STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056177	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Double Tree Post Acute Care Center	7400 24th Street Sacramento, CA 95822

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 industry standards for food safety were met for a resident population of 102, when: Kitchen walls had chipped paint and damaged dry walls, food shelves were rusty, vents over food production area were rusty, floor tiles were chipped, and linoleum tiles had dark discoloration and rust stains making it difficult to determine if clean and sanitary;Spices were labeled using inconsistent use by dating system and one spice had expired;Plastic containers and lids were stacked and stored while wet in ready-to-use area; A metal colander was observed with dried food inside the openings and along the base, a plastic scoop had food residue inside its bowl, and a knife case had dust and crumbs all along the top near insertion sites. All were found in the clean ready-to-use area; andSix out of eight fry pans were found with chipped and greasy cooking surfaces and were available for use. These failures had the potential to put residents at risk for foodborne illnesses. Findings: 1. During a concurrent observation and interview on 1/20/26 at 9 a.m. in the dry storage room during the initial kitchen tour with the Dietary Manager (DM), the walls in the dry storage area and kitchen were seen with chipped paint and dry wall damage near the floorboards. The floor tiles by the dish machine were worn and chipped. The linoleum in the dry storage area and utility closet had dark discoloration, rust stains and gouges. The bread shelf was noted to be rusted on the bottom two shelves, and the food storage shelves also showed rust development. The DM concurred with these observations, noting that the floors had just been cleaned and buffed. During an observation on 1/21/26 at 10:10 a.m. in the kitchen, two air vents over food production areas were noted with many layers of paint and rust. During an interview on 1/22/26 at 11 a.m., with the Maintenance Director (MD), the MD concurred with these observations and stated that the holes in the walls could allow bugs to live and multiply, and the areas of rust and dirt could cause cross contamination of food. A review of the facility's policy titled, Sanitization, revised 10/08, indicated that the food service area shall be maintained in a clean and sanitary manner. Review of the US Food and Drug Administration's (FDA) 2022 Food Guide section 6-501.11 on Repairing indicated that Physical Facilities shall be maintained in good repair.Poor repair and maintenance compromise the functionality of the physical facilities. This requirement is intended to ensure that the physical facilities are properly maintained in order to serve their intended purpose. 2. During a concurrent observation and interview on 1/20/26 at 10:25 a.m. in the kitchen with the DM, 20 spices were observed with inconsistent use by dates. Several spices had a use by date of 3 months, several had a use by date of 20 days, some spices had only received on dates, some spices had no use by date, and a curry spice that expired on 8/12/25 was found. The DM concurred and agreed that the labeling was inconsistent and could cause confusion, and the curry should have been discarded. A review of the facility's policy titled, Suggested Dry Goods Storage Guidelines, dated 2012, was posted in the dry goods storage room and indicated that dried spices and herbs should have a use-by-date of 6-12 months. A review of the facility's policy titled, Food Receiving and Storage, revised 10/17, indicated that dry foods shall be labeled and dated with a 'use by' date. 3. During a concurrent observation and interview on 1/20/26 at 10:10 a.m. in the kitchen with the DM, 5 large plastic containers, and 20 plastic container lids, were seen stacked with visible moisture between each piece (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of equipment. All were found in the clean and ready-to-use area. The DM stated this did not meet her expectations and could cause bacterial growth. A review of the facility's policy titled, Dishwashing Machine Use, revised 03/10, indicated after running items through entire cycle, allow to air dry. Review of the US FDA 2022 Food Guide section 4-901.11on Equipment and Utensils, Air-Drying Required indicated that After cleaning and sanitizing, equipment.Shall be air-dried.before contact with food.Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms (tiny living things such a bacteria and viruses) can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils. 4. During a concurrent observation and interview on 1/20/26 at 10:10 a.m. in the kitchen with the DM, a metal colander was observed in the ready-to-use area with brown food residue inside the hole openings and around the base. A plastic scoop was observed with brown food residue inside its bowl in a ready to use drawer. A knife holder was observed covered with dust and crumbs near the knife insertion sites. The DM stated it was not acceptable and was unsanitary. A review of the facility's policy titled, Preventing Foodborne Illness-Food Handling, revised 7/14, indicated a critical factor implicated in foodborne illness is contaminated (having been made impure) equipment, and.all food service equipment and utensils will be sanitized according to current guidelines. Review of the US FDA 2022 Food Guide section 4-602.11 on Equipment Food-Contact Surfaces and Utensils indicated in bullet A that Equipment food-contact surfaces and utensils shall be cleaned.Microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces. 5. During a concurrent observation and interview on 1/20/26 at 10:10 a.m. in the kitchen with the DM, six out of eight fry pans were observed with chipped cooking surfaces and greasy residue covering the pans. The DM stated these should have been thrown away as the chipped particles could leach into food that was prepared in them. A review of the facility's policy titled, Sanitization, revised 10/08, indicated all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracked and chipped areas that may affect their use or proper cleaning.