

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056073	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2024
NAME OF PROVIDER OR SUPPLIER  Sacramento Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  5255 Hemlock Street Sacramento, CA 95841	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46995</p> <p>Based on interview and record review, the facility failed to notify the physician promptly or implement monitoring timely for one of four sampled residents (Resident 2) when Resident 2 was administered Norco (a narcotic medication that contained hydrocodone and acetaminophen) when hydrocodone was listed as an allergy.</p> <p>This failure resulted in Resident 2 not being monitored for an allergic reaction for approximately 20 hours, which increased the risk for unmet health care needs.</p> <p>Findings:</p> <p>Resident 2 admitted early 2023 with diagnoses which included Multiple Sclerosis (a disease of the brain and spinal cord), stage four pressure ulcer (wound caused by pressure that extends to the muscle and bone), and paraplegia (paralysis that affect the legs). Resident 2 was listed as his own responsible party (RP).</p> <p>During a review of Resident 2's face sheet (a document that gives patient information at a quick glance), admitted ,d+[DATE], the face sheet indicated, .Allergies: HYDROcodone (sic) .</p> <p>During a review of Resident 2's Order Summary Report (OSR), Active Orders As Of 6/12/24, the OSR indicated, Allergies: HYDROcodone (sic) . Resident 2's OSR further indicated, Percocet Oral Tab . [Oxycodone w/ Acetaminophen] [narcotic medication that contained Oxycodone] .Give 1 tablet my mouth as needed for Pain Severe .</p> <p>During a review of Resident 2's Progress Notes (PN) Type: Physician Progress Note, dated 6/2/24 at 7:30 a. m. the PN indicated, .He [Resident 2] says he was given norco (sic) by mistake yesterday and got some itching and shortness of breath, which is better .Allergies .Hydrocodone .</p> <p>During a review of the facility provided document titled, ONE ON ONE IN-SERVICE SIGN IN SHEET, dated 6/3/24, the document indicated, LN [licensed nurse] ADMINISTERED NARCOTIC TO RESIDENT ON ACCIDENT AND STATES THAT SHE GOT CONFUSED AS HE WAS TALKING TO HER WHILE SHE PREPARING (sic) ANOTHER RESIDENT'S MEDICATIONS .</p> <p>(continued on next page)</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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility provided document titled, MEDICATION ERROR REPORT, dated 6/2/24, the document indicated, On 6/1/24 @1231 [12:31 p.m.], patient received Norco 5/325 [Hydrocodone-Acetaminophen] instead of Percocet 5/325 [Oxycodone-Acetaminophen]. Resident has Hydrocodone Allergy-unknown reaction .</p> <p>During a concurrent interview and record review on 6/12/24 at 11:32 a.m. with the Infection Preventionist (IP-nurse responsible for managing healthcare associated infections), Resident 2's change of condition (COC) for medication error was reviewed. The IP confirmed the COC was completed on 6/2/24, and stated, The incident [medication error] happened on 6/1 and it was reported late to staff. The IP stated the expectation was for the error to be reported immediately. When asked the reason for reporting immediately the IP stated, For any adverse effects, it needs to be reported immediately.</p> <p>During a concurrent interview and record review on 6/12/24 at 11:40 a.m. with the IP, Resident 2's PN were reviewed. The IP confirmed there was no documentation on 6/1 that a medication was given in error or any monitoring of potential allergic reactions. The IP stated she would expect to see a progress note when it happened, It happened a.m. shift, it went 24 hours, there was no documented monitoring.</p> <p>During an interview on 6/12/24 at 12:38 p.m. with LN 1, LN 1 was asked about Resident 2's medication error. LN 1 stated, I was in the middle of passing medications, [Resident 2] knows my name, he said he wanted pain medications. The narcotic drawer was open. I picked up the card that started with [first letter of Resident 2's last name]. I gave Norco, he was asking for oxycodone. I realized it during the count that I gave the wrong medication . When asked if she reported the error to anyone, LN 1 stated, I totally forgot. The next day I told the charge nurse. When asked if any note was entered in Resident 2's chart about receiving a medication error that was listed as an allergy, LN 1 stated, No, I totally forgot .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Adverse Consequences and Medication Errors, dated 2/23, the P&amp;P indicated, .a</p> <p>'medication error' is defined as the preparation or administration of drugs .which is not in accordance with the physician's order, manufacturer specification, or accepted professional standards .Examples of medication errors include .wrong drug .Monitor the resident for medication-related adverse consequences when there is a .medication error .promptly notify the provider of any significant error or adverse consequence . communicate the event to the oncoming shift as needed to alert staff of the need for continued monitoring .</p>		

