STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555337	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Heights Post Acute	7807 Uplands Way Citrus Heights, CA 95610

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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. Based on interview and record review the facility failed to follow physician orders for three of 34 sampled residents (Resident 3, Resident 30 and Resident 129) when blood pressure medications were given outside of ordered parameters for Resident 30 and Resident 129 and pulse was not taken prior to medication administration for Resident 3.These failures had the potential to cause adverse medication outcomes such as low blood pressure and dizziness.Findings:Resident 3 was admitted to the facility in early 2025 with diagnoses that included atrial fibrillation (condition when the heart beats irregularly), heart failure (heart muscles are weak and do not effectively pump blood), and hypertension (HTN, high blood pressure).During a review of Resident 3's Order Summary Report [OSR], dated 3/2/26, the OSR indicated, Amiodarone [medication to treat atrial fibrillation] 200 MG [milligram, unit of measurement] .Give 1 tablet by mouth daily for A [atrial] fibrillation hold for HR [heart rate] <60.During a review of Resident 3's Medication Administration Record [MAR], dated 4/1/26-4/30/26, the MAR did not include a documented heart rate associated with the administration of Amiodarone from 4/1/26-4/15/26. The Amiodarone was marked as administered.Resident 30 was admitted to the facility late 2025 with diagnoses that included hypertension.During a review of Resident 30's OSR dated 4/26, the OSR indicated, amLODIPine Besylate [medication to treat high blood pressure] Oral Tablet 10 MG.Give 1 tablet by mouth one time a day for HTN Hold if SBP [systolic blood pressure] <110.During a review of Resident 30's MAR, dated 4/1/26-4/30/26, the MAR indicated Resident 30 received a dose of amlodipine on 4/7/26 when the SBP was 107 and on 4/12/26 when the SBP was 106. Resident 30's amlodipine was not held as directed in the physician orders for SBP less than 110.Resident 129 was admitted to the facility early 2025 with diagnoses that included atrial fibrillation and hypertension.During a review of Resident 129's OSR, dated 4/26, the OSR indicated, carvedilol [medication to treat high blood pressure] oral tablet 12.5 MG.Give 2 tablets by mouth two times a day for HTN Hold if SBP <110.During a review of the Resident 129's MAR, dated 4/1/26-4/30/26, the MAR indicated received a dose of carvedilol on 4/6/26 when the SBP was 103. Resident 129's carvedilol was not held as directed in the physician orders for an SBP less than 110).During a concurrent interview and record review on 4/23/26 at 10:19 a.m. with the Unit Manager (UM) of Resident 3, Resident 30 and Resident 129's MAR, the UM confirmed the heart rate was not checked prior to the administration of Resident 3's Amiodarone, the amlodipine was administered outside of the physician ordered parameters for Resident 30 and the carvedilol was given outside of the physician ordered parameters for Resident 129. The UM stated the amlodipine and carvedilol should have been held because it [SBP] was less than 110. The UM stated she expected nurses to read the orders carefully and follow physician orders.During an interview on 4/23/26 at 11:19 a.m. with the Director of Nursing (DON) the DON stated she expected nurses to check vital signs (blood pressure, heart rate) before they administered medications and follow physician orders.During a review of the facility's policy and procedures (P&P) titled, Administering Medications, dated 4/19, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including any time frame.The following information is checked/verified for each resident prior to administering medications.vital signs, if necessary.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two out of 34 sampled residents (Resident 35 and Resident 12) received treatment and care in accordance with professional standards of practice, facility's policy and procedure (P&P), and physician's order when;1. Resident 35's order for the use and monitoring of for Jackson Pratt (JP) drain bulb (closed-suction device used after surgery to remove fluids-like blood or serum-from the wound site, reducing infection risk and aiding healing) was not followed; and,2. Resident 12's elevated blood sugar (BS-the main sugar in body that gives you energy) was not monitored according to physician's order and plan of care. These failures had the potential for Resident 35 and Resident 12's medical condition to get worse, and for the residents to not achieve their highest practicable well-being. Findings: 1. A review of Resident 35's clinical record indicated Resident 35 was admitted March of 2026 and had diagnoses that included other postprocedural [after medical procedure or surgery] complications and disorders of digestive system, infection following a procedure, diabetes mellitus (a chronic condition causing too much sugar in the blood which inhibits the body's natural wound-healing capabilities), and muscle weakness. A review of Resident 35's Minimum Data Set (MDS– a federally mandated resident assessment tool) Cognitive Patterns, dated 4/2/26, indicated Resident 35 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 11 out of 15 which indicated Resident 35 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). During a concurrent observation and interview on 4/20/26 at 9:08 a.m. with Resident 35, in Resident 35's room, Resident 35 was observed awake and was lying on his bed. Resident 35 had a drainage