

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/06/2025
NAME OF PROVIDER OR SUPPLIER  Acc Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7801 Rush River Drive Sacramento, CA 95831	
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>50541</p> <p>Based on observation, interview, and record review, the facility failed to meet professional standards of quality for one of three sampled residents (Resident 1) when Resident 1's prophylactic (intended to prevent disease) aspirin was discontinued incorrectly.</p> <p>This failure resulted in Resident 1 not receiving aspirin as ordered and had increased potential for developing blood clots.</p> <p>Findings:</p> <p>Resident 1 was initially admitted in November 2024 with an admission diagnosis of a left broken thigh bone and was readmitted in December 2024 with admission diagnoses of blood clot in the lungs and sudden development of a blood clot in the legs. Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 out of 15 which indicated Resident 1 was cognitively intact.</p> <p>During an interview on 1/6/25 at 10:36 a.m. with Resident 1, Resident 1 stated, I had a blood clot. I have no idea whatsoever what happened. I was here and next thing I knew I was back at the hospital. My kids said I was delirious, but I don't know. I was out of it.</p> <p>Review of Resident 1's Progress Note, dated 11/18/24, indicated Resident 1's physician (MD, Medical Doctor) ordered aspirin 81mg (milligrams) by mouth twice daily for six weeks until 12/24/24.</p> <p>During a concurrent interview and record review on 1/6/25 at 11:48 a.m. with Director of Nursing (DON), Resident 1's Medication Administration Record (MAR) for November 2024 was reviewed. The MAR indicated Resident 1's last dose of aspirin was given on 11/24/24 and the stop date was 11/24/24. The DON stated the stop date for the aspirin should have been 12/24/24 not 11/24/24. The DON explained she was notified by Resident 1's family member, after he was hospitalized, that Resident 1 wasn't receiving the prescribed aspirin. The DON stated, somewhere a miscommunication occurred between the [name of doctor] and [name of Licensed Nurse 1 (LN 1)] regarding the aspirin stop date. The DON verified the MD signed a stop aspirin order on 12/24/24. The DON acknowledged LN 1 discontinued aspirin on the wrong date.</p> <p>During a phone interview on 1/6/25 at 12:48 p.m. with MD, MD stated he ordered the aspirin 81mg for Resident 1 to be continued until 12/24/24. MD stated, unfortunately, the aspirin was stopped before it was supposed to be discontinued.</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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F 0658  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Review of the facility's policy and procedure titled, Medication and Treatment Order, dated 2001, indicated, Orders for medications .will be consistent with safe and effective order writing.		