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the pureed and alternate foods made for lunch on 1/21/26 were not made by methods that conserved nutritive value, flavor and appearance when recipes were not utilized. This failure had the potential to lead to poor intake, weight loss and malnutrition for the 6 residents eating the chicken entree and 10 residents (Residents 2, 14, 16, 24, 42, 52, 63, 71, 90 & 95) receiving the pureed pot roast and pureed peas.Findings: During a return visit to the kitchen on 1/21/2026 at 9:42 a.m., [NAME] 1 (Ck 1) was preparing the lunch meal. The main meal consisted of pot roast and roasted potatoes which had been prepared and were in the oven. The alternative entree was Lemon Almond Chicken. No recipes were seen on the counter.Ck 1 opened a bag of thawed chicken breasts, counted out 6 pieces and placed them into a high sided pan. Ck 1 proceeded to sprinkle the chicken with an unmeasured amount of dry mustard, lemon/pepper seasoning, salt, chicken bouillon and garlic powder. Ck 1 mixed the seasonings with the chicken, moved to a flat pan before placing the chicken in the oven. Review of facility provided Lemon Almond Chicken recipe ([NAME] Corporate Dietitians, undated) included the following steps. The recipe began by creating a marinade by blending specific amounts of the following ingredients: Lemon Juice, Canola Oil, Dijon Mustard, Fresh Whole Garlic Cloves, and Ground Rosemary which was to be poured over the chicken and then marinaded for an hour in the refrigerator. Other ingredients used before cooking the chicken included Cornstarch, Low Sodium Chicken Broth, Margarine, Blanched Almonds, Grated or Zested Lemon, Salt and Pepper. During an observation on 1/21/26 at 10:30 a.m. Ck 1 poured an unmeasured amount of boiling beef juices (fluid from the beef being boiled in water) and an unmeasured amount of beef (approximately 1/3 of the total cooked amount) to the blender. Ck 1 blended 3 times d before deciding it was too thin. Ck 1 then added 1/2 of a plastic scoop filled with thickener into the blender (roughly 2 ounces/oz or approximately 4 tablespoons) and proceeded to blend. Ck 1 was content with the texture and added 1/2 of the mixture to a steam table pan. Ck 1 next added the remaining (unmeasured) boiled pot roast to the blender which still contained 1/2 of the original pureed meat mixture. Ck 1 blended before adding an additional (unmeasured) amount of thickener (approximately 3oz or 6 tablespoons). When finished, Ck 1 added to the same steam table pan holding the previous pureed mixture and mixed them together. Ck 1 was unsatisfied with the amount of pureed meat in the pan. Ck 1 grabbed 2 more slices of pot roast from the oven and placed the meat slices into the blender. Ck 1 then added an unmeasured amount of water and an unmeasured amount of chicken broth base. Ck 1 blended and mixed into the pan containing the previously made pureed pot roast. Review of facility provided recipe for pureed fish/meat/poultry ([NAME] Corporate Dietitians, undated) indicated specific amounts of liquid and food thickener (1 Tablespoon for the 10-portion recipe provided). Instructions indicated in bullet 2 that All liquid may not be required, depending on texture of meat . Amount of thickener will vary slightly. Start with 1 1/2 teaspoon (1/2 tablespoon) and add more gradually until desired texture is achieved. During this same kitchen observation on 1/21/26 at 11:04 a.m., Ck 1 removed a pan of peas from the steamer. Ck 1 moved the peas into the blender and added an unmeasured amount of butter and an unmeasured amount of chicken broth. Ck 1 proceeded to blend the peas but found the mixture too thin. Ck 1 then added approximately 3.5 oz (7 tablespoons) of thickener to correct the texture before moving the pureed peas to a steam table pan for lunch. Review of facility provided recipe for pureed vegetables ([NAME] Corporate Dietitians, undated) indicated the following instructions: 1. Remove portions required from regular prepared recipe; drain and reserve cooking liquid. Place in food processor or blender and process until smooth. If necessary, add a small amount of reserved cooking liquid.If needed, gradually add thickener and process until smooth in consistency.Start with 1 1/2 teaspoon (1/2 tablespoon) and add more gradually until desired texture is achieved. Ingredient list for 10 servings indicated 1 tablespoon of thickener. During an interview on 1/22/26 at 4:10 p.m. with the dietary manager (DM), the DM stated that Cooks should (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use the minimal amount of fluid, so less thickener is needed. When excessive fluid and thickener are used, it leads to the food having less nutrition and flavor.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 46) for unnecessary medications, received safe and adequate monitoring of a psychotropic medication (any drug that affects behavior, mood, thoughts or perception), when Resident 46's Lithium (a naturally occurring salt used as a powerful mood stabilizer medication) level had not been ordered or drawn since 12/26/24.This failure had the potential to put Resident 46 at risk for ineffective low Lithium levels and/or levels that were too high which could lead to toxicity (a potentially fatal condition that occurs when too much Lithium builds up in the blood).Findings:A review of Resident 46's admission Record indicated he was admitted in early 2017 with diagnoses which included Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Schizophrenia (a mental illness that is characterized by disturbances in thought).During a concurrent observation and interview on 1/20/26 at 12:10 p.m. in the dining hall with Resident 46, Resident 46 was eating his lunch and his arms and hands were visibly shaking. Resident 46 stated, This place is like a warehouse where they keep us, I am kept here because I get very depressed.A review of Resident 46's Care Plan Report indicated an intervention to monitor Lithium levels every 3 months and was initiated on 5/17/19 and revised to continue 3/4/23.A review of Resident 46's lab (laboratory) results indicated the last Lithium level was drawn on 12/26/24.A review of Resident 46's most recent Psychiatric Provider Note, dated 11/12/25, referenced his last Lithium