STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Post Acute	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681 Based on observation, interview, and record review, the facility failed to ensure the care plan to prevent falls was implemented for one resident (Resident 1) for a census of 47. This failure increased Resident 1's risk of falling, which could result in injury. Findings: A review of the clinical record indicated Resident 1 was admitted [DATE] with diagnoses including conversion disorder (a mental health condition where psychological stress is expressed as physical symptoms) with decreased coordination or balance and episodes of involuntary muscle contractions and spasms. A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/13/25, indicated Resident 1 had moderate cognitive impairment with BIMS (Brief Interview for Mental Status- an assessment used to screen and identify memory, orientation, and status of the resident) score of 10 out of 15. Resident 1's functional abilities indicated she had impairment on both lower extremities and used a wheelchair for mobility device. Further review of Resident 1's clinical records indicated the following: 1. An SBAR (Situation, Background, Appearance, Review) Communication Form indicated Resident 1 had a fall on 3/16/25; 2. A care plan, dated 3/16/25, indicated Resident 1 had an unwitnessed fall and the interventions included, Maintain on low bed and fall mat on the floor. 3. An IDT (Interdisciplinary Team) note dated 3/17/25 indicated Resident 1 was found lying on floor mat (cushioned pad to help minimize injury following a fall), the bed on lowest position and there was no injury. The new interventions implemented indicated, maintained bed on lowest position, continue floor mat on floor. In an observation conducted on 4/29/25 at 10:03 a.m., Resident 1 was lying in bed with right arm covering her eyes. Resident 1's bed was not in a low position and there was no fall mat in place. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Post Acute	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent observation and interview was conducted on 4/30/25 at 10:08 a.m. in Resident 1's room. Resident 1 was lying in bed with a hooded sweatshirt. The bed was not in a low position and there was no floor mat. Resident 1 stated the staff helped her get in and out of bed. Resident 1 further stated she wanted the height of her bed in this [regular] position. In a concurrent observation and interview on 4/30/25 at 10:12 a.m., Certified Nurse Assistant 1 (CNA 1) confirmed Resident 1's height of bed was not in the lowest position and there was no fall mat. CNA 1 stated resident required a hoyer lift (a mechanical device) for transfers and was totally dependent on staff for her care. CNA 1 further stated she positioned the bed in the lowest position earlier today and resident adjusted the height of the bed. CNA 1 added Resident 1 indicated she did not like her bed to be in low position. In an observation and interview on 4/30/25 at 1:23 p.m., Licensed Nurse 1 (LN 1) and CNA 1 were unable to find Resident 1's floor mat inside her room. LN 1 stated there was no fall mat and CNA 1 stated she did not see a fall mat when she came in this morning. LN 1 further stated she thought Resident 1 had a fall before and the height of her bed was lowered because [Resident 1] was high risk for falls. A concurrent interview and record review was conducted with the Director of Nursing (DON) on 4/30/25 at 3:23 p.m. Resident 1's clinical record including SBAR, IDT note and care plan was reviewed with the DON. The DON stated his expectation was for staff to fulfill the interventions to keep the bed at the lowest position and to have a fall mat in place. The DON further stated whenever resident was in bed, the bed should be in the lowest position and if resident preferred the height of the bed in a regular position, it should be documented. A review of the facility's policy revised March 2018 and titled, Falls and Fall Risk, Managing indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Environmental factors that contribute to the risk of falls include: .Incorrect bed height .Resident conditions that may contribute to the risk of falls include: .other cognitive impairment .functional impairments .The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Post Acute	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)
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. 