tube coming from the right side of his abdomen, labelled 4/18, and was connected to a drainage bag. The drainage bag was draining dark yellow fluid and was placed on the bed which was on the same level as the drainage site. Resident 35 confirmed the observation. Resident 35 stated he had an infection, that was why he had a drain. Resident 35 further stated that staff would sometimes drain the fluids from the bag, but he doesn't know if they would change the drainage bag. A review of Resident 35's Care Plan Report, dated 2/13/26, indicated, Pain: at risk for [x] pain or discomfort due to: Acute cholecystitis [inflammation of the gallbladder], s/p [status post- after] subtotal cholecystectomy [surgical removal of a large portion of the gallbladder] 2/7, Resident has [NAME] Prtt [sic] surgical drain . A review of Resident 35's active physician's order, dated 3/31/26, indicated, JP Drain / Bulb Monitoring: Monitor for decreased/absent output, sudden increase in output, or change in color (e.g., bright red, purulent). Report signs of infection or complications to provider every shift for JP Drain. A review of Resident 35's active physician's order, dated 4/14/26, indicated, JP Drain Insertion Site Care: .Ensure bulb remains compressed to maintain suction. Empty JP drain, measure and record output, noting color and consistency. as needed for Soiling/Loosening. During a concurrent observation and interview on 4/20/26 at 1:27 p.m. with Licensed Nurse (LN) 5, in Resident 35's room, Resident 35 was observed lying on his bed, awake, has a drainage tube coming from the right side of his abdomen, and was connected to a drainage bag which was draining dark yellow fluid and was placed on the bed. LN 5 confirmed the observation. LN 5 stated Resident 35 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	always had a drainage bag and never had a JP drain bulb. LN 5 further stated the drainage bag should always be placed lower than the drainage site to facilitate draining and prevent further infection and complications. During a concurrent interview and record review on 4/20/26 at 1:30 p.m. with LN 5, Resident 35's medical records were reviewed. LN 5 confirmed that Resident 35 came back from the hospital on 3/30/26 with a drain and has an order to monitor JP drain bulb on 3/31/26. LN 5 stated the order for JP drain bulb should have been followed because the JP drain bulb provides suction which would prevent complications and would provide faster and better healing. During an interview on 4/22/26 at 2:13 p.m. with the Director of Staff Development (DSD), the DSD stated the order for drainage bulb should have been followed because a drainage bag does not provide sufficient suction to drain. The DSD also stated if they were using a drainage bag, the bag should be placed below the drainage site to promote drainage. The DSD further stated the resident would be at risk for wound complication and infection if the physician's order was not followed. A review of an online article titled, Jackson Pratt (JP) Drain, dated 10/23/23, indicated, A Jackson Pratt (JP) drain is a surgical suction drain that gently draws fluid from a wound to help you recover after surgery. To use one, you'll need to regularly empty a collection bulb that catches the fluid draining from your wound. The bulb pulls the fluid out when it's squeezed. It can speed up your healing time and reduce your risk of an infection. (https://my.clevelandclinic.org/health/articles/21104-[NAME]-[NAME]-jp-drain) A review of the facility's P&P titled, Jackson Pratt (JP) Drain, revised 3/2019, indicated, The purpose of this procedure is to empty the Jackson Pratt drain bulb, clean the surgical wound, and monitor for infection .Emptying the drain: .5. Squeeze the bulb flat. 6. While the bulb is flat, put the plug back into the bulb. 7. The bulb should stay flat after it is plugged so that the vacuum suction can restart. 8. If you can't squeeze the bulb flat and plug it at the same time, use a hard, flat surface (such as a table) to help you press the bulb flat while you replug it . 2. Review of Resident 12's clinical record indicated Resident 12 was admitted to the facility on [DATE] with multiple diagnoses which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control) and adult failure to thrive (substantial decline in overall health and functional abilities). A review of Resident 12's April 2026 Order Summary Report contained a physician's order dated 6/28/25 for HumaLOG KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 70 - 150 = 0; 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 14 units Notify MD for >400, subcutaneously (under the skin) before meals for DM (Notify MD for BS<70,>350). During a concurrent interview and record review on 4/21/26 12:41 p.m. with the Director of Nursing (DON) and the Resource Nurse, Resident 12's Medication Administration Record (MAR) dated March 2026 was reviewed. The March MAR indicated on 3/24/26 at 11:30 a.m. Resident 12's blood sugar was 502 and there was a 9 in the LN's initial box for Resident 12's Humalog. The Resource Nurse stated 9 indicated the LN wrote a note. Review of a eMar - Medication Administration Note, dated 3/24/26 at 1:04 p.m. the LN documented, NP (Nurse Practitioners) informed to give 14 units sliding scale. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 12's Progress Note eINTERACT SBAR Summary for Providers, dated 3/24/26 at 3:50 p.m. indicated on 3/24/26 at 1:04 p.m. Resident 12's blood glucose (blood sugar) was 502. The LN further documented under Nursing observations, evaluation, and recommendations are: resident blood sugar 502 no sign symptom of hyperglycemia (high blood sugar) NP informed give schedule sliding scale insulin and recheck. no complain of pain. refused to recheck blood sugar Np informed nonew (sic) order monitor. During a concurrent interview and record review on 4/21/26 at 12:41 p.m. with the DON and the Resource Nurse, Resident 12's MAR dated March 2026 was reviewed. The MAR indicated on 3/24/26 at 4:30 p.m. the LN documented NA (not applicable) in the box for Resident 12's blood sugar and there was 9 in the LN's initial box for Resident 12's Humalog. The Resource Nurse stated 9 indicated the LN wrote a note. The Resource Nurse stated there was no progress note written for the entry, 3/24/26 at 4:30 p.m. The Resource Nurse stated there was no documentation that Resident 12's blood sugar was re-checked at 4:30 p.m. and no documentation that Resident 12 received his insulin as prescribed. The DON stated she would expect the LN to have re-checked Resident 12's BS and administer insulin as prescribed. A review of Resident 12's April 2026 Order Summary Report contained a physician's order dated 5/31/24 for Humalog KwikPen Subcutaneous Solution 100 UNIT/ML Inject as per sliding scale: if 70 - 150 = 0; 151 - 200 = 0; 201 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units Notify MD for BS>400, subcutaneously at bedtime for DM (Notify MD for BG<70 or >400). During a concurrent interview and record review on 4/21/26 at 12:41 p.m. with the DON and the Resource Nurse, Resident 12's MAR dated March 2026 was reviewed. The March MAR indicated on 3/24/26 at 9 p.m. Resident 12's BS was 401 and there was 9 in the LN's initial box for Resident 12's Humalog. The Resource Nurse stated there was no note written by the LN for the entry 3/24/26 at 9 p.m. The DON stated she would expect the LN to have re-checked Resident 12's BS and administer insulin as prescribed. Review of Resident 12's care plan titled, Diabetes: Resident has a diagnosis of diabetes and is at risk for complications manifested by elevated BS 502, dated 3/24/26. Under the Interventions/Tasks was listed, Administer medication as ordered and Interventions to manage hypo/hyperglycemic (low/high blood sugar) episodes as indicated. During a review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, revision dated February 2021 indicated, The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper sanitation and storage practices in accordance with professional standards for food service safety when:1a. One steam table pan had food residue in the pan, one pot had food residue on the bottom of the pan.b. One steam table pan was stored wet.2a. The dry storage area floor had an unopened bag of rice on the floor.b. The dry storage area had debris on the floor. These failures had the potential to lead to food borne illness for the 150 Residents out of 158 Residents eating facility prepared meals.Findings:1a. During an observation and concurrent interview on 4/13/26 at 7:06 a.m., with the Assistant Dietary Supervisor (AKS) during the initial kitchen tour, one steam table pan had food residue in the pan, one pot had food residue on the bottom of the pot in the ready to use storage rack. The AKS removed the pan and pot to the washing area, stating they are supposed to be checked for debris before being placed back on the ready to use storage rack.b. During a continued observation and interview on 4/13/26 at 7:07 a.m., with the AKS during the initial kitchen tour, a steam table pan was stored wet (wet nesting) in the ready to use storage rack. The AKS removed the steam table pan to the washing area, stating the expectation was that the pans are to be air dried before placing in the ready to use storage rack.During an interview with the Registered Dietician (RD) on 4/22/26 at 12:09 p.m., regarding what may happen with food residue left on pans, pans stacked away wet, RD confirmed it may harbor bacteria.Review of the facility policy titled Pot and Pan Washing (Healthcare Menus Direct, LLC., 2023) stated pots and pans will be properly sanitized. Review of the facility policy Kitchen Sanitation: Definition of Terms (Healthcare Menus Direct, LLC., 2023) stated under Cleaning: Removal of soil, particles, debris, and microorganisms adherent to the surface.Review of the facility policy Compartment Procedure for Manual Dishwashing (Healthcare Menus Direct, LLC., 2023) stated under step 6 that All items are to be air-dried, which means no water droplets are present.Review of the 2022 Federal Food and Drug Administration Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (B) The food contact surfaces of cooking equipment and pans shall be free of encrusted grease deposits and other soil accumulations. 1/18/23 version, indicated .(C) Surfaces . shall be kept free of an accumulation of dust, dirt, food residue, and other debris.2a. During a continued observation and interview on 4/13/26 at 7:23 a.m., with the AKS during the initial kitchen tour, the dry storage area had an unopened 50 pound bag of rice stored on the floor by the door. The AKS placed the bag of rice on a rack. The AKS confirmed that the rice should not be stored on the floor.b. During a continued observation and interview o 4/13/26 at 7:24 a.m., with the AKS during the initial kitchen tour, the dry storage area had two forks, a piece of cardboard, a piece of plastic wrap with brown paper on the floor. The AKS confirmed that there should not be any items on the floor.Review of the 2022 Federal Food and Drug Administration Food Code, section 3-305.11, titled, Food Storage, (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs for one out of 34 sampled residents (Resident 11) when Resident 11's call light button