level of 0.5 drawn on 12/26/24. The note indicated Lithium levels should be monitored regularly and there was a plan to order a new Lithium level. A review of Resident 46's Order Summary Report indicated that there were no current orders for Lithium level lab draws.A review of Resident 46's Lithium prescriptions indicated the medication was last refilled by the Facility Medical Director (FMD) on 11/17/25.A review of the Pharmacy Consultant's (PC), Monthly Medication Reviews from 1/2025-1/2026 indicated Resident 46's medications were reviewed monthly and there were no recommendations from the PC.During an interview on 1/22/26 at 11:02 a.m. at the nurses' station with Licensed Nurse 2 (LN 2), LN 2 stated that Resident 46's Lithium level had last been checked on 12/26/24 and she could not locate a more recent level or current orders to have the level drawn. LN 2 stated that Resident 46 was at risk for Lithium levels being too low or too high which could lead to toxicity.During an interview on 1/22/26 at 2:35 p.m. with the Director of Nursing (DON) in her office, the DON confirmed that Resident 46's Lithium level was last checked 12/26/24 and she could not locate a current order for Lithium lab draws. The DON stated the orders should have been placed and Resident 46's Lithium levels should have been monitored every 6 months. The DON stated a lack of monitoring could put Resident 46 at risk for Lithium levels being too high which could cause symptoms of toxicity. During a telephone interview on 1/23/26 at 11:24 a.m. with the PC, the PC stated if a Resident was stable, the Lithium level should be checked every 6 months and if Resident 46's Care Plan Report indicated levels were to be checked every 3 months this should have been followed. The PC stated he did review labs when he completed his monthly medication reviews but must had missed the Lithium levels.During a telephone interview on 1/23/26 at 11:45 a.m. with the Facility Medical Director (FMD), the FMD stated his expectation was for the psychiatrist to have placed the lab orders but if this was not done and the facility team should have identified this gap in care and provided monitoring.A facility policy and procedure on Lithium monitoring was requested but was not provided.A review of the facility's policy titled, Psychotropic Medications Use, updated 4/22, indicated any psychoactive medication prescribed must have an individualized care plan which includes monitoring of side effects of medication.and pharmacy will review psychotropic medication usage on admission, monthly, and as needed.A review of the NIH (National Library of Medicine) drug information website, updated 7/15/22, indicated, Serum lithium levels in uncomplicated cases receiving maintenance therapy during remission should be monitored at least every two months (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and.blood samples for serum lithium determinations should be drawn immediately prior to the next dose when lithium concentrations are relatively stable (i.e., 8 to 12 hours after the previous dose). Total reliance must not be placed on serum levels alone. Accurate patient evaluation requires both clinical and laboratory analysis.

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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 the interview and record review, the facility failed to report an allegation of theft within 24 hours to CDPH (California Department of Public Health) for one of 28 sampled residents (Resident 102). This failure delayed the theft allegation investigation by the department and had the potential to compromise Resident 102's safety and psychosocial well-being.Findings: During a review of Resident 102's admission Record (AR), dated 1/23/26 (print date), the AR indicated Resident 102 was readmitted to the facility in July of 2024 with diagnoses which included intellectual disabilities, substance abuse, and cognitive communication deficit. During a review of Resident 102's nursing note (NN), dated 4/23/25, the NN indicated, Resident came to nursing station at 7:05pm reporting that his money worth $2300 is missing from his fanny pack. Per resident, he took a nap, when he woke up he checked his fanny pack and his money is gone. Reported and referred incident to Social Services. During an interview on 1/22/26 at 12:44 p.m. with Resident 102, Resident 102 stated that months ago facility complained about his truck parked on the parking lot and he had to sell it for $2300, and sometime after the sale he brought his money into the room and placed it into his fanny pack in the room, and then went to sleep and when he woke up the money was gone. Resident 102 stated that he was angry and didn't know who took his money. During an interview on 1/23/26 at 9:33 a.m. with the Social Services Director (SSD), the SSD confirmed that Resident 102 sold his truck and reported to social services that the money was missing. The SSD confirmed that it was a large amount, and it had to be investigated. The SSD stated that she expected this incident to be reported to the department. During an interview on 1/23/26 at 9:50 a.m. with the Administrator (ADM), the ADM confirmed that Resident 102 sold his truck and reported that money from the sale was missing. The ADM confirmed that he expected this incident to be reported to the department, but he was unable to provide evidence that the report was sent. During a review of the facility's policy and procedure (P&P) titled, Investigating Incidents of Theft and/or Misappropriation of Resident Property, revised 4/2017, the P&P indicated, All reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated. Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.Should an alleged or suspected case of staff misappropriation of resident property be reported, the facility Administrator, or his/her designee, will notify the following persons or agencies within twenty-four (24) hours of such incident, as appropriate: a. State Licensing and Certification Agency.