Section 4-903, indicated, Cleaned Equipment and Utensils . shall be stored . where they are not exposed to splash, dust, or other contamination; The guidance further indicated, (1) In a self-draining position that allows air drying; and (2) covered or inverted.2.During a subsequent observation and interview on 3/16/26 at 8:10 a.m., two of five ten-pound frozen turkey breasts were piled up in a container but not completely submerged in water with a low volume stream of water running over the roast to thaw them. The DD verified the observation and said, They should be submerged with water running over them.During a review of the facility P&P titled Food Preparation and Service, dated 2001, the P&P indicated Thawing Frozen Food.Foods are not thawed at room temperature. Appropriate thawing procedures include.completely submerging in cold running water.that is running fast enough to agitate and remove loose ice particles.

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F 0910 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure resident rooms meet each resident's needs. Based on observation, interview and record review, the facility failed to ensure the rights for privacy and a dignified existence were respected for seven residents (Residents 31, 39, 66, 76, 130, 141, and 143) in a census of 152 when their curtains did not enclose their cubicles for privacy.This failure increased the potential for embarrassment during personal care and private visits for the residents.Findings: During multiple observations on 3/16/26 through 3/19/26, seven residents were observed with curtains which did not surround their beds for privacy. During a concurrent observation and interview on 3/16/26 at 9:21 a.m. with Certified Nurse's Assistant (CNA) 3, CNA 3 verified the curtains did not reach around the beds of Resident 66 and Resident 130's beds for privacy and said, They should be longer. During a concurrent observation and interview on 3/16/26 at 10:54 a.m. with CNA 4, CNA 4 verified Residents 76 and Resident 141's privacy curtains did not reach around their beds. During an interview on 3/16/26 at 11:08 a.m., the Director of Nursing (DON) was asked her expectations for the privacy curtains and said, The curtains should reach around the bed for privacy. During a concurrent observation and interview on 3/17/26 at 8:42 a.m., Resident 39 verified her privacy curtain did not surround her bed completely and said, There's no privacy if I have to use the bathroom [in bed]. When I'm going to the bathroom [in bed] or taking a bed bath, staff can come in and pass my bed when I need privacy. During a concurrent observation and interview on 3/18/26 at 9:24 a.m. with Resident 31, Resident 31 confirmed her privacy curtain did not extend around her bed. Resident 31 stated staff and visitors passed by her bed to get to her roommate's bed and she was exposed without a privacy curtain. Resident 31 further stated she would like a privacy curtain to maintain her dignity. During a concurrent observation and interview on 3/18/26 at 9:48 a.m. with Resident 143, Resident 143 confirmed her privacy curtain did not extend around her bed. Resident 143 further stated staff and visitors frequently passed by her to get to her roommate's bed. Resident 143 stated she would like the curtain to extend all the way around her bed. During an interview on 3/18/26 at 10:05 a.m. with CNA 6, CNA 6 stated Resident 31 and Resident 143's privacy curtains did not extend all the way around their beds. CNA 6 further stated Residents 31 and Resident 143 had no privacy when staff or visitors wanted to pass through to the adjacent beds. During an interview on 3/19/26 at 7:59 a.m. with the Housekeeping (HS), the HS said, Curtains are replaced between each resident and as needed by Housekeeping. Sometimes Maintenance needs to replace hooks or add hooks. We've had a very limited supply recently.The curtains should surround each bedspace for privacy. During a review of the Maintenance Log for all five halls, dated 1/14/26 through 3/18/26, no request for curtain replacement or lengthening was found. During a review of the facility policy and procedure (P&P) titled Bedrooms, dated 2001, the P&P (continued on next page)