was not within reach.This failure placed the resident at risk for unmet needs and compromised safety.Findings:A review of Resident 11's clinical record indicated Resident 11 was admitted February of 2026 and had diagnoses that included myasthenia gravis (a disorder causing fluctuating weakness in muscles, particularly those controlling the eyes, face, swallowing, and breathing), dementia (memory loss that interferes with daily functions), congestive heart failure (a serious condition in which the heart does not pump blood as efficiently as it should), and muscle weakness.A review of Resident 11's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 4/7/26, indicated Resident 11 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 7 out of 15 which indicated Resident 11 had a severely impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 11's MDS Functional Abilities, dated 4/7/26, indicated Resident 11 needed substantial/maximal assistance with toileting hygiene, supervision or touching assistance with oral hygiene, and setup or clean-up assistance with eating. A further review of Resident 11's MDS Functional Abilities indicated Resident 11 needed supervision or touching assistance Sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfer, and toilet transfers.A review of Resident 11's care plan, dated 2/23/26, indicated, Falls: Resident is at risk for falls with or without injury related to cardiovascular disease, decreased muscular coordination, unsteady gait, dementia .history of falling .Keep call light within reach.During a concurrent observation and interview on 4/20/26 at 10:09 a.m. with Resident 11 in Resident 11's room, Resident 11 was observed lying on her bed, awake. Resident 11 stated she does not know where her call light button was. Resident 11's call light button was observed on the floor, at the back of Resident 11's bedside drawer, which was 3-4 feet away from the resident. During a concurrent observation and interview on 4/20/26 at 3:25 p.m. with Certified Nurse Assistant (CNA) 2, in Resident 11's room, Resident 11 was observed lying on bed, awake, and there was no call button within Resident 11's reach. CNA 2 confirmed the observation. CNA 2 searched Resident 11's room and found Resident 11's call light button on the floor, at the back of Resident 11's bedside drawer, which was 3-4 feet away from Resident 11. CNA 2 also confirmed that Resident 11's call system was not within her reach. CNA 2 stated Resident 11's call light button should be within her reach when she was in bed so she could call for help when she needs assistance. During an interview on 4/21/26 at 12:04 p.m. with Licensed Nurse (LN) 6, LN 6 stated call light buttons should be placed within the resident's reach so that the resident can call for help during emergencies or when they need assistance.During an interview on 4/22/26 at 2:13 p.m. with the Director of Staff Development (DSD), the DSD stated that staff should always be sure to place call light within the reach of the residents when they are in bed so they could use it to call for help if needed. During an interview on 4/23/26 at 9:16 p.m. with the Administrator (ADM), the ADM stated they try to keep the call light buttons next to the resident A review of the facility's policy and procedures titled, Call Light Policy and Procedure, undated, indicated, It is the policy of this facility to ensure all resident/patient call lights are answered promptly, courteously, and safely to promote comfort, dignity, and timely care. Staff are expected to respond to all call lights as soon as possible .Procedure .1. All staff are responsible for responding to call lights immediately when able, regardless of department .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 34 sampled residents (Resident 12) received adequate supervision to prevent accidents.This lack of supervision and assistance resulted in Resident 12 sustaining a fall that caused a fracture (break in a bone), severe pain, and a decline in functional ability.Findings:Review of Resident 12's clinical record indicated Resident 12 was admitted to the facility on [DATE] with multiple diagnoses that included muscle weakness and reduced mobility.Review of Resident 12's Annual Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/2/26 indicated Resident 12 had moderately impaired cognition. The MDS described Resident 12 as needing setup or clean-up assistance with eating, partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral hygiene and upper body dressing and substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, lower body dressing and personal hygiene.Review of Resident 12's Fall Risk Observation/assessment dated [DATE] indicated Resident 12 was moderate risk for having a fall.Review of Resident 12's Progress Note, dated 2/18/2026 at 3:28 p.m., indicated, The resident returned from hospital after being sent out for fall. Resident returned with right pattiler (sic patella-knee) fracture. Resident has a new order to apply knee brace. Upon arrival resident noted to have skin tear on right elbow. Treatment nurse was notified. Resident requested pain medication upon arrival and stated that he was in severe pain.Review of Resident 12's hospital CT (Computerized Tomography-a more detailed picture of inside the body) results dated 2/18/26 at 7:30 a.m. indicated, FINDINGS: Acute comminuted (broken into three or more pieces typically caused by high-force accident or trauma) nondisplaced fracture of the involving the patella. The CT results also indicated, Diffuse patchy osteopenia (loss of bone density) is present throughout the knee. Chondrocalcinosis (painful type of