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 74) in a census of 102, received his nasal spray medication properly when Licensed Nurse (LN) did not follow the medication administration instructions. This failure had the potential risk for Resident 74's not getting the full benefits of the nasal spray medication and could worsen the allergy symptoms.Findings: During a review of Resident 74's admission Record (AR), dated 1/11/25, the AR indicated Resident 74 was admitted with diagnoses which included nasal allergy symptoms. During a review of the Resident 74's Order Summary Report (OSR), dated 6/25/25, the OSR indicated, Fluticasone Propionate [an allergy medication] Allergy Relief Nasal Suspension 50 mcg/ACT (microgram per actuation, unit of measurement/) Fluticasone Propionate (Nasal) 1 spray in both nostrils one time a day for allergy symptoms. During a review of Resident 74's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 1/26, the MAR indicated, Flonase Allergy Relief Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 1 spray in both nostrils one time a day for allergy symptoms at 1700 [5p.m.]During a medication pass observation on 1/22/26 at 4:21 p.m., LN 4 prepared the medications for Resident 74 which included the nasal spray. LN 4 then entered the Resident 74's room and handed the nasal spray to Resident 74, and Resident 74 sprayed the medication to each of his nostrils. LN 4 did not provide instructions on how to administer the medication to Resident 74. During a concurrent observation, interview, and record review on 1/22/26 at 4:21 p.m., Resident 74's fluticasone propionate nasal spray quick start guide was reviewed together with LN 4. LN 4 confirmed she allowed Resident 74 to use the nasal spray to his own nostrils but did not follow medication instructions and would not get the full benefit from the medication and the allergy symptoms could worsen. During a concurrent interview and record review on 1/23/26 at 7:41 a.m. with the Director of Nursing (DON), Resident 74's clinical record was reviewed. The DON stated she expected the LNs to follow the medication specifications during administration to ensure Resident 74 would get the full benefit of the medications and not to worsen the allergy symptoms. During a review of the Fluticasone Propionate Nasal Spray, United States Pharmacopeia (USP) Quick Start Guide, the guide indicated, Fr best results, it is important to get a full dose, here's how, in five easy steps:1. shake: gently shake spray bottle. Remove translucent cap; 2. Prime: do this when starting new bottle, have not used it in a week, just cleaned the nozzle. Aim away from face. Grasp spray bottle, pump until fine mist appear; 3. Blow: blow nose gently to clear nostrils; 4. Aim: Close one nostril and put tip of spray nozzle in other nostril. Put just the tip into the nose. Aim slightly away from center of nose. 5. Breathe and Spray: While sniffing gently, press down on spray nozzle once or twice according to dosing instructions. Breathe out through your mouth. Repeat in other nostril. Wipe spray nozzle with clean tissue and replace cap. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 2007, the P&P indicated, 7.1: General Guidelines: Medications are administered as prescribed in accordance with manufacturer's specifications .Medication Administration: Medications are administered in accordance with written orders of the prescriber .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to provide care and services in accordance with professional standards of practice for one of 28 sampled residents (Resident 113), when:1. The facility did not obtain Resident 113's hemoglobin A1c (HbA1c-a test that indicates the average level of blood sugar [BS] control, a high or low number is a sign of poor blood sugar control) as ordered by the physician;2. The facility did not provide the required diabetic education for Resident 113; and3. The facility did not provide diabetic training, for licensed staff, year 2025 to current date. These failures had the potential to negatively compromise the necessary quality of care and treatment for Resident 113. A review of Resident 113's admission Record (AR) indicated Resident 113 had diagnoses which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control), malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). During a review of Resident 113's Order Summary Report (OSR), dated 1/12/26, the OSR indicated, Diabetic: HgA1C [sic HbA1c] Q [every] 3 Months-First to be obtained 01/13/26 one time a day every 3 month(s) starting on the 13th for 1 day(s) for Diabetes. During a review of Resident 113's Care Plan Report (CPR), dated 1/13/26, the CPR indicated a focus for DM, with an intervention, Lab work as ordered and report to MD. the CPR did not identify a focus for malnutrition, or for diabetic education. A review of Resident 113's Laboratory [lab]: 1/13/2026 21:55 CBC [Complete Blood Count - routine blood test that measures the number and type of cells in your blood] Report Information did not show a result for the HbA1c. A review of Resident 113's Weights and Vitals Summary indicated the Blood Sugar Summary showed a BS reading of 49 milligrams per deciliter (mg/dl-a unit of measurement used to determine the concentration of blood sugar in the body) on 1/17/26. During a concurrent observation and interview on 1/21/26 at 10:10 a.m. in Resident 113's room, Resident 113 indicated he was a diabetic and on insulin for eleven years. Resident 113 stated that BS was checked last night. it was high, that BS had not been checked and he had not received medication for BS this morning. Resident 113 acknowledged his boxes of sugary food items at bedside and stated the dietitian told me to stuff one in my mouth when my blood sugar drops. Resident 113 stated had not had diabetic teaching from facility staff and would be interested in the information and resources. During a concurrent interview and record review on 1/21/26 at 12:40 p.m. in the Director of Nursing's (DON) office, the DON acknowledged the facility missed obtaining Resident 113's HbA1c lab order, and that licensed staff did not follow the physician's order on 1/13/26. The DON stated it was important staff followed physician's orders to avoid adverse outcomes for Resident 113. During a concurrent interview and record review on 1/21/26 at 12:43 p.m. in the DON's office, the DON acknowledged Resident 113 had not received admission, or periodic, diabetic teaching from staff. The DON stated it was important