STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555261	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Acc Care Center	7801 Rush River Drive Sacramento, CA 95831

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 48445 Based on interview and record review, the facility failed to ensure residents were free from misappropriation of property for a census of 84 when multiple doses of controlled pain medications and count sheets were missing and unaccounted for. These failures resulted in the facility's lack of accountability of residents controlled medications with potential for uncontrolled pain and suffering. Findings: During a review of the facility provided statement signed by Licensed Nurse 2 (LN 2), dated 10/15/24, the statement indicated, I was assigned to the first cart on [name of the hall]. I received the report from [LN 3], the NOC [night shift] nurse, at around 0615 [6:15 a.m.]. When we counted the narcotics [controlled medications], we noticed that the medication for [Resident 1] was missing. The count sheet issued by the pharmacy for that medication was in the binder. We also discovered that the count sheet for the medication for [Resident 3] was missing, though the medication itself was present in the narcotic box .We thoroughly searched the narcotic and non-narcotic medications, but the missing medication was nowhere to be found . [LN 3] voiced out her concerns about the narcotics count, according to her the narcotic count from the previous night (10/14/24) had been accurate. Together, we asked [LN 1] if we could check the cart at the back, hoping the medication might be there, but we still couldn't locate it. [LN 1] then checked the computer and informed us that the order for [Resident 1] had been discontinued and changed to a different dose. [LN 1] took the count sheet for [Resident 1] and created a handwritten count sheet for [Resident 3]. I expressed my concerns to her and said I didn't feel comfortable taking over the first cart due to the missing narcotics. [LN 1] said It's okay, let's switch carts and I'll handle it. [LN 3] later mentioned that [LN 1] had borrowed the key to the first cart and searched through the medication cart while [LN 3] was administering medications to patients in another room. Then, [LN 3] and I found the torn pieces of the original narcotic count sheet for the missing medication .I checked the order and saw that the new order was placed earlier that morning. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided statement by LN 3, dated 10/15/24, the statement indicated, .When [LN 1] and I counted her cart 2, the narcotics were fine. I then went to cart 1 and waited for [LN 2]. [LN 1] asked to borrow my keys for cart 1, so I gave it to her. She opened the cart to look for something, and I proceeded .to give medication. After about 5 mins [minutes], [LN 1] returned the keys. Once I gave report to [LN 2], we did the count and found out that the Oxycodone for [Resident 1] was missing. The count sheet in the narcotic book was still there, but the bubble pack with 20 Oxycodone tablets, delivered on 10/11/24 was gone. The count sheet for [Resident 3] was also missing, but the Oxycodone bubble pack [blister pack, a form of tamper-evident packaging] was still there. At that point, I told [LN 1] that narcotic meds were missing after she borrowed the keys. She responded not to worry because the order has been dc/d [discontinued] and changed. She suggested to [LN 2] that they switch carts and she'll take care of it. When I proceeded to [LN 2] cart 1, I noticed the paper for the missing narcotic meds was shredded. I called [LN 2] and showed her the shredded paper. [LN 2] also told me that [LN 1] had changed the order without any progress notes. During an interview on 10/24/24 at 1:45 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, We had a nurse that we believe is diverting oxycodone, September and October. Thru [through] the audit, 1,915 doses unaccounted for .Initially it was reported, a nurse came to the DON (Director of Nursing) that there was a narcotic discrepancy, a bubble pack was missing and that there's a separate count sheet missing .Nurses said they found the bubble pack. There were handwritten count sheets. I looked on the bubble pack which is smashed on the side .There was a tape at the back of the blister pack .We audited all oxycodone within that timespan when there were missing count sheets .Those orders correlated with her on PCC (electronic chart). During an interview on 10/24/24 at 3:22 p.m. with LN 4, LN 4 stated, The process is to give pills to resident, sign the MAR and sign the narcotic sheet .If there are discrepancies, we try to find why is it off, maybe they make a mistake .If we can't find any reason, we notify the DON .It can mean people took the wrong medication out or maybe someone stole medication, that's a possibility. During an interview on 10/24/24 at 3:45 p.m. with LN 5, LN 5 stated, The expectation is making sure there are no discrepancies, and that we are giving the medication correctly and make sure the numbers are correct .Always protect yourself and make sure residents have what they need. During a continued interview on 10/24/24 at 4:17 p.m. with the ADON, the ADON stated, We believe that [LN 1] had put in an order and discontinued the order, she took the drug sheet as well as the drugs, it would appear that it was not missing, no order, no count sheet, and no drugs. During an interview on 10/24/24 at 4:33 p.m. with the Administrator (ADM), the ADM stated, , [LN 1]'s operation was she will order into PCC (electronic chart), write the prescription and sign it, fax it to [name pharmacy], she would come in the next day and discontinue the order, make sure it's in the cart, get the bubble pack and the count sheet before discontinuing the medication .The only reason why we were alerted was because that morning when she took one pack, she took the wrong count sheet, if she didn't get the wrong sheet, we wouldn't be able to know. During a review of the facility provided document titled F. Employee Conduct, undated, the document indicated, [Facility] expects its employees to act in a professional and respectful manner at all times. Examples of conduct that may lead to disciplinary action are identified below .Unauthorized possession, destruction, use, or removal of property .

