STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056304	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Carmichael Healthcare Center	3630 Mission Avenue Carmichael, CA 95608

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for two of 27 sampled residents (Resident 126 and Resident 51) when:1. Follow-up appointments were cancelled and delayed for Resident 51; and,2. There was no monitoring and care plan for Resident 126's use of offloading boot (a specialized medical device designed to reduce pressure, friction, and weight on specific areas of the foot or heel).These failures resulted in delays in care for Resident 51 and increased Resident 126's risk to develop skin breakdown.Findings:During a review of Resident 51's admission records, the records indicated Resident 51 was admitted in February 2026 with diagnoses that included displaced comminuted fracture of shaft of left tibia and left fibula (both lower leg bones are broken into three or more fragments), fracture of part of neck of left femur (broken hip), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Resident 51's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/8/26, indicated Resident 51 had moderate cognitive impairment.During a review of Resident 51's physician order, dated 2/3/26, the order indicated, .[Resident 51] has capacity to make health care decisions.During a review of Resident 51's hospital records, dated 2/3/26, the records indicated, .F/u [follow-up] ortho [orthopedic - a specialty focused on diagnosing, treating and preventing disorders of muscles and bones] [name of physician] on 03/17/2026 at 10:15 AM.one hour early for Xray [an imaging test used to create images of bones and internal organs].During a review of Resident 51's nurses progress note, dated 3/17/26, the note indicated, .Called [name of physician] office to re schedule resident appt [appointment].Follow up Appt: March 24, 2026 @ 8:15.Communicated with SSD [Social Services Director] and resident informed of her schedule.During a review of Resident 51's nurses progress note, dated 3/24/26, the note indicated, .[Resident 51's] F/U DOCTOR APPOINTMENT WAS RESCHEDULED. [Resident 51] DOES NOT HAVE CAPACITY TO MAKE HEALTH CARE DECISION AND HAS TO HAVE FAMILY/STAFF TO ACCOMPANIED HER TO THE APPOINTMENT.During a review of Resident 51's nurses progress note, dated 4/7/26, the note indicated, .[physician] ordered to have Xrays done in facility if AP [anteroposterior - from front to back] lateral knee [outside of knee] 2 views and images forwarded to their clinic for review.During a review of Resident 51's social services progress note, dated 4/9/26, the note indicated, .Called [physician] office. They are still waiting for the X-rays of left knee before they can schedule appointment.During a review of Resident 51's nurses progress note, dated 4/10/26, the note indicated, NP [nurse practitioner].reviewed left knee x-ray, done on 4/8/26. No new order was received. [NP] noted, admitted for this (fracture), a follow-up x-ray for ortho.During a review of Resident 51's social services progress note, dated 4/10/26, the note indicated, .Appointment: 5/19/2026 9:30am.During an interview on 5/19/26 at 9:56 a.m. with Resident 51, Resident 51 stated she was not feeling good because her appointment for x-ray and left leg brace was cancelled. Resident 51 stated the appointment was scheduled in the morning of 5/19/26 and stated she did not know the reason for the cancellation.During a concurrent interview and record review on 5/22/26 at 8:47 a.m. with the SSD, the SSD reviewed Resident 51's progress notes and confirmed Resident 51 was scheduled to have her orthopedic appointment on 3/17/26 and was rescheduled on 3/24/26. The SSD stated she was not aware of the reason why the appointment (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was rescheduled. The SSD further confirmed that Resident 51's appointment was cancelled again on 3/24/26 because Resident 51 did not have the capacity to make healthcare decisions and required a family member or staff to accompany Resident 51 to the appointment. Contrary to the reason why Resident 51's appointment was cancelled, the SSD confirmed that Resident 51's physician order indicated that Resident 51 had the capacity to make healthcare decisions. The SSD stated that if there was a cancellation of appointment, there should be a reason why and it should be documented. The SSD confirmed that there was no documented evidence on why Resident 51's appointment was cancelled on 3/17/26 and the SSD stated that she did not understand the situation on Resident 51's capacity to make healthcare decisions. The SSD stated that there was a break in communication between the team.During a concurrent interview and record review on 5/22/26 at 11 a.m. with the Director of Nursing (DON), the DON confirmed Resident 51 had an orthopedic follow-up appointment scheduled for 3/17/26. The DON stated that the transportation company wanted the facility to give notification about the appointment at least a week prior to the appointment. The DON further stated the facility could not book the transportation on time to meet the appointment, so the appointment needed to be rescheduled. The DON confirmed that there was no documented evidence on why the appointment was cancelled and rescheduled and stated, .they [staff] probably forgot to document. The DON also confirmed that Resident 51's appointment was rescheduled for 3/24/26 but got cancelled again because Resident 51 did not have the capacity to make healthcare decisions and