STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056073	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sacramento Post-Acute	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069 Based on interviews and record review, the facility failed to report an incident of alleged abuse for one of three sampled residents (Resident 1), when Resident 1 verbalized he was treated roughly and handled like a rag doll. This failure had the potential to place the resident at risk for further harm. Findings: Review of an anonymous staff report received by the department on [DATE] indicated, During Afternoon shift, Resident [Resident 1] acquired an avulsion (degloving) [avulsion-a traumatic injury that occurs when the layers of skin and tissue are torn away from the underlying muscle, connective tissue, or bone] injury to RUE [right upper extremity] while brief change. Per resident CNA [certified nursing assistant] grabbed him by his arm and stated, she pulled me, and was so strong .she tore the last piece of skin I had. DON [director of nursing]/ administrator do not want to report and is insisting to Nursing staff to reword documentation, due to I can misinterpret to physical abuse. CNA was not written up. During a review of Resident 1's face sheet, Resident 1, [AGE] years old, was admitted to the facility on [DATE], on hospice care (focuses on care, comfort, and quality of life of a person with serious illness who is approaching the end of life) and with diagnoses that included acute respiratory failure with hypoxia (low levels of oxygen in body tissue), malignant (cancer) neoplasm (tumor) of skin, and heart failure. Resident 1 was his own responsible party. During a review of Resident 1's Significant Change in Status Minimum Data Set (MDS-an assessment tool), dated [DATE], the MDS described Resident 1 as able to make himself understood and able to understand others. Resident 1's Brief Interview for Mental Status (BIMS-a screening that aids in detecting cognitive impairment) score was 5 which indicated he had severe cognitive impairment. The MDS described Resident 1 as having no signs or symptoms of delirium or behavioral symptoms. The MDS also described Resident 1 as needing setup or clean up assistance with eating, oral hygiene and personal hygiene, as needing substantial/maximal assistance with toileting hygiene and lower body dressing and as needing partial/moderate assistance with shower/bathe self and upper body dressing. (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
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Sacramento Post-Acute	5255 Hemlock Street Sacramento, CA 95841

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's physician orders contained an order, dated [DATE], indicating Resident 1 had the capacity to make his medical decisions and a physician's order, dated [DATE], indicating Resident 1 was capable of understanding rights and responsibilities, and/or able to participate in treatment plan. During a review of Resident 1's Progress Notes, dated [DATE] at 5:23 p.m. Wound Nurse 1 documented she was alerted by a CNA that patient had a 'skin tear' and moment later by charge nurse that patient had a tear to arm. Upon entering room, patient alone, lying in bed to left side with arm resting on side rail. Degloving noted to right forearm and finger point areas to posterior right forearm and right wrist. Patient tearful and in pain asking repeatedly ' why did she do this to me' and ' they treat me like a rag doll' when I asked if he was having difficulty turning when CNA grabbed his arm to reposition? Patient also remarked 'she took the last of my skin I had.' Writer able to gently unroll flap of skin approximately halfway up forearm and at wrist securing edges with steri-strips (thin adhesive strips) .MD (Medical Doctor)/NP (Nurse Practitioner) sent message for notification . During a review of Resident 1's Progress Note, dated [DATE] at 11:23 p.m., Charge Nurse (CN) 1 documented Notified by CNA at 1610 [4:10 p.m.] about resident's skin tear that occurred while CNA is changing resident. Upon entering room, resident is lying in bed with a major skin tear while being changed and wound nurse notified immediately. Resident stated, 'watch out with this one, s/he's tough.' While talking about the CNA. Resident alert and oriented x4. Hospice notified about incident. Resident also stated that the CNA ' skinned' him today. During an interview, on [DATE] at 10:47 a.m., with the Wound Nurse 1, she stated she was in her office when a CNA came by and told her about Resident 1's skin tear. Wound Nurse 1 stated she went to the treatment cart to get supplies and then proceeded to Resident 1's room. Resident 1 stated to her, Why did she do this to me. Wound Nurse 1 stated Resident 1's skin was pulled back from wrist area up forearm to elbow area. Wound Nurse 1 stated Resident 1 stated out loud, Treated me like a rag doll. Wound Nurse 1 verified she had documented her findings in Resident 1's Progress Notes on [DATE]. She verified she had not documented, any other information regarding Resident 1's skin tear, anywhere else in Resident 1's clinical record. Wound Nurse 1 stated she had taken pictures of Resident 1's wounds and sent a notification, along with the wound pictures, to the physician. During a follow up interview on [DATE] at 10:18 a.m., with Wound Nurse 1, she confirmed she reported Resident 1's skin tear to Charge Nurse (CN) 1 and Desk Nurse (DN) 1, and to the DON on [DATE]. Resident 1 was not able to be interviewed because he expired [DATE]. During an interview on [DATE] at 10:52 a.m., with the Director of Nursing (DON), the DON confirmed she became aware of Resident 1's skin tear on [DATE] from Wound Nurse 1. The DON confirmed she reviewed Resident 1's clinical record on [DATE] and was aware of the statements made by Resident 1 and documented in the Progress Notes on [DATE]. (continued on next page)