arthritis) is present.During a concurrent record review and interview on 4/21/2026 3:32 p.m. with the Resource Nurse and the Director of Nursing (DON), Resident 12's Progress Notes dated 2/18/26 at 3:20 a.m. and Resident 12's Progress Note labeled, IDT-Fall dated 2/18/26 at 10:44 a.m. were reviewed. The Resource Nurse stated the IDT documented the fall as witnessed fall. The Resource Nurse confirmed the LN note documented Resident 12's bed to be elevated above the waist level. The Resource Nurse stated Resident 12' sustained a right knee fracture and left elbow skin tear from the fall. The DON was asked what she would have expected staff to do in this situation she stated she would expect staff to utilize two people if needed or keep one hand on resident to help prevent from falling. In a concurrent interview and record review on 4/22/2026 at 1:24 p.m. with the MDS Coordinator, Resident 12's MDS's were reviewed. The MDS Coordinator stated Resident 12's trigger to complete a significant change MDS was a fall with fracture. The MDS Coordinator compared Resident 12's Annual MDS dated [DATE] with Resident 12's Significant Change MDS dated [DATE] and stated Resident 12 had a significant change in his functional abilities. The MDS Coordinator stated his functional abilities went down to mostly dependent, (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for most of his activities of daily living after the fall and fractured knee.During a review of the facility's policy and procedure (P&P) titled, Assessing Falls and Their Causes, revision dated March 2018 indicated, The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Preparation 1. Review the resident's care plan to assess for any special needs of the resident.3. Assemble the equipment and supplies as needed.During a review of the facility's P&P titled, Activities of Daily Living (ADL), Supporting, revision dated March 2018 indicated, Residents will be provided with care, treatment and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). 1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Heights Post Acute	7807 Uplands Way Citrus Heights, CA 95610

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure one out of 34 sampled residents (Resident 24) received dialysis care services consistent with professional standards of practice, facility's policy and procedure (P&P) when Resident 24 had an inaccurate dialysis medical record.This failure had the potential for Resident 24 to not receive safe and appropriate dialysis care treatment and services and to not achieve her highest practicable well-being.Findings:A review of Resident 24's clinical record indicated Resident 24 was admitted February of 2026 and had diagnoses that included end stage renal disease (ESRD- occurs when the gradual loss of kidney function reaches an advanced state where kidneys no longer work as they should to meet the body's needs), dependence on renal dialysis (the process of removing excess water, particles, and toxins from the blood in people whose kidneys can no longer perform these functions naturally), and muscle weakness.A review of Resident 24's Weekly Summary Notes, dated 4/15/26, indicated Resident 24 was on dialysis and was alert and oriented to person, place, time, and situation. A review of Resident 24's Minimum Data Set (MDS- an assessment tool used to guide care) Special Treatments, Procedures, and Programs, dated 2/7/26, indicated Resident 24 was on hemodialysis (a treatment to filter waste and water from the blood) on admission and while she is a resident in the facility.A review of Resident 24's Care Plan Report, dated 2/5/26, indicated, Dialysis: Resident Requires [x] Hemodialysis [x] End Stage Renal Failure .is at risk for bleeding at access site, hypotension [low blood pressure], infection .weakness, weight fluctuations. Resident requiring Hemodialysis 3x/wk [three times a week] on Tuesday, Thursday, Saturday. Chair time: 1500 (3PM) to 1830 (6:30PM) .A review of Resident 24's active physician's order, dated 2/9/26, indicated, End Stage Renal Disease (ESRD) requiring Hemodialysis 3x/wk [three times a week] on Tuesday, Thursday, Saturday. Chair Time: 1500 (3PM) .A review of Resident 24's active physician's order, dated 2/9/26, indicated, Epoetin Alfa (epoetin alfa-ephz .Retacrit) [short-acting erythropoiesis-stimulating agent (ESA) used to treat anemia by stimulating the bone marrow to produce red blood cells] 1 ml [milliliters- unit of measurement] Intravenous [IV- directly into the vein] every Tuesday, Thursday and Saturday in Hemodialysis clinic.During an interview on 4/21/26 at 12:04 p.m. with Licensed Nurse (LN) 6, LN 6 stated they would fill out the dialysis communication paper to assess the resident before going to the dialysis center and send the resident to the dialysis center with the paper. When the resident comes back, they would check the dialysis communication paper for any post dialysis [after dialysis] assessment and communication from the dialysis center and would clarify it as needed. A review of Resident 24's DIALYSIS CENTER HEMODIALYSIS COMMUNICATION OBSERVATION/ASSESSMENT, dated 3/31/26, indicated, Resident Name: [Resident 24] .Medication Administered: .Mircera [Epoetin beta- a long-acting ESA used to treat anemia associated with kidney diseases] .During a concurrent phone interview and record review on 4/22/26 at 3:47 p.m. with the Administrative Assistant (AA) from Resident 24's dialysis center, Resident 24's medical records were reviewed. The AA confirmed that Resident 24 was receiving Mircera 50 mcg [micrograms- unit of measurement] IV push once every 2 weeks. The AA stated Resident 24 has been receiving