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F 0910 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Bedrooms are designed to provide full visual privacy for each resident (in the form of ceiling-suspended curtains that extend around the bed) and equipped for adequate nursing care.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 33 of 60 resident' rooms (Rooms 100, 102, 103, 104, 105, 106, 107, 108, 111, 204, 205, 206, 207, 208, 209, 210, 212, 300, 301, 302, 303, 304, 305, 306, 307, 310, 311, 408, 410, 411, 503, 505, and 517) met the minimum requirement of 80 square feet (sq. ft.) per resident.This failure had the potential to result in inadequate space for the provision of care for 100 residents.Findings:During a review of facility letter, dated 3/17/26, the letter indicated 33 rooms measure less than 80 sq. ft. per resident. The letter further indicated, Residents occupying these rooms have a reasonable amount of privacy, closet, and storage space. All rooms have a bedside table and bedside nightstand for their use. The residents are not restricted in their mobility with a wheelchair or with ambulation and have access to the use of their toilet. During an observation on 3/16/26 at 9:15 a.m. in room [ROOM NUMBER], staff was observed assisting a resident using a wheelchair in the room. Both the staff and resident had adequate space to maneuver without complaints.During an observation on 3/16/26 at 11:11 a.m. in room [ROOM NUMBER], staff was observed assisting a resident to stand from the bed using a walker. Both the staff and resident had adequate space to maneuver, despite the presence of a bedside table. During a concurrent observation and interview on 3/18/26 at 9:24 a.m. with Resident 120 in room [ROOM NUMBER], Resident 120 was observed lying in bed with a nightstand and bedside table next to the head of the bed. A wheelchair was observed at the end of the bed nearly touching the curtain separating the space from the adjacent bed. This writer had no space to maneuver into the room to speak privately with Resident 120 without moving the table. Resident 120 stated the space was too small; staff always had to move things around when they came in to assist her. Resident 120 further stated her visitors had no where to sit when they came to visit and would frequently hover at the end of her bed spilling into her roommate's space. During a concurrent observation and interview on 3/18/26 at 9:38 a.m. with Resident 106 in room [ROOM NUMBER], Resident 106 was observed sitting in his bed with a wheelchair next to the bed. This writer had no space to maneuver into the room to speak privately with Resident 106 without moving the wheelchair out of the space entirely. Resident 106 stated the space was too cramped and didn't provide enough privacy. Resident 106 further stated, If I was sitting in my wheelchair, I would have to speak with my back to you.During a concurrent observation and interview on 3/18/26 at 9:42 a.m. with Resident 66, Resident 66 was observed lying in bed. Resident 66 stated she had sufficient space to maneuver and had no issues transferring in and out of her wheelchair and had enough space for her personal belongings.During a concurrent observation and interview on 3/18/26 at 9:48 a.m. with Certified Nursing Assistant (CNA) 5 in Resident 120's room, CNA 5 was observed moving a bedside table. CNA 5 stated the table needed to be moved to maneuver around the room.The Department recommends granting a room waiver per the facility request for rooms 100, 102, 103, 104, 105, 106, 107, 108, 111, 204, 205, 206, 207, 208, 209, 210, 212, 300, 301, 302, 303, 304, 305, 306, 307, 310, 311, 408, 410, 411, 503, 505, and 517.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to protect one of 35 sampled residents' (Resident 77) right to be free from physical and verbal abuse by another resident when Resident 79 cursed at Resident 77 and threw a water pitcher at Resident 77's head.This failure had the potential to cause physical and mental harm to Resident 77. Findings:Resident 77 was admitted to the facility in June of 2024 with diagnoses that included rectal cancer.A review of Resident 77's Minimum Data Set (MDS, a standardized assessment tool used in nursing homes), dated 2/13/26, indicated Resident 77 had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident 77 was cognitively intact.Resident 79 was admitted to the facility in September of 2025 with diagnoses that included type 2 diabetes (disease where the body has poor blood sugar control). A review of Resident 79's MDS, dated [DATE], indicated Resident 79 had a BIMS score of 6 indicating Resident 79 had significant cognitive impairments.A review of Resident 77's Progress Note (PN), dated 2/26/26, the PN indicated, Resident [Resident 77] had a verbal altercation with his roommate [Resident 79]. Per resident, his roommate threw water at him. Close contact of aggressive nature was alleged to have happened.During an interview on 3/16/26 at 4:22 p.m. with the Social Services Assistant (SSA), the SSA indicated that, besides physical abuse, abuse could be verbal and confirmed the incident that took place on 2/26/26 between Resident 77 and Resident 79 would be considered abuse.During an interview on 3/17/26 at 8:31 a.m. with Resident 77, Resident 77 indicated that on 2/26/26, he was positioned in his wheelchair between his and Resident 79's bed. Resident 77 indicated he had asked Certified Nursing Assistant 7 (CNA 7) to open the curtains to the outside window and that is when Resident 79 became frustrated. Resident 77 then stated, He [Resident 79] threw a full water pitcher at me and yelled, ?Fxxx you. Goddamnit'.the water pitcher hit me on the right side. Resident 77 confirmed that the impact of the water pitcher caused him pain to the right side of his head.During an interview on 3/17/26 at 8:46 a.m. with CNA 7, CNA 7 confirmed that, during the incident on 2/26/26, he had witnessed Resident 79 throw a water pitcher at Resident 77 and heard Resident 79 curse at Resident 77.During an interview on 3/19/26 at 8:18 a.m. with Licensed Nurse 6 (LN 6), LN 6 confirmed that the incident on 2/26/26 between Resident 77 and Resident 79 would be considered abuse.During a review of the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/21, the P&P indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of abuse, for two of 35 sampled residents (Resident 77 and Resident 79), when an incident on 2/26/26 involving Resident 77 and Resident 79 was not reported to the Department.This failure had the potential to place Resident 77 at risk for continued abuse.Findings:A review of Resident 77's Progress Note (PN), dated 2/26/26, the PN indicated, Resident [Resident 77] had a verbal altercation with his roommate [Resident 79]. Per resident, his roommate threw water at him. Close contact of aggressive nature was alleged to have happened.During an interview on 3/17/26 at 8:31 a.m. with Resident 77, Resident 77 indicated that on 2/26/26, he was positioned in his wheelchair between his and Resident 79's bed. Resident 77 indicated he had asked Certified Nursing Assistant 7 (CNA 7) to open the curtains to the outside window and that is when Resident 79 became frustrated. Resident 77 then stated, He [Resident 79] threw a full water pitcher at me and yelled, ?Fxxx you. Goddamnit'.the water pitcher hit me on the right side. Resident 77 confirmed that the impact of the water pitcher caused him pain to the right side of his head.During an interview on 3/17/26 at 8:46 a.m. with CNA 7, CNA 7 confirmed that, during the incident on 2/26/26, he had witnessed Resident 79 throw a water pitcher at Resident 77 and heard Resident 79 curse at Resident 77. CNA 7 further confirmed that he had reported the incident to Licensed Nurse 6 (LN 6).During an interview on 3/18/26 at 11 a.m. with the Administrator (ADM), the ADM confirmed that he was made aware of the incident between Resident 77 and Resident 79 but did not report it to the Department.During an interview on 3/19/26 at 8:18 a.m. with Licensed Nurse 6 (LN 6), LN 6 confirmed that the incident on 2/26/26 between Resident 77 and Resident 79 would be considered abuse and would require reporting to facility management. LN 6 indicated that a SOC341(abuse reporting form used by facilities) form would have to be filled out. LN 6 further indicated she had reported the incident to the ADM.During an interview on 3/19/26 at 9:03 a.m. with the ADM, the ADM indicated that he had investigated the incident between Resident 77 and Resident 79 and, after the investigation was completed, the ADM decided the incident would not be considered abuse. The ADM further explained that because he felt the incident didn't rise to the level of abuse, he did not report the incident to the Department.During a review of the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 9/22, the P&P indicated, All reports of resident abuse (including injuries of known origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.The administrator or the individual making the allegation immediately reports his or her suspicion to the following person or agencies.The state licensing/certification agency responsible for surveying/licensing the facility.

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	03/19/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review the facility failed to maintain an accurate medical record for one of 35 sampled residents (Resident 157) when PICC (peripherally inserted central catheter, a long thin flexible tube inserted through a vein in the upper arm and into a large vein just above the heart used to deliver medications directly into the bloodstream) dressing changes and an administration of IV (intravenous) medication were not recorded in the resident's medical record.These failures resulted in an inaccurate medical record and had the potential for miscommunication among healthcare professional which could lead to inadequate care for Resident 157.Findings:Resident 157 was admitted to the facility in early 2026 with diagnoses which included a serious lung infection caused by a specific type of staph bacteria that is resistant to many common antibiotics.During a review of Resident 157's Order Summary Report [OSR], dated 3/2/26, the OSR indicated an order for PICC dressing changes every seven days and as needed.During an observation on 3/16/26 at 10:26 a.m. of Resident 157 in her room, Resident 157 had a PICC line inserted into her left upper arm. The bandage covering the PICC line showed the date 3/15. There were no staff initials or time on the dressing.During a review of Resident 157's IV Administration Record [IVAR], dated 3/26, the IVAR indicated PICC dressing changes were completed on 3/3/26, 3/8/26, and 3/10/26. There was no documentation that the PICC dressing was changed on 3/15/26.During a concurrent interview and record review on 3/18/26 at 8:39 a.m. with Licensed Nurse (LN 8), of Resident 157's medical record, LN 8 confirmed the PICC line on Resident 157 was dated 3/15. LN 8 stated she did not see any initials on the PICC dressing which would indicate who changed the dressing. LN 8 confirmed there was no documentation in the IVAR or in the progress notes regarding a PICC line dressing change on 3/15/26. LN 8 stated the documentation should have been completed according to the physician orders, and it was important to have accurate records to provide continuity of care for the residents and to ensure other nurses knew what had been completed.During a review of Resident 157's OSR dated 3/9/26, the OSR indicated an order for Vancomycin (an antibiotic) to be administered intravenously (IV, into a vein via PICC line) every 12 hours for a lung infection.During a review of Resident 157's Medication Administration Record [MAR], dated 3/26, the MAR indicated, Vancomycin HCl Intravenous Solution.every 12 hours [for lung infection]. The MAR was blank on 3/11/26 for the 9 p.m. dose of Vancomycin.During a concurrent interview and record review on 3/18/26 at 10:55 a.m. with LN 8 of Resident 157's MAR, LN 8 confirmed there was no documentation in the MAR or progress notes indicating Resident 157 received the medication on 3/11/26 at 9 p.m. LN 8 stated it was important for the resident to receive the antibiotic because it was a necessary medication.During a concurrent interview and record review on 3/19/26 at 2:37 p.m. with the Director of Nursing (DON), of Resident 157's medical record, the DON confirmed the lack of documentation for the 3/11/26 Vancomycin dose and stated she would expect to see documentation of the administered dose in the MAR or in a progress note.During an interview on 3/19/26 at 2:42 p.m. with LN 9 with the DON present, LN 9 stated he administered Resident 157's dose of Vancomycin on 3/11/26 at 9 p.m. but stated he forget to document the administration in the medical record.During a review of the facility's policy and procedures (P&P) titled, Administering Medications, dated 4/19, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next one.As required or indicated for a medication, the individual administering the medication records in the resident's medical record: the date and time the medication was administered.During a review of the facility's P&P titled, Peripheral and Midline IV Dressing Changes, dated 5/25, the P&P indicated, This (sic) purpose of this procedure is to prevent complications associated with the intravenous therapy.The following should be documented in the resident's medical record: Date, time, type of dressing, and reason for change.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to maintain three resident wheelchairs (Resident 80, Resident 130 and Resident 143) in a census of 152 in safe operating order when the armrests were damaged and unable to be sanitized.This failure placed the residents at risk for discomfort, skin tears, abrasions and infection.Findings: During observations on 3/16/26, three resident wheelchairs were found in disrepair when both armrests were found cracked, missing pieces of upholstery for Resident 80, Resident 130and Resident 143.During a concurrent observation and interview on 3/16/26 at 9:21 a.m. with Certified Nurses Assistant (CNA) 3, CNA 3 verified the wheelchair armrests used by Resident 130 was cracked and missing pieces of the upholstery and unable to be sanitized.During an observation and interview on 3/16/26 at 12:17 p.m. with the Director of Nurses (DON), the DON verified the wheelchair armrests of Residents 80 and Resident 143 were in disrepair, unable to be sanitized and said, Skin could get caught on the armrests when the cover is worn and the fabric is showing through.During an interview on 3/18/26 at 6:54 a.m. with the Maintenance Supervisor (MS), the MS was asked about the procedure for repairs and said, We check the maintenance log every morning and if some repairs needs to be done, we do it right away and sign that it's done.During an interview on 3/18/26 at 9:13 a.m. with Licensed Nurse (LN) 5, LN 5 was asked about damage to the wheelchair armrests and said, If the wheelchair armrest cover is ripped .It could contribute to skin breakdown and infection.During an interview on 3/19/26 at 7:59 a.m. with the Housekeeping Supervisor (HS), the HS said, We sanitize the wheelchairs but Maintenance repairs them .I've never used the Maintenance log.During a review of the facility document titled, WORK ORDER / REPAIR REQUEST, dated 1/14/26 through 3/18/26, no request for wheelchair repair was documented.During a review of the facility policy and procedure (P&P) titled Assistive Devices and Equipment, dated 2001, the P&P indicated Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents. These may include.wheelchairs.Defective or worn devices are discarded or repaired .