

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055956	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2024
NAME OF PROVIDER OR SUPPLIER  Bridgewood Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  5901 Lemon Hill Ave Sacramento, CA 95824	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42255</p> <p>Based on interview and record review, the facility failed to develop a specific care plan for weight loss and pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for one resident (Resident 1) out three sampled residents, that included measurable objectives and timeframes.</p> <p>This failure had the potential to compromise the nutritional and health status for Resident 1.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility in early 2024 with diagnoses which included sepsis (a life-threatening blood infection), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hypertensive heart (high blood pressure) and chronic kidney disease.</p> <p>A review of Resident 1's Interdisciplinary team (IDT) note dated 9/23/24, indicated there was a weight change of 5.7%.</p> <p>A review of Resident 1's Order Summary Report (OSR), dated 9/12/24, indicated, Sacrococcyx, stage 4 PU (pressure ulcer)-cleanse with NS/Vashe (normal saline moistened gauze), pat dry. Apply scant medihoney and cal alginate, lightly pack with 4x4 gauze; cover with foam dressing .</p> <p>During a concurrent observation and interview on 10/8/24 at 10:08 a.m. with the License Nurse (LN), the LN confirmed there were no care plans for Resident 1's weight loss or pressure ulcer/injury and stated, The nurses and the interdisciplinary team do the care plans.</p> <p>During an interview on 10/8/24 at 1:50 p.m. with the Director of Nursing (DON), the DON stated, My expectation are that care plans are implemented right away when orders are written.</p> <p>Upon Request, the facility was not able to provide the facility's policy and procedure (P&amp;P) for care plans.</p>

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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