Mircera since March of 2024. The AA also stated their center has discontinued the use of epoetin alfa long time ago because of the side effects of the medication. The AA further stated Resident 24 should not be receiving epoetin alfa because it would be double dosing of ESA medication.During a concurrent interview and record review on 4/23/26 at 9:04 a.m. with the Director of Staff Development (DSD), Resident 24's medical records were reviewed. The DSD confirmed Resident 24 has an active order that indicated Resident 24 was receiving Epoetin Alfa (Retacrit) at the dialysis center. The DSD also confirmed that Resident 24's hemodialysis communication sheet indicated Resident 24 was receiving Epoetin Beta (Mircera) at the dialysis center. The DSD further confirmed that Resident 24's medical record was not accurate. The DSD stated that nurses were supposed to check and reconcile the dialysis communication sheet. The DSD further stated that residents should have an accurate medical record so they could safely receive (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis treatments.A review of the facility's P&P titled, CARE OF THE DIALYSIS RESIDENT, undated, indicated, Dialysis resident will be provided care and services in a manner that promotes the resident's quality of life, and to attain or maintain the resident's highest possible physical, mental and psychosocial well being .The nursing staff will follow established protocol for all dialysis residents .b. The Provider's dialysis nurse will be responsible for documentation of dialysis treatment. Documentation will be maintained in the resident medical records.A review of the facility's AGREEMENTS FOR RESIDENT CARE SERVICES BETWEEN A DIALYSIS UNIT AND NURSING FACILITY with Resident 24's dialysis center, signed on 7/10/02, indicated, 4. Coordination of care may include the following: .Information transmitted to the Dialysis Unit by the Facility prior to dialysis .Information transmitted to the Facility by the Dialysis Unit after dialysis .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two out of 34 sampled residents (Resident 35 and Resident 9) were free from significant medication error when:1. Resident 35 did not receive prescribed insulin (medication used to manage blood sugar level) in accordance with the standards of practice; and,2. Resident 9's insulin was not administered as prescribed.These failures had the potential to result in Resident 35 and Resident 9 experiencing hypoglycemia (too low blood sugar level) and other unnecessary insulin side effects which could negatively affect Resident 35's health.Findings: 1. A review of Resident 35's clinical record indicated Resident 35 was admitted March of 2026 and had diagnoses that included diabetes mellitus type 2 (DM2- a chronic condition causing too much sugar in the blood), respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), and muscle weakness. A review of Resident 35's Minimum Data Set (MDS– a federally mandated resident assessment tool) Cognitive Patterns, dated 4/2/26, indicated Resident 35 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 11 out of 15 which indicated Resident 35 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 35's MDS Functional Abilities, dated 4/2/26, indicated Resident 35 needed set-up or clean-up assistance with eating. A review of Resident 35's Care Plan Report, dated 2/13/26, indicated, Diabetes: Resident has a diagnosis of diabetes and is at risk for complications manifested by hyperglycemia [high blood sugar], hypoglycemia [low blood sugar], skin breakdown. A review of Resident 35's active physician's order, dated 3/30/26, indicated, Insulin Lispro [a fast-acting type of insulin used to manage high blood sugar] .Injection Solution 100 UNIT/ML [unit/milliliters- unit of measurement] Inject 5 unit [unit of insulin measurement] subcutaneously [under the skin] three times a day for DM2 . A review of Resident 35's active physician's order, dated 3/30/26, indicated, Insulin Lispro Injection Solution 100 UNIT/ML .Inject as per sliding scale [a method of managing blood sugar levels where insulin doses are adjusted based on current blood sugar reading]: if 71 - 150 = none; 151 - 200 = 1 unit; 201 - 250 = 2 unit; 251 - 300 = 3 unit; 301 - 350 = 4 unit; 351 - 400 = 6 unit more than 400 = 8 units, subcutaneously three times a day for DM2 . During a concurrent interview and record review on 4/20/26 at 1:14 p.m. with Licensed Nurse (LN) 5, Resident 35's medication administration record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of April 2026 was reviewed. LN 5 stated that Resident 35 had a blood sugar reading of 155 units and was given a total of 6 units before 1 pm. LN 5 also stated that the lunch meal should have been given to the resident within 15 minutes of the insulin administration and she was not sure why the lunch meal was late today. LN 5 further stated Resident 35 was at risk for hypoglycemia if the lunch meal was not given within 15 minutes from the time the insulin was administered. During an interview on 4/20/26 at 1:45 p.m. with Resident 35, Resident 35 stated he was still waiting (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for his lunch meal. Resident 35 further stated he was hungry, but he could not do anything but wait. During a concurrent observation and interview on 4/20/26 at 1:56 p.m. with Certified Nurse Assistant (CNA) 3, CNA 3 was observed passing Resident 35's lunch meal tray to Resident 35. CNA 3 confirmed the observation. During an interview on 4/22/26 at 2:13 p.m. with the Director of Staff Development (DSD), the DSD stated lispro is a rapid acting insulin and a resident