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46995</p> <p>Based on interview and record review, the facility failed to ensure person centered care plans were developed which included specific goals and interventions for one of four sampled residents (Resident 2) when Resident 2 was administered Norco (a narcotic medication that contained hydrocodone and acetaminophen) when hydrocodone was listed as an allergy.</p> <p>This failure had the potential for Resident 2 to experience unmet care needs.</p> <p>Findings:</p> <p>Resident 2 admitted early 2023 with diagnoses which included Multiple Sclerosis (a disease of the brain and spinal cord), stage four pressure ulcer (wound caused by pressure that extends to the muscle and bone), and paraplegia (paralysis that affect the legs). Resident 2 is listed as his own responsible party (RP).</p> <p>During a review of Resident 2's face sheet (a document that gives patient information at a quick glance), admitted ,d+[DATE], the face sheet indicated, .Allergies: HYDROcodone (sic) .</p> <p>During a review of Resident 2's Order Summary Report (OSR), Active Orders As Of 6/12/24, the OSR indicated, Allergies: HYDROcodone (sic) . Resident 2's OSR further indicated, Percocet Oral Tab . [Oxycodone w/ Acetaminophen] [narcotic medication that contained Oxycodone] .Give 1 tablet my mouth as needed for Pain Severe .</p> <p>During a review of Resident 2's ' Progress Notes (PN) Type: Physician Progress Note, dated 6/2/24 at 7:30 a. m. the PN indicated, .He [Resident 2] says he was given norco (sic) by mistake yesterday and got some itching and shortness of breath, which is better .Allergies .Hydrocodone .</p> <p>During a review of the facility provided document titled, ONE ON ONE IN-SERVICE SIGN IN SHEET, dated 6/3/24, the document indicated, LN [licensed nurse] ADMINISTERED NARCOTIC TO RESIDENT ON ACCIDENT AND STATES THAT SHE GOT CONFUSED AS HE WAS TALKING TO HER WHILE SHE PREPARING (sic) ANOTHER RESIDENT'S MEDICATIONS .</p> <p>During a review of the facility provided document titled, MEDICATION ERROR REPORT, dated 6/2/24, the document indicated, On 6/1/24 @1231 [12:31 p.m.], patient received Norco 5/325 [Hydrocodone-Acetaminophen] instead of Percocet 5/325 [Oxycodone-Acetaminophen]. Resident has Hydrocodone Allergy-unknown reaction .</p> <p>During a concurrent interview and record review on 6/12/24 at 12:03 p.m. with the Infection Preventionist (IP-nurse responsible for managing healthcare associated infections), Resident 2's care plans (CP) were reviewed. A CP for the medication error was not found. The IP confirmed there was not a care plan. When asked the expectation of care plans, the IP stated, They are implemented immediately .They are important because it tells our interventions .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Goals and Objectives, Care Plans, dated 3/23, the P&amp;P indicated, .Care plan goals and objectives are defined as the desired outcome for a specific resident problem .Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information .</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46995</p> <p>Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for one of four sampled residents (Resident 2) when Resident 2 was administered Norco (a narcotic medication that contained hydrocodone and acetaminophen) when hydrocodone was listed as an allergy.</p> <p>This failure had the potential for adverse systemic effects and jeopardized Resident 2's health.</p> <p>Findings:</p> <p>Resident 2 admitted early 2023 with diagnoses which included Multiple Sclerosis (a disease of the brain and spinal cord), stage four pressure ulcer (wound caused by pressure that extends to the muscle and bone), and paraplegia (paralysis that affect the legs). Resident 2 is listed as his own responsible party (RP).</p> <p>During a review of Resident 2's face sheet (a document that gives patient information at a quick glance), admitted ,d+[DATE], the face sheet indicated, .Allergies: HYDROcodone (sic) .</p> <p>During a review of Resident 2's Order Summary Report (OSR), Active Orders As Of 6/12/24, the OSR indicated, Allergies: HYDROcodone (sic) . Resident 2's OSR further indicated, Percocet Oral Tab . [Oxycodone w/ Acetaminophen] [narcotic medication that contained Oxycodone] .Give 1 tablet my mouth as needed for Pain Severe .</p> <p>During a review of Resident 2's Progress Notes (PN) Type: Physician Progress Note, dated 6/2/24 at 7:30 a. m. the PN indicated, .He [Resident 2] says he was given norco (sic) by mistake yesterday and got some itching and shortness of breath, which is better .Allergies .Hydrocodone .</p> <p>During a review of the facility provided document titled, ONE ON ONE IN-SERVICE SIGN IN SHEET , dated 6/3/24, the document indicated, LN [licensed nurse] ADMINISTERED NARCOTIC TO RESIDENT ON ACCIDENT AND STATES THAT SHE GOT CONFUSED AS HE WAS TALKING TO HER WHILE SHE PREPARING (sic) ANOTHER RESIDENT'S MEDICATIONS .</p> <p>During a review of the facility provided document titled, MEDICATION ERROR REPORT, dated 6/2/24, the document indicated, On 6/1/24 @1231 [12:31 p.m.], patient received Norco 5/325 [Hydrocodone-Acetaminophen] instead of Percocet 5/325 [Oxycodone-Acetaminophen]. Resident has Hydrocodone Allergy-unknown reaction .</p> <p>During an interview on 6/12/24 at 11:16 a.m. with the Infection Preventionist (IP- nurse responsible for managing healthcare associated infections), the IP confirmed Resident 2 was given the wrong medication . [Licensed Nurse (LN1) name] was the nurse who gave the wrong medication .</p> <p>(continued on next page)</p>		

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