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Sacramento Post-Acute	5255 Hemlock Street Sacramento, CA 95841

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised [DATE], indicated, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator / designee or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Law enforcement officials; . Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury .Upon receiving any allegations of abuse. neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069 Based on interviews and record reviews, the facility failed to follow their policy and procedure (P&P) to investigate an allegation of abuse for one of three sampled residents (Resident 1), when on [DATE] Resident 1 was noted to have a degloving (avulsion-a traumatic injury that occurs when the top layers of skin and tissue are torn away from the underlying muscle, connective tissue, or bone) injury to right forearm and finger point areas to posterior right forearm and right wrist', and claimed it was from rough treatment from the Certified Nursing Assistant. This failure had the potential to place the resident at risk for further harm. Findings: Review of an anonymous staff report received by the department on [DATE] indicated, During Afternoon shift, Resident acquired an avulsion (degloving) [avulsion-a traumatic injury that occurs when the layers of skin and tissue are torn away from the underlying muscle, connective tissue, or bone] injury to RUE [right upper extremity] while brief change. Per resident CNA [certified nursing assistant] grabbed him by his arm and stated, she pulled me, and was so strong .she tore the last piece of skin I had DON [director of nursing]/ administrator do not want to report and is insisting to Nursing staff to reword documentation, due to I can misinterpret to physical abuse. CNA was not written up. During a review of Resident 1's face sheet, Resident 1, [AGE] years old, was admitted to the facility on [DATE], on hospice care (focuses on care, comfort, and quality of life of a person with serious illness who is approaching the end of life) and with diagnoses that included acute respiratory failure with hypoxia (low levels of oxygen in body tissue), malignant (cancer) neoplasm (tumor) of skin, and heart failure. Resident 1 was his own responsible party. During a review of Resident 1's Significant Change in Status Minimum Data Set (MDS-an assessment tool), dated [DATE], the MDS described Resident 1 as able to make himself understood and able to understand others. Resident 1's Brief Interview for Mental Status (BIMS-a screening that aids in detecting cognitive impairment) score was 5 which indicated he had severe cognitive impairment. The MDS described Resident 1 as having no signs or symptoms of delirium or behavioral symptoms. The MDS also described Resident 1 as needing setup or clean up assistance with eating, oral hygiene and personal hygiene, as needing substantial/maximal assistance with toileting hygiene and lower body dressing and as needing partial/moderate assistance with shower/bathe self and upper body dressing. Review of Resident 1's physician orders contained an order, dated [DATE], indicating Resident 1 had the capacity to make his medical decisions and a physician's order, dated [DATE], indicating Resident 1 was capable of understanding rights and responsibilities, and/or able to participate in treatment plan. A review of Resident 1's care plan, dated [DATE] **Hospice Skin Care Plan** At risk for altered skin integrity R/T (related to): Clinical Risk Factors: Altered ADL (Activities of Daily Living-activities related to personal care) Ability, Bowel & Or Bladder Incontinence. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Progress Notes, dated [DATE] at 5:23 p.m., Wound Nurse 1 documented she was alerted by a CNA that patient had a 'skin tear' and moments later by charge nurse that patient had a tear to arm. Upon entering room, patient alone, lying in bed to left side with arm resting on side rail. Degloving noted to right forearm and finger point areas to posterior right forearm and right wrist. Patient tearful and in pain asking repeatedly, 'why did she do this to me' and 'they treat me like a rag doll' when I asked if he was having difficulty turning when CNA grabbed his arm to reposition? Patient also remarked 'she took the last of my skin I had.' Writer able to gently unroll flap of skin approximately halfway up forearm and at wrist securing edges with steri-strips (thin adhesive strips) .MD (Medical Doctor)/NP (Nurse Practitioner) sent message for notification . During a review of Resident 1's Progress Note, dated [DATE] at 11:23 p.m., Charge Nurse (CN) 1 documented notified by CNA at 1610 (4:10 p.m.) about resident's skin tear that occurred while CNA is changing resident. Upon entering room, resident is lying in bed with a major skin tear while being changed and wound nurse notified immediately. Resident stated, 'watch out with this one, s/he's tough.' While talking about the CNA. Resident alert and oriented x4. Hospice notified about incident. Resident also stated that the CNA 'skinned' him today. During an interview, on [DATE] at 10:47 a.m., with the Wound Nurse 1, she stated she was in her office when a CNA came by and told her about Resident 1's skin tear. Wound Nurse 1 stated she went to the treatment cart to get supplies and then proceeded to Resident 1's room. Resident 1 stated to her, Why did she do this to me. Wound Nurse 1 stated Resident 1's skin was pulled back from wrist area up forearm