Resident 113 had diabetic teaching for overall health and safety. During a concurrent interview and record review on 1/21/26 at 12:45 p.m. in the DON's office, the DON confirmed Resident 113's Medication Administration Record [MAR-a document used to track all medications administered to a patient], the column labeled Diabetic: HgA1C Q3 Months., had a check mark, which indicated the HgA1c was done on 1/13/26, The DON verified the check mark was documented in error by the licensed staff. The DON confirmed licensed staff did not document Resident 113's BS reading of 49 mg/dl on the MAR, column labeled Diabetic: If pt (patient) is responsive and BS <70mg/dl., for date 1/17/26. The DON presented a white notebook, labeled In Service Binder. The DON acknowledged there were no in-services for staff related to diabetes, diabetic medication, or documentation. The DON stated it was important licensed staff were properly trained, and competent, to provide diabetic care and treatment for continuity of care. During a telephone interview on 1/22/26 at 1:30 p.m. with the Registered Dietitian (RD), the RD confirmed Resident 113's clinical history for diabetes and malnutrition. The RD saw Resident 113's personal sugary food items at bedside and stated she did not have a discussion and had not reviewed Resident 113's Blood Sugar Summary. The RD acknowledged did not document the bedside foods in the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress notes, did not provide diabetic education for Resident 113, and did not present diabetic in-services for staff. The RD stated it was important to assess how much Resident 113 knew about diabetes, and that education would minimize negative outcomes. During a review of the facility's policy and procedure (P&P) titled, Diabetes-Clinical Protocol, revised 11/2020, the P&P indicated, Assessment and Recognition.Treatment/Management.Monitoring and Follow-Up.Monitor A1C on admission.The staff will identify and report issues that may affect.a patient's.diabetes management. During a review of the facility's P&P titled, Lab and Diagnostic Test Results-Clinical Protocol, revised 11/2018, the P&P indicated, The staff will process test requisitions and arrange for tests. During a review of the facility's P&P titled, Goals and Objectives, Care Plans, revised 4/2009, the P&P indicated, .are entered on the resident's care plan so that all disciplines have access to.information and are able to report whether or not the desired outcomes are being achieved. During a review of the facility's P&P titled, Resident Rights, revised 12/2016, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.be informed of, and participate in, his or her care planning and treatment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a safe environment for one of 28 sampled residents (Resident 83) when resident 83's call light was not in reach.This failure had the potential to result in injury of Resident 83.Findings:During a review of Resident 83's admission Record (AR), the AR indicated Resident 83 was admitted in the fall of 2021 with diagnoses which included abnormalities of gait and mobility (difficulty walking and moving around), and history of falls.During a review of Resident 83's Care Plan Report (CPR), dated 12/25, the CPR indicated Resident 83 had a fall assessment score of 12, which indicated he was at a high risk for falls, and Resident 83's call light should remain within reach.During a concurrent observation and interview on [DATE] at 9 a.m. with Resident 83, Resident 83 lay in bed with his call light tucked above his head. Resident 83 stated he was unable to reach his call light.During a concurrent observation and interview on [DATE] at 9:05 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 83's room, CNA 1 confirmed call light was not within reach. CNA 1 stated Resident 83's call light should be in reach to avoid falls and to give assistance to the restroom.During a concurrent observation and interview on [DATE] at 2:59 p.m. with CNA 3 in Resident 83's room, CNA 3 confirmed Resident 83's call light was not within reach. CNA 3 stated it was expected for the call light to be clipped on the bed or near the resident, and could be a safety concern if not within reach.During a concurrent observation and interview on [DATE] at 5:26 p.m. with Licensed Nurse (LN) 5 in Resident 83's room, Resident 83's call light was observed on the floor. Resident 83 stated he could not reach the call light. LN 5 stated call light should be close to the resident along with bed positioning to avoid emergencies. LN 5 stated that Resident 83 was a fall risk and needed his call light to remain safe. During a concurrent observation and interview on [DATE] at 7:29 a.m. with LN 1 in Resident 83's room, Resident 83's call light was tucked behind Resident 83's pillow. LN 1 confirmed Resident 83's call light was not within reach and expected call light to be in reach. During a concurrent observation and interview on [DATE] at 9:47 a.m. in Resident 83's room, CNA 2 confirmed Resident 83's call light was on the floor. CNA 2 stated the call light was expected to be on the side of the bed or close to the residents so they could reach it. CNA 2 further stated the call light was expected to be placed so it did not fall in the case of an emergency.During an interview on [DATE] at 10 a.m. with the Director of Nursing (DON), the DON stated it was the expectation that call lights be within reach for assistance and needs.During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, dated 2017, the P&P indicated, Individualized, Resident-Centered Approach to Safety: Implementing interventions to reduce accident risks and hazards shall include the following: d. Ensuring that interventions are implemented.