Resident 51's family member was unable to go with Resident 51 to the appointment. The DON confirmed that Resident 51's physician order indicated that Resident 51 had the capacity to make healthcare decisions. The DON further stated that the facility was not informed that Resident 5's family member was not able to make it to the appointment, and it was hard for the facility to provide the staff to go to the appointment. The DON confirmed that there was no documented evidence that the family member or staff member was not available for the appointment. The DON stated, .nurses communicate but sometimes, things get forgotten.During a review of the facility's policy and procedure (P&P) titled Provision of Physician Ordered Services, revised 5/15/23, the P&P indicated, .The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician services according to professional standards of quality.1. Diagnostic tests: a. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders.b. Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to the appropriate entity.d. Documentation of consultations, diagnostic tests.will be maintained in the resident's clinical record.5. Follow-up appointments: Facility staff will assist residents in scheduling and attending follow-up appointments as ordered by the physician.Necessary documentation of scheduled appointments and resident attendance may be maintained.2. During a review of Resident 126's admission records, the records indicated Resident 126 was admitted in April 2026 with diagnoses that included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), necrotizing fasciitis (severe bacterial infection that destroys the body's soft tissue), polyneuropathy (occurs when multiple peripheral nerves become damaged), and major depressive disorder. Resident 126's MDS indicated Resident 126 had intact cognition.During a review of Resident 126's care plan, initiated on 4/30/26 and revised on 5/8/26, the care plan indicated, .[Resident 126] has potential/actual impairment to skin integrity and is at continued risk for skin breakdown r/t [related to] fragile skin.During a concurrent observation and interview on 5/19/26 at 10:42 a.m. with Resident 126 in his room, Resident 126 was observed alert and calm, lying in bed, with offloading boots on both feet. Resident 126 stated he wears the offloading boot most of the time.During an interview on 5/21/26 at 9:05 a.m. with Licensed Nurse 10 (LN 10), LN 10 stated that residents that use offloading boots needed to have a physician order to monitor the skin integrity. LN 10 further stated, .We want to know how long it's [offloading boots] been there. LN 10 added that the use of offloading boots should be included in the care plan. LN 10 stated it was important for the staff to be aware that a resident is wearing offloading (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	boots to make sure they were properly placed and to monitor the condition of the skin.During an interview on 5/21/26 at 11:51 a.m. with Treatment Nurse 2 (TN 2), TN 2 stated the use of offloading boots should be checked and assessed every shift and the assessment is documented under the skin assessment. TN 2 further stated that there is usually an order for the use of the offloading boots and the nurses document that they did the assessment. TN 2 stated that there should be a physician order for the use of the offloading boots and it should be included in the care plan. TN 2 also stated that if the use of offloading boots was not monitored, it could give the residents more pressure on the skin and high risk for skin breakdown. TN 2 further stated it was important to include the use of the offloading boots in the care plan because the care plan was the guide on what care to provide for the residents.During a follow-up interview on 5/21/26 at 3:10 p.m. with TN 2, TN 2 confirmed that Resident 126 was using offloading boots on both feet since admission. TN 2 confirmed that there was no physician order or Treatment Administration Record (TAR) for Resident 126's use of the boots. TN 2 also confirmed that Resident 126's use of offloading boots was not included in the care plan. TN 2 confirmed that she just entered the order and the care plan today, 5/21/26, for Resident 126's use of the offloading boots because she remembered that Resident 126 uses offloading boots.During a concurrent interview and record review on 5/21/26 at 3:16 p.m. with the DON, the DON stated that for residents wearing offloading boots, the nurses check the use of the boots every shift to make sure they were on. The DON further stated that if a resident had a high risk for skin breakdown, the use of offloading boots should be part of the interventions in the care plan. The DON confirmed that Resident 126 had a high risk for skin breakdown because he was bedbound and had a history of open wound. The DON stated that there should have been monitoring on Resident 126's use of the boots and it should have been added to the care plan. The DON confirmed there was no documented evidence that Resident 126's use of the boots was being monitored.During a review of the facility's P&P titled Pressure Injury Prevention and Management, revised 9/12/23, the P&P indicated, .2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.4. Interventions for Prevention and to Promote Healing.a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc).f. Interventions will be documented in the care plan and communicated to all relevant staff.g. Compliance with interventions will be documented in the weekly summary charting.