to elbow area. Wound Nurse 1 stated Resident 1 stated out loud, Treated me like a rag doll. Wound Nurse 1 verified she had documented her findings in Resident 1's Progress Notes on [DATE]. She verified she had not documented, any other information regarding Res 1's skin tear, anywhere else in Resident 1's clinical record. Wound Nurse 1 stated she had taken pictures of Resident 1's wounds and sent a notification, along with the wound pictures, to the physician. During a follow up interview on [DATE] at 10:18 a.m., with Wound Nurse 1, she confirmed she reported Resident 1's skin tear to Charge Nurse (CN) 1 and Desk Nurse (DN) 1, and to the Director of Nursing (DON), on [DATE]. Resident 1 was not able to be interviewed because he expired [DATE]. During an interview on [DATE] at 10:52 a.m., with the DON, the DON confirmed she had become aware of Resident 1's skin tear on [DATE] from Wound Nurse 1. The DON confirmed she reviewed Resident 1's clinical record on [DATE] and was aware of the statements made by Resident 1 documented in the Progress Notes on [DATE]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Progress Notes, an Interdisciplinary team (IDT) Note dated [DATE] at 12:17 p.m., indicated, Resident hospice since admission to the facility with cachectic (sic) (physical wasting with loss of weight and muscle mass due to disease) appearance d/t (due to) severe loss of body weight and muscle most likely d/t to progression of chronic disease. admitted with terminal dx [diagnoses] of hypertensive disease and heart failure. Alert and oriented x2 with baseline confusion, verbally responsive to care, at times able to verbalize needs, one person assist with ADLs, has very thin, fragile skin. Sustained a skin tear to right forearm, and right wrist during pericare [cleaning of a person's genital area] and repositioning. Per report resident became severely agitated during care possibly due to generalized pain pulling his right forearm out from CNA's hold scraping his right forearm on the hard surface of right side rail. Resident at high risk for sudden onset of skin breakdown r/t (related to) end of life status (hospice status), very thin fragile skin, and poor safety awareness. During an interview on [DATE] at 9:18 a.m., with the Assistant Director of Nursing (ADON) and the Infection Preventionist (IP) Nurse, the ADON reviewed Resident 1's clinical record and indicated there was no documentation and no care plan that Resident 1 had a history of being resistive to care or combative. The Department requested a copy of the facility's investigation report regarding Resident 1's skin tear and allegation of alleged abuse. The ADON stated he called the Director of Nursing who was currently out of the facility at the time, the DON informed the ADON, via the telephone call, the facility's investigation report was documented in the IDT Note dated [DATE] at 12:17 p.m. The Department requested the name and information of the CNA, involved in the alleged abuse, the Department was given CNA 2's name. The IP Nurse then stated CNA 2 was not the CNA after all and it was CNA 1 instead. During a review of the facility's investigation report, which according to the DON, was the IDT Note dated [DATE] at12:17 p.m., the investigation report did not include the following elements per the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised [DATE]: Observations of the alleged victim, including his or her interactions with staff and other residents, did not include interviews of the person(s) reporting the incident, did not include interviews with any witnesses to the incident, did not include interviews with Resident 1, did not include interviews with staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, did not include interviews with the resident's roommate, did not include interviews with other residents to whom the accused employee provided care or services to, did not include review of all events leading up to the alleged incident, did not include complete and thorough documentation of the investigation, and did not include upon conclusion of the investigation, the findings of the investigation on approved documentation forms. The facility's investigation report also did not provide a five day follow up investigation report that described the result of the investigation, any corrective actions taken if the allegation was verified. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised [DATE], the P&P indicated, All allegations are thoroughly investigated. The administrator initiates investigations .The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility .The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. interviews the resident's roommate; I. interviews other residents to whom the accused employee provides care or services; j. review all events leading up to the alleged incident; and k. documents the investigation completely and thoroughly .Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator . The P&P titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised [DATE], also indicated, With five (5) business days of the incident, the Administrator will provide a follow-up investigation report. The follow- up investigation report will provide sufficient information, to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. The follow- up investigation report will provide as much information as possible at the time of the submission of the report. The resident and/or representative are notified at the outcome immediately upon conclusion of the investigation. Any allegation of abuse are filed in the accused employee's personal record along with any statement by the employee disputing the allegation, if the employee chooses to make one.