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to address Resident 46's weight loss of 22 pounds over 6 months. This had the potential of leading to Resident 46's malnutrition, muscle loss and functional decline. Findings:During an observation in the lunch dining room on 1/20/26 at 12:31 p.m., Resident 46 was noted to be slowly feeding himself. Resident 46 was noted to have a tremor (shaking movement in one or more body parts) which increased the time needed for self-feeding.During a subsequent interview with Resident 46 on 1/20/26 at 12:37 p.m., Resident 46 stated he doesn't pay attention to his weight and was unsure if there was a change. Resident 46 stated he has a history of depression and felt that he was being warehoused at the facility. Resident 46 also mentioned being bored with the facility food and felt that he had no choice in what he was served. During an observation on 1/21/26 at 7:57 a.m., Resident 46 was the only resident in the dining room. Resident 46 had finished 90% of the breakfast meal and was still eating. During a review of Resident 46's admission Record (AR) on 1/21/26 at 2:36 p.m., the AR indicated Resident 46 was admitted in 2/2017 with diagnoses which included type 2 diabetes, major depressive disorder, dysphagia, and schizophrenia. During a review of Resident 46's electronic medical record a weight variance note from 11/6/25 included the following weight history: Current weight of 189# (pounds)11/1/25=188# 10/5/25=195#9/1/25=200#8/2/25=202#7/1/25-205#6/1/25=207#5/3/25=210# This weight variance note entered on 11/6/25 indicated that Resident 46 had a weight loss of 7 pounds over 1 month (a 3.6% decrease in body weight), a 17-pound weight loss over 3 months (a 8.3% decrease in body weight), and a 22-pound weight loss over 6 months (a 10.5% decrease in body weight). The weight variance note did not discuss a potential cause for weight loss or add interventions to the care plan. A review of Registered Dietitian (RD) Notes indicated Resident 46 had not been assessed by the RD since 08/21/25. During an interview on 1/21/26 at 4:33 p.m. with the Registered Dietitian (RD), the RD stated that significant weight losses were discussed with the interdisciplinary team (IDT, usually consisting of the RD, nursing, rehabilitation and social services, though may include the Physician and Administrator) at the beginning of the month. The RD further indicated that the purpose of this meeting was to determine the root cause for weight change and to make recommendations to stabilize the weight loss based on the root cause. During this interview on 1/21/26, the RD was asked about the IDT meeting for Resident 46 in November 2025. The RD recalled Resident 46 did not want to get out of bed or talk during that time. When asked the root cause for the weight loss, the RD did not have a cause and stated that depression had not been considered. The RD concurred that no interventions had been initiated. During an interview with the Director of Nursing (DON) on 1/22/26 at 2:32 p.m., the DON discussed how weight changes were handled. The DON stated that the RD would apprise the IDT of those with weight loss. The IDT would then meet to tease out potential causes for weight loss such as diuretic use, poor food intake, or dislike of the facility. The team would then work with the physician to develop and implement a plan to address the weight change. The DON did not give a root cause for Resident 46's weight loss. A review of facility provided policy titled, Weight Assessment and Intervention (Med-Pass, Inc., Revised September 2008) indicated that the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. In the weight assessment section, bullet 6 defines significant and severe weight loss as follows: a. 1 month-5% weight loss is significant, greater than 5% is severe.b. 3 months-7.5% weight loss is significant, greater than 7.5% is severe.c. 6 months-10% weight loss is significant, greater than10% is severe. In the analysis section, the weight assessment further indicated Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding .1. c. The relationship between current medical condition or clinical situation and recent fluctuations in weight . The Physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia (poor appetite), weight loss or increasing the risk of weight loss. In the care (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	planning section, the policy indicated that 1. Care planning for weight loss or impaired nutrition will be a multidisciplinary effort .2. Individual care plans shall address to the extent possible: a. The identified cause of weight loss; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment. In the section on interventions the policy indicated that 1. Interventions for undesirable weight loss shall be based on careful considerations of the following: a. Resident choice and preferences. c. Functional factors that may inhibit independent eating. f. Medications that may interfere with appetite, chewing, swallowing, or digestion.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure appropriate care and services were provided for one of twenty-eight sampled residents (Resident 8), when Resident 8's swallow evaluation (test performed to determine if food or liquid is passing safely to the stomach without entering the lungs) was not rescheduled and completed. This failure had the potential to result in delayed restoration of eating and placed Resident 8 at risk for aspiration (choking).Findings:During a review of Resident 8's admission Record (AR), the AR indicated Resident 8 was admitted in spring of 2025 with diagnoses which included dysphagia (difficulty swallowing) and esophagitis with bleeding (pain and swelling to throat).During a review of Resident 8's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 10/1/25, the MDS indicated Resident 8 had no memory impairment and received more than fifty one percent (51%) of nutrition enteral feeding [tube feeding] (nutrition provided directly to the stomach via a tube).During a review of Resident 8's Care Plan Report (CPR), dated 1/11/26, the CPR indicated Resident 8's diet order was NPO (nothing to eat by mouth) and received tube feeding twenty (20) hours per day due to dysphagia. The CPR indicated Resident 8 was at risk for aspiration.During a review of Resident 8's Progress Notes (PN), dated 10/30/25, the PN indicated Resident 8 had a new order for a swallow screen for diet update.During a review of Resident 8's PN dated 10/30/25, the PN indicated Resident 8's swallow screen ended early due to Resident 8's report of pain. The PN indicated a further swallow evaluation treatment was needed when Resident 8 is feeling her best. and demonstrate the ability to participate.During