should be given meals within 10-15 minutes of administration of the medication. The DSD also stated that 1 hour was a big gap between lispro administration and the receiving his meal. The DSD further stated the Resident's blood sugar could drop and could endanger the resident's health condition if the lunch meal was given late. 2. A review of Resident 9's clinical record indicated Resident 9 was admitted to the facility on [DATE] with multiple diagnoses which included diabetes, Stage 3 chronic kidney disease (moderate kidney damage which impairs waste removal from the body). A review of Resident 9's April 2026 Order Summary Report contained a physician's order dated 2/26/26 for Insulin Lispro Injection Solution 100 UNIT/ML (milliliter) (Insulin Lispro) Inject 4 unit subcutaneously (under the skin) three times a day for DM2 (diabetes) Hold for blood sugar (BS-main sugar in body that gives you energy) less than 150 or when patient does not eat. Administer with meals. Notify MD (Medical Doctor)/NP (Nurse Practitioner) for blood sugar less than 70 or greater than 300. During a concurrent interview and record review on 4/22/2026 11:36 a.m. with the Director of Nursing (DON) and the Resource Nurse, Resident 9's Medication Administration Record (MAR) dated April 2026 was reviewed. The DON confirmed a check mark in the box with the LN's initials indicated the LN gave the medication. The April MAR indicated on 4/4/26 at 12:30 p.m. Resident 9's blood sugar was 119 and there was a check mark in box with the LN's initials. The DON confirmed this indicated the LN gave the insulin and stated the LN should not have given the insulin per parameter and should have been held for a blood sugar less than 150. The April MAR further indicated on 4/20/26 at 12:30 p.m. Resident 9's blood sugar was 148 and there was a check mark in the box with the LN's initials. The DON confirmed this indicated the LN gave the insulin and stated the LN should not have given the insulin per parameter and should have been held for a blood sugar less than 150. Administering insulin when blood sugar is below 150 can increase the risk of hypoglycemia, which may lead to adverse health outcomes for Resident 9. A review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, indicated, 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food interactions .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . A review of the facility's P&P titled, Insulin Administration, revised 3/2025, indicated, 2. The type of insulin, dosage requirements, strength, and method of administration are verified with the order on the medication sheet and the physician's order before administration .4. The nursing staff have access to specific instructions (from the manufacturer, if appropriate) on all forms of insulin delivery systems prior to their use .General Guidelines .1. Insulin therapy is individualized based on prognosis, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment goals, and blood glucose levels. 2. The three key characteristics of insulin are: a. Onset of action – how quickly the insulin reaches the bloodstream and begins to lower blood glucose .6. The types of insulin and their pharmacokinetics are: Category .Rapid-acting .Type .Insulin Lispro .Onset* .within 15 min [minutes] .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview and record review, the facility failed to provide timely dental services to two of 34 sampled resident (Resident 16 and Resident 52) when the facility did not carry out recommended tooth extractions.This failure had the potential to cause tooth pain and infection.Resident 16 was admitted to the facility in late 2018 with diagnoses that included a stroke with left side weakness.During an interview on 4/21/26 at 9:35 a.m. with Resident 16 in her room, Resident 16 stated she had a bad tooth and was waiting for the dentist to fix her mouth.During a review of Resident 16's dental exam notes, dated 10/2/25, the dental note indicated Resident 16 had tooth pain in the top left side of her mouth and that the tooth is mobile [loose] and needs EXT [extraction, removal].During a concurrent interview and record review on 4/22/26 at 9:33 a.m. with the Social Service Director (SSD) of Resident 16's dental exam, the SSD confirmed the dental note indicated Resident 16 needed a tooth extraction, the SSD acknowledged the facility had not completed any followˆup on Resident 16's dental needs since September 2025. The SSD stated a sixˆmonth delay was unacceptable and that she expected dental care to be provided as needed to prevent infection, weight loss, and pain.During an observation on 4/22/26 at 10:54 a.m. with Licensed Nurse (LN 4) of Resident 16's tooth, LN 4 asked to see Resident 16's tooth, Resident 16 had a blackened tooth loosely hanging from the back left upper side of her mouth. Resident 16 stated her tooth hurt. LN 4 confirmed the blackened tooth.During a review of Resident 16's dental visit notes dated 4/22/26, the dental notes indicated resident's tooth was mobile and decayed. Resident 16 was prescribed antibiotics for likely infection.Resident 52 was admitted to the facility in late 2024 with diagnoses that included memory loss and muscle weakness.During a concurrent observation and interview on 4/21/26 at 9:22 a.m. with Resident 52, Resident stated she had broken teeth and wanted to see a dentist. Resident 52 opened her mouth and revealed several broken jagged teeth with several dark blackened areas along the gumline.During a review of Resident 52's dental notes dated 5/15/25, the dental note indicated Resident 52 needed (tooth) extractions on the next visit.During a concurrent interview