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	06/06/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 32096 Based on observation, interview and documentation review, the facility failed to resolve one of 16 sampled residents (Resident 38's) grievance when the resident's co-pay for replacement of lost hearing aids was not reimbursed in a timely manner. This failure resulted in Resident 38's family member wondering if and when the co-pay was to be reimbursed by the facility. Findings: Review of Resident 38's clinical record, Admission Record, indicated the resident had diagnoses that included a cognitive communication deficit. In a Resident Representative (RR) interview on 6/3/24 at 11:18 p.m. in the hallway outside Resident 38's room, the RR reported that the resident's hearing aids were lost in the facility that the resident brought with them upon admission. The RR stated, The hearing aids, charger and everything was gone. The RR stated the family reported the missing hearing aids to the facility and was told they were not able to locate them. The RR stated the family decided to replace the missing/lost hearing aids with the resident's personal insurance rather than wait for the facility to replace them as the hearing aids were indispensable for Resident 38's quality of daily life. The RR stated there was about $100 co-pay for the new hearing aids, but it had not been reimbursed by the facility and indicated she was not sure if and when the facility would refund them. Review of the facility's 1/2010 policy and procedure, Grievance, stipulated, To assure that concerns are quickly and thoroughly evaluated and acted upon in order to resolve issues which affect the quality of life and care for residents in our facility .Prompt efforts by the facility to resolve grievances that the resident may have .The Administrator/Designee will respond to the individual expressing the concerns within (3) three working days of the initial concern . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent interview and documentation review on 6/4/24 starting at 1:22 p.m. in the Social Service Director's (SSD) office, the SSD verified Resident 38 brought her hearing aids with her upon admission and lost them in the facility. Review of the Lost/Stolen/Damaged Resident Property Report, dated 5/20/24, indicated Resident 38's hearing aids were marked as Lost and in the section of the form what actions the facility took to prevent future damage/loss of property documented, Hearing Aids were replaced by res (resident) [Name of Insurer] insurance. The Administrator signed the form, 5/28/24. There was no further action documented in the form what the facility did take in resolving the issue. The SSD stated he had neither heard of the co-pay nor received the receipt from the family, otherwise it would have been reimbursed. A telephone interview was conducted with Resident 38's RR during the interview with the SSD and the RR clarified her sister gave the $100 co-pay receipt to the SSD right after they replaced the hearing aids. After the phone call, the SSD presented a HEARING AID receipt for Resident 38, dated 5/21/24, of $108.74 ($99.99 for the hearing aids charger plus tax) and stated he thought the receipt was an estimate. The receipt indicated APPROVE-Purchase, paid with credit card and at the bottom printed, Item Sold: 1. In the margin of the receipt, a handwritten note, charger, underlined, was visible. The SSD stated the receipt was given to him on 5/21/24. In an interview on 6/5/24 at 10:20 a.m. in the Administrator's office, the Administrator stated it was the facility policy to resolve grievances as soon as possible and indicated Resident 38's co-pay should have been reimbursed. The Administrator stated there was no reason to hold the bill.