a review of Resident 8's Nurses Note SBAR [situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents], dated 1/1/26, the SBAR indicated, Resident was yelling i (sic) am in pain because am hungry.Resident continue to say I want to eat.During a review of Resident 8's PN with a print date 1/22/26, the PN indicated Resident 8 was not scheduled for a follow up swallow evaluation after Resident 8 requested to eat on 11/8/25, 11/18/25, 11/28/25, 1/1/26, and 1/14/25.During a concurrent observation and interview on 1/20/26 at 10:27 a.m. with Resident 8 in his bedroom, Resident 8 was lying in bed and was receiving her tube feeding from a pump (a device that automatically provides nutrition at a programmed rate). Resident 8 stated her swallow evaluation was not completed and that she only received nutrition through tube feeding since admission. Resident 8 further stated she had notified staff she wanted to eat by mouth and had not received a follow up evaluation. During a concurrent interview and record review on 1/22/26 at 10:39 a.m. with LN 1, LN 1 confirmed Resident 8 did not have a completed swallow screen on record since 4/2025. LN 1 stated, I would expect her to have one by now .It is important for clients to eat even if it's a thick diet.During an interview and record review on 1/22/26 at 11:14 a.m. with Resident 8's Speech Therapist (ST), the ST confirmed Resident 8 swallow screen was not completed and stated she expected Resident 8 to be re-evaluated for her swallow screen by now.During a concurrent observation and interview on 1/23/26 at 9:44 a.m. with Resident 8 in his room, Resident 8 was lying in bed and was receiving her tube feeding from a pump. Resident 8 stated she was expecting a follow-up from her incomplete swallow evaluation and stated again she would like to eat by mouth. During an interview on 1/23/26 at 10 a.m. with the Director of Nursing (DON), the DON indicated she expected staff to address patient needs. The DON stated it was the expectation that an incomplete swallow evaluation should be followed up on and completed for Resident 8. During a review of the facility's policy and procedure (P&P) titled, Enteral Nutrition, dated 2018, the P&P indicated, .6. If the resident has a feeding tube placed prior to admission or returning to the facility, the provider and the interdisciplinary team will review the rationale.and the treatment goals and wishes of the resident.the decision to continue or discontinue the use of the feeding tube is made through collaboration between the interdisciplinary team, the provider and the resident.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure one of 35 sampled residents (Resident 119) received his diabetic medications with meals as ordered.This failure could potentially result to Resident 119's blood sugar level to drop in dangerous levels and suffer stomach upset. Findings: During a review of Resident 119's admission Record (AR) dated 1/19/26, the AR indicated, Resident 119 had diagnoses which included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 119's Order Summary Report (OSR), dated 1/19/26, the OSR indicated, Metformin HCl Oral Tablet 1000 MG (Metformin HCl). Give 1 tablet by mouth two times a day for DM. Give with meals. During a review of Resident 119's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/19/26, the MAR indicated, Metformin HCl Oral Tablet 1000 MG Give 1 tablet by mouth two times a day for diabetes. diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). Give with meals at 17:00 [5 p.m.]During a medication pass observation on 1/22/26 at 5:05 p.m. with Licensed Nurse 5 (LN 5), LN 5 administered the medication Metformin HCl Oral Tablet 1000 MG (milligram, metric unit of measurement, used for medication dosage and/or amount) to Resident 119 without meals. During a concurrent observation, interview, and record review on 1/22/26 on 5:05 p.m. with LN 5, Resident 119's metformin medication bubble pack was reviewed. LN 5 confirmed the medication instruction clearly indicated give with meals. LN 5 confirmed she administered the medication without meals or food to Resident 119. LN 5 stated Resident 119 blood sugar level could go to a very dangerous level and could have stomach upset because she administered the medication without meals. During an interview on 1/22/26 at 5:08 p.m. with Resident 119 inside his room, Resident 119 confirmed he did not take any snacks prior and his dinner was serve around or after 6 p.m. During an interview and record review on 1/23/26 at 7:41 a.m. with the Director of Nursing (DON), Resident 119's clinical record was reviewed. The DON stated she expected the LN to follow the medication instructions when administering anti-diabetic medications. The DON stated if the medication order indicated give with food, the LN should administer the medication with food to ensure Resident 119 would not experience dangerous low blood sugar level which could result to life threatening complications. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration, dated 2007, the P&P indicated, 7.1: General Guidelines: Medications are administered as prescribed in accordance with manufacturer's specifications .Medication Administration: Medications are administered in accordance with written orders of the prescriber .3.b: Medications to be given with meals are to be scheduled for administration at the resident's meal times .