and record review on 4/22/26 at 9:30 a.m. with the SSD of Resident 52's dental notes dated 5/15/25, the DDS confirmed the dental notes which indicated Resident 52 needed dental extraction. The SSD acknowledged the facility had not completed any followˆup to schedule them. She stated the delay was unacceptable and could lead to pain and infection.During a review of Resident 52's dental notes dated 4/22/26, the dental note indicated Resident 52 had two teeth that appeared decayed. Resident 52 was prescribed antibiotics for likely dental infection.During an interview on 4/23/26 at 11:12 a.m. with the Director of Nursing (DON), the DON stated she expected dental care and follow-up services to be provided for residents.During a review of the facility's policy and procedures (P&P) titled, Dental Consultant, dated 4/26, the P&P indicated, Dental care shall be provided through the services of a Consultant Dentist.A consultant dentist is retained by our facility and is responsible for.providing consultation to physicians and providing other services relative to dental matters.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the prepared menu and meet the nutritional needs for one out of 34 sampled residents (Resident 155) when Resident 155 was not served with a regular portion of protein during the 4/20/26 lunch meal. This failure had the potential to result in Resident 155 not being able to meet and maintain her nutritional needs and achieve her highest practicable wellbeing.Findings:A review of Resident 155's clinical record indicated Resident 155 was admitted November of 2023 and had diagnoses that included dementia (memory loss that interferes with daily functions), diabetes mellitus (a chronic condition causing too much sugar in the blood), severe protein-calorie malnutrition (PCM- a severe nutritional deficiency where inadequate intake of protein and calories leads to dangerous changes in body composition, function, and weight loss), and muscle weakness.A review of Resident 155's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/15/26, indicated Resident 155 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 11 out of 15 which indicated Resident 155 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 155's MDS Functional Abilities, dated 2/15/26, indicated Resident 155 needed set-up or clean-up assistance with eating.A review of Resident 155's active physician's order, dated 10/22/25, indicated, CCHO diet [Consistent Carbohydrate Diet/Controlled Carbohydrate- a nutrition plan designed for people with diabetes or prediabetes to keep blood glucose levels stable] .Regular texture .small starch portions.A review of Resident 155's Care Plan Report, revised 12/31/25, indicated, Nutritional Risk: [Resident 155] has the potential for altered nutrition and/or hydration status related to .DM, Severe PCM .muscle weakness .Hx [history] of sig wt loss [significant weight loss] and poor PO [oral] intake .A review of Resident 155's NUTRITIONAL RISK REVIEW (QUARTERLY), dated 2/15/26, indicated, Diet approx [approximately] provides 1917kcal [kilocalorie- unit of energy measuring the nutritional value of food and beverages] and 94g [grams- unit of measurement] protein .5. Diet Order .CCHO diet .Regular texture .small starch portions .A review of the facility's Good For Your Health Menus, dated 4/20-26/26, indicated the lunch menu for 4/20/26, Monday, included, Baked Hamburger with [NAME] Sauce, Diced Fried Potatoes, Capri Blend Vegetables, Wheat Roll, Spring Fruit Crisp.During a concurrent observation and interview on 4/20/26 at 12:56 p.m. with Resident 155 at MedBridge Dining Room, Resident 155's lunch meal was observed which included a half slice of hamburger patty with brown sauce. Resident 155's meal ticket was checked and indicated, Texture: .Regular, Special Diets: CCHO .Notes: .SMALL STARCH PORTION . Resident 155 confirmed the observation. Resident 155 stated it has been recently that they started giving her half portion of meat. Resident 155 also stated she never requested for a half portion of meat. Resident 155 further stated she would always end up eating a lot of cookies and extra sweets because they would only serve her half portion of meat. During a concurrent observation and interview on 4/20/26 at 1:01 p.m. with the Clinical Resource Nurse (CRN) at MedBridge Dining Room, the CRN confirmed that Resident 155 only received a half slice of hamburger patty. The CRN checked Resident 155's meal ticket and stated the meal ticket did not indicate that Resident 155 would have half portion of meat so she should have received a regular portion of meat. The CRN further stated the meal ticket should have been followed. During an interview on 4/20/26 at 1:13 p.m. with the Registered Dietician (RD) at MedBridge Dining Room, the RD stated Resident 155 should receive a regular portion of protein and should not be getting a half portion only. The RD further stated Resident 155 was supposed to get regular portion of protein to maintain her desired nutritional intake. A review of the facility's policy and procedure (P&P) titled, Tray Identification, revised 4/2007, indicated, Appropriate identification/coding shall be used to identify various diets .2. The food services manager or supervisor will check trays for correct diets before the food carts are transported to their designated areas. 3. Nursing staff shall check each food (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tray for the correct diet before serving the residents. 4. If there is an error, the nurse supervisor will notify the dietary department immediately by phone so that the appropriate food tray can be served.