49814 Based on interview and record review, the facility failed to ensure the availability and timely administration of medications for four of 15 sampled residents (Residents 2, 3, 7, and 9) when: 1. Resident 2 did not receive a dose of Venlafaxine (A drug used to treat depression and certain anxiety disorders) and two doses of Clonazepam (a medication used to treat anxiety), 2. Resident 3 did not receive four doses of Clozapine (a medication that treats mental health conditions like schizophrenia - a mental illness that is characterized by disturbances in thought), 3. Resident 7 did not receive four doses of Haloperidol Decanoate injection (Haldol, medication used to treat schizophrenia), and 4. Resident 9 did not receive nine doses of Clozapine and three doses of Austedo (a medication used to treat movement disorders). These failures had the potential to negatively affect the residents' mental health and stability. Findings: 1. Resident 2 was admitted to the facility in October of 2024 with diagnoses that included paranoid schizophrenia, bipolar disorder, major depressive disorder. A review of Resident 2's Physician Order for Venlafaxine, dated 10/4/24, indicated, Venlafaxine HCl ER [extended release] Oral Tablet Extended Release 24 Hour 150MG [milligrams, a unit of measurement] (Venlafaxine HCl) Give 1 tablet by mouth one time a day for depression MB [manifested by] verbalization of depression ICO by MD from RP. Do not crush or chew. A review of Resident 2's Physician Order for Clonazepam, dated 2/11/25, indicated, Give 1 tablet by mouth at bedtime for Anxiety m/b inability to nocturnal restlessness. A review of Resident 2's Nurse Progress Note (NPN), dated 2/11/25, indicated Clonazepam was on order. A different NPN, dated 3/24/25, indicated Venlafaxine was not available and was await (sic) supply. During an interview on 4/29/25 at 1:48 p.m. with Licensed Nurse 2 (LN 2), LN 2 confirmed Clonazepam was not available to give for Resident 2 in February. LN 2 indicated the facility sometimes had problems ensuring medications were available for residents. LN 2 also indicated the dispensing pharmacy required blood work prior to dispensing medication for Resident 2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Post Acute	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/30/25 at 1:18 p.m. with the Director of Nursing (DON), Resident 2's Medication Administration Record (MAR) for February and March were reviewed. The DON confirmed Resident 2 did not receive a dose of Venlafaxine on 3/24/25 and did not receive two doses of Clonazepam on 2/11/25 and 2/12/25. The DON also confirmed the NPNs that indicated these medications were not available to administer. 2. Resident 3 was admitted to the facility in December of 2024 with diagnoses that included suicidal ideations, schizoaffective disorder, bipolar disorder, and major depressive disorder. A review of Resident 3's Physician Order for Clozapine, dated 12/21/24, indicated, Give 1 tablet by mouth one time a day for schizophrenia MB [manifested by] visual and auditory hallucinations Take 1 tablet (200 mg total) by mouth in the morning AND 2 tablets (400 mg total) at bedtime. +50mg by mouth at bedtime = 450mg total at bedtime. A review of Resident 3's NPN, dated 1/8/25 to 1/10/25, indicated Clozapine was not available due to being on order or waiting for pharmacy. A review of Resident 3's NPN, dated 1/10/25, indicated, call pharmacy, talk to [staff] regarding clozapine, ask for CBC (a lab test usually required for the dispensing of Clozapine) LAB result, fax to her. Await supply. During a concurrent interview and record review on 4/30/25 at 1:18 p.m. with the DON, Resident 3's MAR for January was reviewed. The DON confirmed that the resident's MAR indicated that he did not receive his morning dose of Clozapine from 1/8/25 to 1/10/25 and on 1/19/25. The DON indicated that nursing staff were responsible for ensuring pharmacy had all the necessary lab results for dispensing Clozapine. The DON also indicated that he expected nursing staff to notify him regarding pharmacy not delivering medications and to notify the provider regarding missed medication doses. During an interview on 4/30/25 at 4:54 p.m. with the Pharmacist Consultant (PC), the PC indicated the pharmacy required lab results prior to dispensing Clozapine, and it was the responsibility of the facility to do so to ensure timely dispensing of the medication. 3. During a review of Resident 7's admission records, the records indicated Resident 7 was admitted in July 2024 with diagnoses that included Schizophrenia. During a review of Resident 7's physician's order, dated 7/29/24, the order indicated, Haloperidol Decanoate Intramuscular [into the muscles] Solution 100mg/mL [milligrams/milliliter, a unit of measurement] .Inject 2.5 ml intramuscularly one time a day every 28 day(s) for Schizophrenia M/B visual hallucination [seeing images that are not actually present] . During a review of Resident 7's care plan, undated, the care plan indicated, Black box warning for use of Haldol (Haloperidol) .The resident will be/remain free of drug related complications, including movement disorder .or cognitive/behavioral impairment .Administer medications as ordered . During a review of Resident 7's MAR for the month of September 2024, the MAR indicated Resident 7's Haldol was scheduled to be given on 9/23/24. The MAR indicated the dose was not administered and was coded with the number 9 which indicated to refer to progress notes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Post Acute	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's progress notes, dated 9/23/2024, the notes indicated .spoke with [name of staff] from pharmacy. Haloperidol dec [sic] 100 mg/ml vial not available in ekit [emergency kit]. Order refilled. Should be delivered by tonight. To be admin as soon as med arrives. There was no documented evidence that Resident 7's Haldol was delivered