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 of a discharged resident were removed from the nurse's medication cart and mixed with other residents' active medication supplies. This failure had the potential to result in medication errors when the medications were accidentally given by mistake to other residents. During a facility task observation, two medication carts were inspected on [DATE] at 1:21 p.m. Cart #3 was inspected together with Licensed Nurse 3 (LN 3). Inside med cart #3, the lower medication cart drawer contained oral, liquid, and topical medications of active residents. The same lower drawer also contained one box of lidocaine patch which belonged to a resident who was discharged on [DATE]. During a concurrent observation and interview with LN 3 on [DATE] at 1:21 p.m., LN 3 confirmed the resident's name imprinted on the 1 full box of lidocaine patch was already discharged last [DATE]. LN 3 stated medications of discharged residents should have been removed from the nurse's medication cart and not mixed with the medication supplies of active residents. LN 3 stated LNs were not supposed to keep any medication for residents who were no longer in the facility to ensure LNs will not administer medications in error. LN 3 stated, LNs might give the lidocaine patch by mistake to other residents. LN 3 indicated giving the wrong medication to another resident could have an adverse side effect that could be life threatening. During an interview on [DATE] at 7:41 a.m. with the DON, the DON stated the expectations was for the LNs to remove all medications of the residents once they were discharged . The DON stated when medications were just kept there, it could be expired and could be administered in error to other residents. A review of the facility's policy and procedure (P&P) titled, DISPOSAL OF MEDICATIONS, dated 2007, the P&P indicated, Discontinued medications and/or medications left in the nursing care center after a resident's discharge are identified and removed from current medication supply in a timely manner for disposition.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview and record review, the facility Registered Dietitian lacked the skill set to assess a non-English speaking resident (Resident 11) when language interpreter services were not utilized though the resident appeared to have lost 22 pounds during her 3 months at the facility. This failure had the potential of leading to further weight and muscle loss as well as malnutrition for Resident 11.Findings: During a concurrent observation and interview of the lunch meal on 1/20/26 at 12:36 p.m., Resident 11 was in bed, awake and alert. Resident 11 nodded to answer questions, but after a couple of questions Resident 11 stated she did not speak English and reported her preferred language. During a review of Resident 11's electronic medical record on 1/20/26 at 2:17 p.m. a weight variance note from 1/15/26 was observed. This note included the following weight history:Current wt (weight)=88# (pounds) 1/3/26=84#12/1/25=89#11/1/25=99.5#10/11/25=106# During a concurrent observation and interview on 1/21/26 at 8:27 a.m. with Resident 11, Certified Nursing Assistant 4 (CNA 4) provided interpretation. Resident 11 had eaten most of the breakfast meal tray leaving only the sausage on the plate and her nutrition supplemental drink. Five additional supplement drinks were observed in her room (3 on the cabinet, 2 on the tray table, plus the one on her breakfast tray). Resident 11 pointed out that she ate differently than what was served at the facility, preferring chicken, rice and vegetables. Resident 11 also stated she ate some beef but not often, and avoided pork, fish, and yogurt. Resident 11 reported that she previously weighed 110 pounds and had a current weight of 89 pounds. Resident 11 stated that in her culture nursing homes weren't used and found it depressing to be in one. During a kitchen visit on 1/21/26 at 9:30 a.m., Resident 11's food preferences of chicken, rice and vegetables were shared with the Registered Dietitian (RD) and Dietary Manager (DM) as well as the dislikes. During the lunch meal plating on 1/21/26 at 12:30 p.m., Resident 11 was served pot roast, peas, and roasted potatoes, though chicken, rice, zucchini and carrots were available. During an interview on 1/21/26 at 4:33 p.m. with the RD, the RD found some snack preferences for Resident 11 in the dietary computer system, but no other preferences were listed. The RD stated that she did not speak Resident 11's language and had communicated with her by pointing to things and using body movement. During an interview on 1/22/26 at 2:32 p.m. with the Director of Nursing (DON), communication with a non-English speaking resident was discussed. The DON stated that social services could set up interpretation services within a few minutes and that the expectation was that staff use these services to communicate and provide care when needed. The DON stated that without the use of an interpreter, the residents could not be thoroughly assessed. During an interview on 1/22/26 at 4:40 p.m. with the Dietary Manager (DM), the DM stated that her position and the RD position were the only staff able to input resident food preferences. Resident 11's dietary preferences were reviewed. The dietary computer system indicated that Resident 11 had only one preference which was for rice. No other likes or dislikes had been entered. Review of facility provided Consultant Dietitian Nutritionist Job Description (Nutrition Therapy Essentials, Inc. Food Service Policy & Procedures Manual 2023) indicated, The RDN (Registered Dietitian Nutritionist) provides consultation to the facility for the purpose of providing nutrition care.which will result in optimal health of the resident. Responsibilities included 1. Evaluates the nutritional needs of residents and documents in the nutritional record.5. Reviews and assists.in interdisciplinary care planning and Department of Food and Nutrition Services care plans.10. Visits residents to monitor food acceptance. Review of facility provided policy on Translation and/or Interpretation of Facility Services (Med-Pass, Inc., Revised November 2020) indicated that This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. In bullet 11, it further indicated, Competent oral translation of vital information that is not available in written translation, and non-vital information shall be provided in a timely manner and at no cost to the resident through the following means (as available to the facility): (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056177	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Double Tree Post Acute Care Center	7400 24th Street Sacramento, CA 95822

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A staff member who is trained and competent in the skill of interpreting; b. A staff interpreter who is trained and competent in the skill of interpreting; c. Contracted interpreter service; d. Voluntary community interpreters who are trained and competent in the skill of interpreting; and e. Telephone interpretation service.