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 48445 Based on interview and record review, the facility failed to ensure professional standards of practice were followed when Licensed Nurse (LN 1) entered orders, wrote prescriptions, and discontinued controlled medications without physician authorization for five of nine sampled residents (Residents 1, 3, 4, 5, and 6). This failure resulted in the facility not having accurate accountability of controlled medications, the potential for abuse or misuse of these medications, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions. Findings: During a review of the facility provided statement signed by LN 2, dated 10/15/24, the statement indicated, I was assigned to the first cart on [name of the hall]. I received the report from [LN 3], the NOC [night shift] nurse, at around 0615 [6:15 a.m.]. When we counted the narcotics [controlled medications], we noticed that the medication for [Resident 1] was missing. The count sheet issued by the pharmacy for that medication was in the binder. We also discovered that the count sheet for the medication for [Resident 3] was missing, though the medication itself was present in the narcotic box .We thoroughly searched the narcotic and non-narcotic medications, but the missing medication was nowhere to be found .[LN 3] voiced out her concerns about the narcotics count, according to her the narcotic count from the previous night (10/14/24) had been accurate. Together, we asked [LN 1] if we could check the cart at the back, hoping the medication might be there, but we still couldn't locate it. [LN 1] then checked the computer and informed us that the order for [Resident 1] had been discontinued and changed to a different dose. [LN 1] took the count sheet for [Resident 1] and created a handwritten count sheet for [Resident 3]. I expressed my concerns to her and said I didn't feel comfortable taking over the first cart due to the missing narcotics. [LN 1] said It's okay, let's switch carts and I'll handle it. [LN 3] later mentioned that [LN 1] had borrowed the key to the first cart and searched through the medication cart while [LN 3] was administering medications to patients in another room. Then, [LN 3] and I found the torn pieces of the original narcotic count sheet for the missing medication . I checked the order and saw that the new order was placed earlier that morning. During a review of the facility provided statement by LN 3, dated 10/15/24, the statement indicated, .When [LN 1] and I counted her cart 2, the narcotics were fine. I then went to cart 1 and waited for [LN 2]. [LN 1] asked to borrow my keys for cart 1, so I gave it to her. She opened the cart to look for something, and I proceeded .to give medication. After about 5 mins [minutes], [LN 1] returned the keys. Once I gave report to [LN 2], we did the count and found out that the Oxycodone for [Resident 1] was missing. The count sheet in the narcotic book was still there, but the bubble pack with 20 Oxycodone tablets, delivered on 10/11/24 was gone. The count sheet for [Resident 3] was also missing, but the Oxycodone bubble pack [blister pack, a form of tamper-evident packaging] was still there. At that point, I told [LN 1] that narcotic meds were missing after she borrowed the keys. She responded not to worry because the order has been dc/d [discontinued] and changed. She suggested to [LN 2] that they switch carts and she ' ll take care of it. When I proceeded to [LN 2] cart 1, I noticed the paper for the missing narcotic meds was shredded. I called [LN 2] and showed her the shredded paper. [LN 2] also told me that [LN 1] had changed the order without any progress notes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's physician order, dated 10/15/24 at 6:07 a.m., the order indicated, oxycodone HCl [a drug used to treat moderate to severe pain] Oral [by mouth] Tablet 10mg [milligrams, a unit of measurement] .Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:07 [a.m.]. During a review of Resident 1's prescription, dated 10/15/24, the prescription indicated, Rx [prescription]: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) . The prescription further indicated the physician's signature and DEA [Drug Enforcement Administration, agency that enforces the controlled substance laws and regulations] number [an identifier assigned to a healthcare provider allowing them to write prescriptions for controlled substances]. During a review of Resident 3's physician order, dated 10/8/24 at 9:41 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/8/24 06:18 [a.m.]