or administered. During a review of Resident 7's MAR for the month of December 2024, the MAR indicated Resident 7's Haldol was scheduled to be given on 12/16/24. The MAR indicated the dose was not administered and was coded with the number 9 which indicated to refer to progress notes. During a review of Resident 7's progress notes, there was no documented evidence that Resident 7's Haldol dose was administered on 12/16/25. During a review of Resident 7's MAR for the month of March 2025, the MAR indicated Resident 7's Haldol was scheduled to be given on 3/11/25. The MAR indicated the dose was not administered and was coded with the number 9 which indicated to refer to progress notes. During a review of Resident 7's progress notes, dated 3/11/2025, the notes indicated Spoke to pharmacist, faxed med order over to pharmacy, pharmacy states to deliver on next schedule drop-off. There was no documented evidence that Resident 7's Haldol was delivered or administered. During a review of Resident 7's MAR for the month of April 2024, the MAR indicated Resident 7's Haldol was scheduled to be given on 4/8/25. The MAR indicated the dose was not administered and was coded with the number 9 which indicated to refer to progress notes. During a review of Resident 7's progress notes, dated 4/8/2025, the notes indicated Await supply. Talk to [name of staff] in the pharmacy, promise to send medication later today. DON notified. During a concurrent interview and record review on 4/30/25 at 9:36 a.m. with LN 2, LN 2 confirmed Resident 7 had orders for Haloperidol Decanoate injections every 28 days since admission in July 2024. LN 2 verified there was no documented evidence that Resident 7's Haloperidol injections were given on September 2024, December 2024, March 2025, and April 2025 as ordered. LN 2 stated, Sometimes the pharmacy don't send the medication as they say they will and that nurses were supposed to refill the medication and order it as soon as they used the vial. The LN 2 added Resident 7 could lash out and behavioral symptoms could regress if Resident 7 missed haloperidol doses and stated, It is unacceptable. During a concurrent interview and record review on 4/30/25 at 1:47 p.m. with the DON, the DON verified Resident 7's Haloperidol Decanoate was not delivered by the pharmacy in September 2024, December 2024, March 2025, and April 2025, and that there was no documented evidence that Resident 7 received the injections in those months. The DON added that for April 2025, the medication was not available on the scheduled administration date, was delivered the following day, and stored in the refrigerator but still was not given because it was not delivered on time and already passed due. The DON stated, I wasn't aware, none of the nurses notified me and his expectation was that nurses should notify him and the physician about the missed doses. The DON further stated that if Haloperidol doses were missed, Resident 7's behaviors could occur. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055956	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Post Acute	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/25 at 4:56 p.m. with the PC, the PC stated, We always tell the facility to request 3-5 days before the scheduled dose and before they run out. The PC added that if a resident missed Haldol doses, the resident could go into withdrawal and could be potentially life threatening. 4. Resident 9 was admitted to the facility in January of 2025 with diagnoses that included paranoid personality disorder, schizoaffective disorder, and auditory hallucinations. A review of Resident 9's Physician Order for Clozapine, dated 1/31/25, indicated, cloZAPine Oral Tablet 200 MG (Clozapine) Give 1 tablet by mouth at bedtime for Schizoprenia m/b delusion ICO by MD/RP. A review of Resident 9's Physician Order for Austedo, dated 1/31/25, indicated, Austedo XR Oral Tablet Extended Release 24 Hour 42 MG (Deutetrabenazine) Give 1 tablet by mouth in the morning for tardive dyskinesia [movement disorder brought on by the use of antipsychotic medications] 2/2 long term psychiatric medication use. During a concurrent interview and record review on 5/6/25 at 10:32 a.m. with the DON, Resident 9's MARs for February, March, and April were reviewed. The DON confirmed that Resident 9 missed nine consecutive doses of Clozapine starting on 2/5/25 and ending on 2/13/25, and missed three doses of Austedo on 3/9/25, 3/10/25, and 4/1/25. The DON indicated that Resident 9 was hospitalized in February due to the missed doses of Clozapine. The DON further indicated the pharmacy did not dispense these medications due to nursing staff not relaying lab results to the pharmacy in a timely manner, which nursing staff were responsible for. During a review of the facility's policy and procedure (P&P) titled Medication and Treatment Orders, revised 7/2016, the P&P indicated, .11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available . During a review of the facility's P&P titled Pharmacy Services Overview, revised 4/2019, the P&P indicated, . Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration .7. Medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice .