

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Whitney Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3529 Walnut 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>48445</p> <p>Based on interview and record review, the facility failed to ensure professional standards of practice were followed for one of three sampled residents (Resident 1), when the dose of Resident 1's Seroquel (Quetiapine Fumarate, a medication used to treat mental/mood disorders) was not given per physician's order.</p> <p>This failure had the potential to result in Resident 1 not having the desired effects of the medication.</p> <p>Findings:</p> <p>During a review of Resident 1's admission record, the record indicated Resident 1 was admitted in July 2024 with diagnoses that included bipolar disorder (a disorder that causes intense changes in mood, energy levels and behavior). Resident 1's Minimum Data Set (MDS, an assessment tool) indicated Resident 1 had intact cognition.</p> <p>During a review of Resident 1's physician order, dated 7/2/24, the order indicated, Quetiapine Fumarate Oral [by mouth] 400 MG (milligrams, a unit of measurement) .Give 2 tablets by mouth at bedtime for BIPOLAR DISORDER M/B [manifested by] rapid mood cycling from pleasant to extreme anger.</p> <p>During a review of Resident 1's care plan initiated on 7/3/24, the care plan indicated, [Resident 1] uses psychotropic medication (Quetiapine) r/t [related to] Bipolar m/b rapid mood cycling form [sic] pleasant to anger .Administer medications as ordered. Monitor/document for side effects and effectiveness.</p> <p>During a review of Resident 1's Medication Administration Record (MAR) for Seroquel, dated 7/2024, the MAR indicated Seroquel was signed as given on 7/10/24 at 8 p.m.</p> <p>During a review of Resident 1's eINTERACT Change in Condition Evaluation - V5.1, dated 7/11/24, the evaluation indicated, 1. The change in condition, symptoms or signs I am calling about is/are .31. Other change in condition .1a. List the other change: .Alleged med error.</p> <p>During a review of Resident 1's Health Status Note, dated 7/11/24, the note indicated, DON informed writer that resident complaint [sic] of receiving only 400 mg of his Seroquel .MD made aware of alleged med error.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's IDT [Interdisciplinary Team] late entry note dated 7/12/24, the note indicated, [Resident 1] was not given correct amount of his Seroquel x1 [once] .</p> <p>During a telephone interview on 7/18/24 at 8:44 a.m. with Family Member 1 (FM 1) to Resident 1, FM stated, He has Seroquel 800 mg, they gave 400 mg, the nurse told me about the milligrams, he was wide awake in the evening. I asked them to investigate, they only gave him half.</p> <p>During an interview on 7/18/24 at 2:44 p.m. with the Director of Nursing (DON), the DON stated, [Resident 1] had a med error .was supposed to have two tabs but we had an orientee and she gave one tab instead of two. [name of nurse] confirmed it and we had some education about it. Resident called [FM 1] then [FM 1] called .the NOC [evening] shift nurse and when we looked and counted the cart, we confirmed that one tablet was given .if doses were incorrect, [Resident 1] might have behaviors .expectation is to follow the doctor's order.</p> <p>During a telephone interview on 7/18/24 at 3:41 with Licensed Nurse 1 (LN 1), LN 1 stated she was not able to remember what happened that night. LN 1 further stated, The DON told me about the incident that I had a med error, and we did the education, and I signed the paper work.</p> <p>During a review of the facility's provided document titled ONE-ON-ONE COACING RECORD, dated 7/16/24, the document indicated LN 1 Will follow 5 rights and To administer medications as ordered.</p> <p>During a review of the facility's undated policy and procedure [P &P] titled IIA-2 Medication Administration - General Guidelines, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so .2) Medications are administered in accordance with written orders of the attending physician.</p> <p>During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require substantial amount of specific knowledge of the following: .(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician . (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing - State of California Department of Consumer Affairs).</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>48445</p> <p>Based on observation, interview, and record review, the facility failed to ensure food preferences were honored for one of three sampled residents (Resident 2), when Resident 2 disliked broccoli but he was served broccoli during the lunch meal.</p> <p>This failure resulted in Resident 2's food preferences not being honored, and Resident 2 not receiving options for food of similar nutritive value.</p> <p>Findings:</p> <p>During a review of Resident 2's admission record, the record indicated Resident 2 was admitted in June 2024 with diagnoses that included transient ischemic attack (a temporary blockage of blood flow to the brain) and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). Resident 2's Minimum Data Set (MDS, an assessment tool) indicated Resident 2 had intact cognition.</p> <p>During a review of Resident 2's document titled, DIETARY INTERVIEW/PRE-SCREEN -V3.0, dated 7/12/24, the document indicated, IV. FOOD LIKES/DISLIKES .CHECK DISLIKES. ITEMS LEFT UNCHECKED INDICATE FOOD LIKES. The document further indicated broccoli and cabbage were checked under F. Vegetables.</p> <p>During a review of the facility's menu for Summer 2024 (Healthcare Menus Direct, LLC), the menu indicated lunch for 7/18/24 included glazed ham, potato medley, broccoli, cornbread, and sherbet.</p> <p>During a concurrent observation and interview on 7/18/24 at 12:41 p.m. with Resident 2 and Family Member 2 (FM 2), Resident 2 was observed having lunch. Resident 2's meal ticket was observed indicating dislikes included broccoli. Lunch plate was observed to include broccoli. FM 2 confirmed there was broccoli on the plate and told Resident 2 that there was broccoli. Resident 2 stated she will not eat the broccoli and started separating the broccoli from the food.</p> <p>During a concurrent interview and record review on 7/18/24 at 2:12 p.m. with the Registered Dietitian (RD), the RD confirmed Resident 2's records indicated she dislikes broccoli, and it was part of the lunch menu for 7/18/24. The RD stated, [Staff] should be following the tray cards and following what's on the dislikes.</p> <p>During a concurrent interview and record review on 7/18/24 at 2:44 p.m. with the Director of Nursing (DON), the DON confirmed broccoli was listed as one of Resident 2's dislikes. The DON stated, Our staff on the floor should ask if residents wanted [the food] or not .[Residents] could not eat the food potentially if they dislike the food.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, revised 7/2017, the P&P indicated, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team . 1. Upon the resident's admission (or within twenty-four (24) hours after his/her admission) the Dietitian or nursing staff will identify a resident's food preferences. 2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. 3. Nursing staff will document the resident's food and eating preferences in the care plan.</p>		