. During a review of Resident 3's physician order, dated 10/15/24 at 6:17 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:18 [a.m.]. During a review of Resident 3's Medication Administration Notes (MAR), dated for October 2024, the MAR indicated the oxycodone ordered on 10/8/24 was discontinued on 10/9/24 at 8:48 a.m., and no doses were given. The MAR further indicated the oxycodone ordered on 10/15/24 was discontinued on 10/15/24 at 7:58 p.m., and no doses were given. During a review of Resident 3's prescription, dated 10/15/24, the prescription indicated, Rx [prescription]: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) . The prescription further indicated the physician's signature and DEA number. During a review of Resident 4's physician order, dated 10/15/24 at 6:10 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:12 [a.m.]. During a review of Resident 4's prescription, dated 10/15/24, the prescription indicated, Rx [prescription]: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) . The prescription further indicated the physician's signature and DEA number. During a review of Resident 5's physician order, dated 10/15/24 at 6:51 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:52 [a.m.]. During a review of Resident 5's prescription, dated 10/15/24, the prescription indicated, Rx [prescription]: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) . The prescription further indicated the physician ' s signature and DEA number. During a review of Resident 6's physician order, dated 10/15/24 at 6:12 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:13 [a.m.]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's prescription, dated 10/15/24, the prescription indicated, Rx [prescription]: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) . The prescription further indicated the physician ' s signature and DEA number. During a review of a facility provided document signed by the Medical Director (MD), dated 10/18/24, the document indicated the list of residents with a triplicate [document created in three copies] signed but verified by MD as not his signature. The list included the prescriptions for Residents 1, 3, 4, 5, and 6. During an interview on 10/24/24 at 3:45 p.m. with LN 4, LN 4 stated, For the process of entering orders, we would call the doctor first to confirm the orders, I don't write prescriptions .Nurses don't sign prescription, doctor needs to sign the prescription. During an interview on 10/24/24 at 4:17 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, We believe that [LN 1] had put in an order and discontinued the order, she took the drug sheet as well as the drugs, it would appear that it was not missing, no order, no count sheet, and no drugs .Nurses are not able to write a prescription, not within a scope of nursing .We take orders from doctors, if signature is needed we let them sign. During an interview on 10/24/24 at 4:33 p.m. with the Administrator (ADM), the ADM stated, [LN 1]'s operation was she will order into PCC (electronic chart), write the prescription and sign it, fax it to [name pharmacy], she would come in the next day and discontinue the order, make sure it's in the cart, get the bubble pack [blister pack, a form of tamper-evident packaging] and the count sheet before discontinuing the medication . During a telephone interview on 10/25/24 at 11:03 a.m. with the Consultant Pharmacy Supervisor (CPS), when asked about the process of controlled meds dispensing, the CPS stated, The facility will request the provider to write a prescription, for SNF [Skilled Nursing Facility], they use a document where the doctor signs, it is faxed to the pharmacy and then the pharmacy prepares the meds and delivers it to the facility . prescription has the doctor's signature on it .[pharmacy] look for the DEA number which is specific to a doctor. During a review of the facility's policy and procedure (P&P) titled Medication Orders, dated 3/2018, the P&P indicated, Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. During a review of the facility provided document titled F. Employee Conduct, undated, the document indicated, [Facility] expects its employees to act in a professional and respectful manner at all times. Examples of conduct that may lead to disciplinary action are identified below .Dishonesty (including falsification of a document or misrepresentations). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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).

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48445 Based on interview, and record review, the facility failed to ensure accurate accountability of controlled medications (that have high potential for abuse, misuse and are addictive) for a census of 84 when: 1. Multiple doses of and Controlled Drug Records (CDR) for Oxycodone (medication used to treat moderate to severe pain) were missing and unaccounted for; 2. Random controlled medication audits of the Medication Administration Record (MAR) and CDRs for seven of nine sampled residents (Residents 1, 2, 3, 6, 7, 8, and 9) did not reconcile to indicate they were given to the residents; and 3. Licensed Nurse (LN 1) entered orders, wrote prescriptions, and discontinued controlled medications without physician authorization for five of nine sampled residents (Residents 1, 3, 4, 5, and 6). These failures resulted in the facility not having accurate accountability of controlled medications, the potential for abuse or misuse of these medications, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions. Findings: 1. During a review of the facility provided statement signed by LN 2, dated 10/15/24, the statement indicated, I was assigned to the first cart on [name of hall]. I received the report from [LN 3], the NOC [night shift] nurse, at around 0615 [6:15 a.m.]. When we counted the narcotics [controlled medications], we noticed that the medication for [Resident 1] was missing. The count sheet issued by the pharmacy for that medication was in the binder. We also discovered that the count sheet for the medication for [Resident 3] was missing, though the medication itself was present in the narcotic box .We thoroughly searched the narcotic and non-narcotic medications, but the missing medication was nowhere to be found .[LN 3] voiced out her concerns about the narcotics count, according to her the narcotic count from the previous night (10/14/24) had been accurate. Together, we asked [LN 1] if we could check the cart at the back, hoping the medication might be there, but we still couldn't locate it. [LN 1] then checked the computer and informed us that the order for [Resident 1] had been discontinued and changed to a different dose. [LN 1] took the count sheet for [Resident 1] and created a handwritten count sheet for [Resident 3]. I expressed my concerns to her and said I didn't feel comfortable taking over the first cart due to the missing narcotics. [LN 1] said It's okay, let's switch carts and I'll handle it. [LN 3] later mentioned that [LN 1] had borrowed the key to the first cart and searched through the medication cart while [LN 3] was administering medications to patients in another room. Then, [LN 3] and I found the torn pieces of the original narcotic count sheet for the missing medication .I checked the order and saw that the new order was placed earlier that morning. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided statement by LN 3, dated 10/15/24, the statement indicated, .When [LN 1] and I counted her cart 2, the narcotics were fine. I then went to cart 1 and waited for [LN 2]. [LN 1] asked to borrow my keys for cart 1, so I gave it to her. She opened the cart to look for something, and I proceeded .to give medication. After about 5 mins [minutes], [LN 1] returned the keys. Once I gave report to [LN 2], we did the count and found out that the Oxycodone for [Resident 1] was missing. The count sheet in the narcotic book was still there, but the bubble pack with 20 Oxycodone tablets, delivered on 10/11/24 was gone. The count sheet for [Resident 3] was also missing, but the Oxycodone bubble pack [blister pack, a form of tamper-evident packaging] was still there. At that point, I told [LN 1] that narcotic meds were missing after she borrowed the keys. She responded not to worry because the order has been dc/d [discontinued] and changed. She suggested to [LN 2] that they switch carts and she'll take care of it. When I proceeded to [LN 2] cart 1, I noticed the paper for the missing narcotic meds was shredded. I called [LN 2] and showed her the shredded paper. [LN 2] also told me that [LN 1] had changed the order without any progress notes. During an interview on 10/24/24 at 1:45 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, We had a nurse that we believe is diverting oxycodone, September and October. Thru the audit, 1915 doses unaccounted for .Initially it was reported, a nurse came to the DON (Director of Nursing) that there was a narcotic discrepancy, a bubble pack was missing and that there's a separate count sheet missing . Nurses said they found the bubble pack. There were handwritten count sheets. I looked on the bubble pack which is smashed on the side .There was a tape at the back of the blister pack .We audited all oxycodone within that timespan when there were missing count sheets .Those orders correlated with her on PCC (electronic chart). During a continued interview on 10/24/24 at 4:17 p.m. with the ADON, the ADON stated, We believe that [LN 1] had put in an order and discontinued the order, she took the drug sheet as well as the drugs, it would appear that it was not missing, no order, no count sheet, and no drugs. During an interview on 10/24/24 at 4:33 p.m. with the Administrator (ADM), the ADM stated, , [LN 1]'s operation was she will order into PCC (electronic chart), write the prescription and sign it, fax it to [name pharmacy], she would come in the next day and discontinue the order, make sure it's in the cart, get the bubble pack and the count sheet before discontinuing the medication .The only reason why we were alerted was because that morning when she took one pack, she took the wrong count sheet, if she didn't get the wrong sheet, we won't be able to know. During a review of the facility's policy and procedure (P&P) titled Controlled Medication Storage, dated 3/2018, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations . 2. During a review of Resident 1's MAR for October 2024, the MAR indicated, Roxicodone 5mg (Oxycodone HCl) 5 mg (milligrams, a unit of measurement) .Give 0.5 tablet by mouth every 6 hours as needed for Pain - Severe . The MAR indicated no doses were given to Resident 1 in October 2024. The MAR further indicated the oxycodone order was discontinued on 10/15/24 at 6:05 a.m. and another oxycodone order was entered. During a review of Resident 1's physician order dated 10/15/24 at 6:07 a.m., the order indicated, Oxycodone HCl Oral Tablet 10mg Give 1 tablet by mouth every 4 hours as needed for Pain . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's CDR dated 10/15/24, the CDR indicated the quantity of tablets received were 10 tablets. The CDR further indicated the last tablet count was 19 and one dose of oxycodone was given on 10/14/24, which was not reflected in the MAR. During a review of Resident 2's MAR for October 2024, the MAR indicated, Roxicodone .5 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for Pain - Severe. The MAR indicated three doses of oxycodone were signed as administered, the last dose was given on 10/13/24 at 6 p.m. and there were no oxycodone doses given after. During a review of Resident 2's CDR for oxycodone, the CDR indicated 18 doses were received on 10/13/24. The CDR further indicated three doses were signed but the last tablet count was 14 which indicated one tablet was missing. During a review of Resident 3's blister pack label, dated 10/8/24, the label indicated, oxycodone HCl 5MG Take 1/2 tab every 6 hours as needed for moderate to severe pain. The blister pack indicated 30 tablets were dispensed for a total of 60 doses and one dose was popped-out. During a review of Resident 3's MAR for October 2024, the MAR indicated, Oxycodone HCl Oral Tablet 5 mg Give 0.5 tablet every 6 hours as needed for Pain . The MAR indicated the last dose of oxycodone was given on 10/10/24 at 6:56 a.m. and the order was discontinued on 10/15/24. During a review of Resident 3's CDR, the CDR indicated 59 tablets were received on 10/14/24 and the last tablet count was 59. There were no CDR for the oxycodone tablets given on 10/10/24. During a review of Resident 6's MAR for October 2024, the MAR indicated, Oxycodone HCl Oral Tablet 5 MG Give 1 tablet by mouth every 6 hours as needed for severe pain. The MAR indicated two doses were administered on 10/15/24. During a review of Resident 6's CDR, the CDR indicated there were four doses of oxycodone signed on 10/15/24 which was not reflected on the MAR. During a review of Resident 7's CDR, the CDR indicated oxycodone 10 mg tablet was given 10/1/24 at 3:40 a.m. and on 10/8/24 at [illegible time]. During a review of Resident 7's MAR for October 2024, the MAR indicated there were no doses administered on 10/1/24 and 10/8/24. During a review of Resident 8's CDR, the CDR indicated oxycodone 5 mg tab was signed once on 9/15/24 at 11 a.m., and twice on 9/18/24 at 6 a.m. During a review of Resident 8's MAR for September 2024, the MAR indicated there were no oxycodone doses administered on 9/15/24 at 11 a.m. and on 9/18/24 at 6 a.m. During a review of Resident 9's CDR, the CDR indicated doses for oxycodone 20 mg were signed on 9/11/24 at [illegible time] , on 9/13/24 at 1 p.m., on 9/14/24 at [illegible time], 9/15/24 at [illegible time], and on 9/16/24 at 1 p.m. and signed as wasted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555261	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Acc Care Center	7801 Rush River Drive Sacramento, CA 95831

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 9's MAR for September 2024, the MAR indicated there were no doses administered on 9/11/24 , 9/13/24 at 1 p.m., 9/14/24 , 9/15/24, and on 9/16/24 at 1 p.m. During an interview on 10/24/24 at 3:22 p.m. with LN 4, LN 4 stated, The process is to give pills to resident, sign the MAR and sign the narcotic sheet .If there are discrepancies, we try to find why is it off, maybe they make a mistake .If we can't find any reason, we notify the DON .It can mean people took the wrong medication out or maybe someone stole medication, that's a possibility. During an interview on 10/24/24 at 3:45 p.m. with LN 5, LN 5 stated, The expectation is making sure there are no discrepancies, and that we are giving the medication correctly and make sure the numbers are correct. During an interview on 10/24/24 at 4:17 p.m. with the ADON, the ADON stated, The expectation is for the MAR and CDR to reconcile and match .staff should be responsible and accountable. During a review of the facility's P&P titled Controlled Medication Storage, dated 3/2018, the P&P indicated, C. A controlled medication accountability record is prepared by the pharmacy .E. Any discrepancy in controlled substance medication counts is reported to the director of nursing immediately. The director or designee investigates and makes reasonable effort to reconcile all reported discrepancies. 3. During a review of Resident 1's physician order, dated 10/15/24 at 6:07 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:07 [a.m.]