STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555265	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Post-Acute Rehab	2120 Stockton Blvd Sacramento, CA 95817

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49821 Based on interview and record review, the facility failed to safely administer medications according to professional standards of care for one of three sampled residents (Resident 1), when staff at day program administered Resident 1's noon medications twice. This failure increased Resident 1's potential to develop adverse effects from medications. Findings: A review of Resident 1's admission record indicated he was readmitted to the facility on [DATE] with diagnoses including epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures), parkinsonism (a clinical syndrome characterized by motor symptoms that mimic Parkinson's disease. Symptoms include involuntary shaking, muscle stiffness, slow movements, and difficulty with balance and coordination.), and gastro-esophageal reflux disease (GERD- common condition in which the stomach contents move up into the esophagus). During an interview on 3/10/25 at 12:33 p.m. with the Director of Nursing (DON), DON stated Resident 1 attended a social enrichment day program one day a week (on Wednesdays). DON further stated the facility agreed in mid-January 2025 with day program to keep and store Resident 1's medication bubble packs (cards that package doses of medication within small, clear plastic bubbles) in a locked cabinet at the day program instead of bringing his noon medications with his lunch bag. A review of Resident 1's Order Summary Report, dated 3/10/25, indicated Resident 1 was receiving: - clonazepam (used to treat seizures- a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) two milligrams (mg; unit of measure) one tablet for seizures; -carbidopa-Levodopa (used to treat Parkinson's disease), extended release tablet 50 mg-200 mg, one tablet for parkinsonism; and -levocarnitine (used to prevent and treat a lack of carnitine- stimulates gastric secretions for digestion) 330 mg, three tablets with meals for carnitine supplement. A review of the facility's progress note, dated 1/29/25, indicated Resident 1's medications bubble packs were delivered and stored at the day program for 12 noon and 1 p.m. scheduled doses. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the day program's document titled, Staff Meeting, dated 1/29/25, indicated staff were informed of residents whose medications were kept at the day program and stored in the locked medication cabinet by the office worker's desk. During an interview on 3/10/25 at 1:02 p.m. with the Day Program Director (PD), PD stated on 2/12/25, the Program Support Trainer (PST) retrieved Resident 1's medications from the locked cabinet, administered his lunchtime set of medications, and documented it in the Medication Administration Record (MAR). PD also stated at approximately 12:45 p.m. the Individual Success Coordinator (ISC) retrieved Resident 1's medications from his lunch bag and gave Resident 1 his lunchtime medications. PD further stated, It was our fault and ISC could have prevented administering Resident 1's medications twice by checking the MAR before giving it. During a phone interview on 3/11/25 at 3:05 p.m. with the day program's ISC, ISC stated he found Resident 1's medications in a plastic bag in his backpack and thought he was supposed to administer those medications instead of the locked ones in the cabinet. A review of the day program's document titled, Monthly Medication Administration Record, dated 2/25, indicated Resident 1's medications were given on 2/12/25 at 12 noon. A review of the day program's document titled, Medication Error Report Form, dated 2/12/25, indicated, After lunch at approximately 12:45 p.m., [ISC] had finished assisting [Resident 1] with his medication, which had been sent in his lunch box. When [ISC] went to initial the medication binder (MAR), he saw that [PST] had already initialed it for today . [PST] had taken the daily medication from the packs and gave it to [Resident 1] first, while [ISC] was away from the group. [ISC] assumed that the medication in his lunch was what we were to give him for the day. A review of the facility's policy and procedure (P&P) titled, Medication Administration-General, dated October 2017, indicated, Medications are administered in accordance with written orders of the attending physician. A review of the day program's undated document titled, Medication Procedures, indicated, If you are assigned to someone who takes a medication, you are responsible for ensuring the accurate administration of that medication . A review of the day program's P&P titled, Medication, revised in December 2009, indicated, Designated staff will lock medication into cabinet until time for administration . Changes in medications, dosage and frequency of medication should be reported to designated staff immediately.