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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. 32096 Based on observation, interview and record review, the facility failed to meet professional standards of quality of care for one of 16 sampled residents (Resident 35) when a pain medication and a renal nutritional supplement were not administered as ordered by the physician. This failure placed Resident 35 at risk for ineffective pain control and for nutritional imbalance. Findings: Review of Resident 35's clinical record, Admission Record, indicated the resident was a long-term resident in the facility with diagnoses that included end stage kidney disease (kidneys lose the ability to remove waste and balance fluids.), unspecified protein-calorie malnutrition and on hemodialysis therapy (a treatment to filter wastes and fluid from the blood using a dialysis machine, an artificial kidney). During the Medication Administration (Med Pass) Observation on 6/4/24 at 8:42 a.m., Licensed Nurse (LN 1), in the presence of LN 2, stated Resident 35 had a physician order for Novasource, a nutrient supplement but it ran out, she, therefore, could not administer it during the med pass. Resident 35's Med Pass was reconciled with the resident's Medication Administration Records (MAR) for June 2024 and noted the resident had the physician orders as follows: 1. Novasource Renal supplement (a formula provides protein, vitamins and minerals specifically to meet the needs of people with chronic kidney disease on dialysis to help maintain lean muscle) 8 fluid oz (ounce, measurement, 29.6 milliliter/oz) two times a day during the medication pass, order date 5/15/24. The MAR indicated the resident had not received Novasource since 6/2/24 a.m. 2. Gabapentin 100 mg (milligram, a unit of measurement) one capsule by mouth two times a day for nerve pain, order date 5/11/24. This medication was not administered during the 6/4/24 a.m. Med Pass. Review of the facility's 12/2012 policy and procedure, Administering Medications, stipulated, Medications shall be administered in a safe and timely manner, and as prescribed. In a follow-up interview on 6/4/24 at 10:18 a.m., LN 1, with LN 2 present, verified the physician order for Gabapentin and acknowledged the pain medication was not administered during the morning Med Pass. LN 1 stated, I must have missed it. In an interview on 6/5/24 at 9:31 a.m. in the Director of Nursing's (DON) office, the DON stated Novasource for Resident 35 should have been ordered in advance for administration. The DON indicated it was the DON's expectation that LNs notify him two to three days before the supplement ran out so the DON could let Dietary Manager reorder. The DON stated Novasource supplement was medically necessary for dialysis patients. The DON acknowledged Gabapentin should have been administered for Resident 35 as prescribed.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 32096 Based on observation, interview and record review, the facility failed to provide a communication board for one of 16 sampled residents (Resident 20) who had expressive aphasia (loss of ability to express speech). This failure resulted in Resident 20 being frustrated and impeded the resident's communication with others. Findings: Review of Resident 20's clinical record, Admission Record, indicated the resident had diagnoses that included aphasia following cerebral infarction (stroke). In a concurrent observation and interview on 6/3/24 at 9:35 a.m., in Resident 20's room, the resident was observed lying in bed wearing headphones. Resident 20 was able to communicate with yes and no answers to questions and maintained eye contact during the interview; however, the resident was unable to say words or phrases. When asked what her first name was, the resident started to write letters with her left index finger in the air. Resident 20 scrawled something in the air, which was difficult, if not impossible, to decipher. There was no writing board, picture board, cards, pens, papers or any other means of communication available in the room. Review of Resident 20's clinical record, care plan for Communication Deficit initiated 5/15/24, included a communication goal for, Resident's ability to interact with others will be enhanced with interventions . The care plan interventions to accomplish the goals included, Provide communication board .Offer pencil and paper to express needs in writing as indicated. In an interview on 6/3/24 at 9:46 a.m., in Resident 20's room, the Director of Staff Development (DSD) stated the resident was non-verbal but able to say yes and no to staff questions. When asked how the call light responses were, the resident began writing something in the air which was incomprehensible. The resident appeared to be frustrated when she was not understood; she clenched her fists and started pounding on the bed while in bed. The DSD verified there was no communication board in the resident's room and stated, She should have one. Review of the facility's March 2010 policy and procedure, Communication with Non-English/Aphasic Resident, stipulated, Social Services will maintain a log of all non-English speaking residents and all expressively aphasic residents within the facility .Social Services will supply residents .with the use of a communication board .the name of each pictured items .staff caring for the resident will be familiarized with the communication tool. The tool will be kept at the resident's bedside for use. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/4/24 at 1:44 p.m., in the Social Services Director's (SSD) office, the SSD stated Resident 20 did not have a communication board because she was able to communicate with yes and no and with facial expressions. The SSD stated that he thought it was inappropriate to place a communication board in her room in case the resident did not use the board. The SSD stated that it was a collaborative work effort among the speech language pathologist, licensed nurses and the SSD to assess for resident communication needs but no one asked the SSD for the communication board for Resident 20. In an interview on 6/5/24 at 9:41 a.m. in the Director of Nursing's (DON) office, the DON acknowledged Resident 20 was cognitively intact but unable to express verbally. The DON indicated the communication board should have been provided to Resident 20 as care planned.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32096 Based on observation, interview and documentation review, the facility failed to discard expired medications and medications with no expiration dates, for a census of 58 when, expired medications were mixed with non-expired medications, available for use, in the medication storage room. This failure increased the potential for medication errors and placed the residents at risk for ineffective drug therapy. Findings: During the medication storage room check on 6/4/24 starting at 3:30 p.m., with Licensed Nurse (LN 3), there were three one oz (ounce, a unit of weight, 28.4 gram) tubes of ointment, TRIPLE ANTIBIOTIC+PAIN RELIEF that were expired and mixed with other non-expired antibiotic ointments in a basket. The expiration date was 1/24. In the medication room, there were three 40 oz Calmoseptine(R) with Menthol 0.44%, zinc oxide 20.6% (an ointment) to treat and prevent minor skin irritations were available for use with no expiration dates. Review of the facility's April 2008 policy and procedure, Medication Storage in the Facility, stipulated, Outdated .are immediately removed from stock, disposed of according to procedures for medication disposal . In a concurrent observation and interview on 6/4/24 starting at 3:30 p.m., Licensed Nurse (LN) 3 verified the name, quantity and the expiration date of the triple antibiotics and the skin ointment had no expiration dates. LN 3 stated LNs should have checked the expiration dates of the medications and should have discarded the expired medications and LN 3 further acknowledged medications without expiration dates should not be used. In an interview on 6/5/24 at 9:31 a.m., in the Director of Nursing's (DON) office, the DON stated that the expired medications and the medications with no expiration date should have been discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39489 Based on observation, interview, and record review, the facility failed to follow guidelines for Enhanced Barrier Precaution (EBP, an infection control intervention to reduce transmission of multi-drug resistant organisms) that require the use of gowns and gloves during direct care activities for two of 16 sampled residents, Resident 9 and Resident 5, when: 1. Licensed Nurse 3 (LN 3) did not wear the full required Personal Protective Equipment (PPE) before entering Resident 9's room to change his wound dressing of his right foot; and 2. Certified Nursing Assistant 1(CNA 1) did not wear the full required PPE while changing Resident 5's undergarments. This deficient practice had the potential for the spread of multi-drug resistant organisms (MDRO's, bacteria that resist treatment with more than one antibiotic) among residents, staff and visitors. Findings: 1. During a review of the Admission Record for Resident 9, the Admission record indicated, Resident 9 was admitted to the facility on [DATE], with diagnoses that included Sepsis (serious infection condition), breakdown of Nephrostomy Catheter (drainage tube placed into kidney to drain urine) and Diabetes (a disease that occurs when your blood sugar is too high). During a review of Resident 9's Order Summary Report, dated 5/20/24, indicated, Resident 9 had right toe gangrene (death of body tissue or serious bacterial infection), right heel ulcer (wound), and right plantar ulcer (wound at the sole of the foot). During a review of Resident 9's Care Plan, dated 4/8/24, indicated, Resident 9 had a new arterial (carrying blood from heart to other parts of the body) ulcer on right foot. During a review of Resident 9's Care Plan, dated 10/30/23, indicated, Resident 9 was at High risk for developing complications including UTI [urinary tract infection] due to presence of Nephrostomy tube related to Bladder CA [cancer]. During an observation on 6/3/24 at 11 a.m., Resident 9's room had an EBP sign (guidance on what and how to properly wear the PPE) posted by the door and a white bin contained PPE supplies. LN 3 entered Resident's 9's room and did not wear the proper PPE. As she proceeded with her task, she informed Resident 9 to turn on his side so she could empty his Nephrostomy bag and discarded the urine into the toilet bowl. When LN 3 returned to Resident 9's bedside, she picked up the pillow from the floor, tucked it under resident's right foot and continued to clean his wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/24 at 11:20 a.m., LN 3 confirmed Resident 9's room had an EBP sign posted by the door and a white bin contained PPE, and acknowledged she did not put on the proper PPE before she entered the room. LN 3 stated, she should have worn the PPE while rendering direct care to the resident and should have not picked up the dirty pillow from the floor and tucked it to Resident 9's right foot which may spread an infection. LN 3 further stated, I absolutely never wore a gown in an Enhanced Precaution room but now I know. During an interview on 6/4/24 at 11:25 a.m., with the Infection Preventionist (IP), the IP stated, LN 3 should wear a gown and gloves while changing the wound dressing and performing Nephrostomy care to Resident 9. The IP further stated, LN 3 should practice infection control prevention to avoid recontamination.