. During a review of Resident 1's prescription, dated 10/15/24, the prescription indicated, Rx [prescription]: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) . Dispense 90. The prescription further indicated the physician signature and DEA [Drug Enforcement Administration] number. During a review of Resident 3's physician order, dated 10/8/24 at 9:41 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/8/24 06:18 [a.m.]. During a review of Resident 3's physician order, dated 10/15/24 at 6:17 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:18 [a.m.]. During a review of Resident 3's MAR, dated 10/24, the MAR indicated the oxycodone ordered on 10/8/24 was discontinued on 10/9/24 at 8:48 a.m., and no doses were given. The MAR further indicated the oxycodone ordered on 10/15/24 was discontinued on 10/15/24 at 7:58 p.m., and no doses were given. During a review of Resident 3's prescription, dated 10/15/24, the prescription indicated, Rx: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) .Dispense 90. The prescription further indicated the physician signature and DEA number. (continued on next page)

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	555261	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Acc Care Center	7801 Rush River Drive Sacramento, CA 95831

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's physician order, dated 10/15/24 at 6:10 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:12 [a.m.]. During a review of Resident 4's prescription, dated 10/15/24, the prescription indicated, Rx: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) .The prescription further indicated the physician signature and DEA number. During a review of Resident 5's physician order, dated 10/15/24 at 6:51 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:52 [a.m.]. During a review of Resident 5's prescription, dated 10/15/24, the prescription indicated, Rx: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) .The prescription further indicated the physician signature and DEA number. During a review of Resident 6's physician order, dated 10/15/24 at 6:12 a.m., the order indicated, oxycodone HCl Oral Tablet 10mg .Audit Details .Created By: [LN 1] .Created date: 10/15/24 06:13 [a.m.]. During a review of Resident 6's prescription, dated 10/15/24, the prescription indicated, Rx: oxycodone HCl Oral tablet 10 MG .Give 1 tablet by mouth every 4 hours as needed for Pain - Severe (8-10) .The prescription further indicated the physician signature and DEA number. During a review of a facility provided document signed by the Medical Director (MD), dated 10/18/24, the document indicated the list of residents with a triplicate [document created in three copies] signed but verified by MD as not his signature. The list included the prescriptions for Residents 1, 3, 4, 5, and 6. In an interview on 10/24/24 at 3:45 p.m. with LN 5, LN 5 stated, For the process of entering orders, we would call the doctor first to confirm the orders, I don't write prescriptions .Nurses don't sign prescription, doctor needs to sign the prescription. During an interview on 10/24/24 at 4:17 p.m. with the ADON, the ADON stated, We believe that [LN 1] had put in an order and discontinued the order, she took the drug sheet as well as the drugs, it would appear that it was not missing, no order, no count sheet, and no drugs .Nurses are not able to write a prescription, not within a scope of nursing .We take orders from doctors, if signature is needed we let them sign. In an interview on 10/24/24 at 4:33 p.m. with the ADM, the ADM stated, [LN 1]'s operation was she will order into PCC (electronic chart), write the prescription and sign it, fax it to [name pharmacy], she would come in the next day and discontinue the order, make sure it's in the cart, get the bubble pack [blister pack] and the count sheet before discontinuing the medication .Prescription forgery, the pharmacy did not catch it on their end. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 10/25/24 at 11:03 a.m. with the Consultant Pharmacy Supervisor (CPS), when asked about the process of dispensing controlled medications, the CPS stated, The facility will request the provider to write a prescription, for SNF [Skilled Nursing Facility], they use a document where the doctor signs, it is faxed to the pharmacy and then the pharmacy prepares the meds and delivers it to the facility . prescription has the doctor's signature on it .[pharmacy] look for the DEA number which is specific to a doctor. When asked regarding the process of prescription verification, the CPS stated, [Pharmacy] just look at them, prescription has the doctor's signature on it .As far as I know they don't call doctor to confirm prescription .It's just like another prescription, it comes from the facility fax, its technically printed on the prescription as well, they don ' t necessarily call the doctor to verify the prescription. During a review of the facility ' s P&P titled Medication Orders, dated 3/2018, the P&P indicated, Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. During a review of the facility provided document titled F. Employee Conduct, undated, the document indicated, [Facility] expects its employees to act in a professional and respectful manner at all times. Examples of conduct that may lead to disciplinary action are identified below .Dishonesty (including falsification of a document or misrepresentations).