

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Bruceville Terrace - D/P Snf of Methodist Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 8151 Bruceville Road Sacramento, CA 95823	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50750</p> <p>Based on observation, interview and record review, the facility failed to ensure pressure injury prevention and treatment consistent with the professional standards of practice were promoted for two of three sampled residents (Resident 1 and Resident 2) when:</p> <ol style="list-style-type: none"> 1. Resident 1's care plan for turning and repositioning every two hours was not implemented; and 2. Resident 2's low air loss (LAL) mattress (specialty bed designed to distribute the patient's body weight over a surface to prevent skin breakdown) bed pump was turned off. <p>These failures had the potential risk to result in delayed healing and deterioration of the pressure ulcers (PUs).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Resident 1 was admitted to the facility in the middle of 2024 with diagnoses which included encephalopathy (a brain condition that causes a rapid decline in brain function), and cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture). <p>During a review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 9/3/24, the MDS indicated the Resident 1 had no memory impairment, needed assistance with rolling left and right, had unhealed unstageable PUs, and used pressure reducing device in bed.</p> <p>During a review of Resident 1's Wound Care Note (WCN), dated 8/28/24, the WCN indicated, .location: Rt [right] buttock, Wound Type: stage: UTD [unstageable] pressure injury, POA [present on admission] .</p> <p>During a review of Resident 1's Skin Risk Care Plan (CP), dated 8/28/24, the CP indicated, Potential for skin breakdown .Plan .Turn & reposition patient Q 2 hours .</p> <p>During a review of Resident 1's WCN, dated 8/28/24 and 8/29/24, the WCN indicated, .Pressure injury treatment and prevention measures .Turn the patient Q2hours [every 2 hours], and avoid positioning on the injury areas .</p> <p>During a review of Resident 1's document titled, Pressure Sore (PS), dated 9/4/24, the PS indicated, . Interventions .Reposition Q2 hours .</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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Physician's Orders (PO), dated 9/16/24, the PO indicated, .Nursing turn Q 2 hours and document R [right] to left side and left to right side.</p> <p>During an interview on 9/18/24 at 11:22 a.m. with Certified Nurse Assistant (CNA) 1, when asked about pressure injury prevention, CNA 1 stated .turn (the resident) every 2 hours . When asked where [the CNAs] documented the turning and repositioning, CNA 1 stated, .you document in the computer the turning .</p> <p>During a concurrent observation and interview on 9/18/24 at 11:47 a.m. in Resident 1's room, Resident 1 sat in a chair, awake, alert and verbally responsive, and stated, I'm still here because of my bed sore. When asked if the bed sore happened in the facility, Resident 1 stated .may have started right before I came in here and deteriorated once I got here . Resident 1 indicated she was not aware of turning and repositioning Q2 hours, and stated, They have never turned me at all .they don't turn me ever. I don't even know if they know what they were supposed to do .I am not able to turn myself.</p> <p>During an interview on 9/18/24 at 11:54 a.m. with Licensed nurse (LN) 1, when asked about pressure injury prevention, LN 1 stated, Check for skin issues .turn and reposition [the resident] every two hours . When asked about Resident 1's ability to turn and reposition, LN 1 stated, .not sure if [Resident 1] is able to turn and reposition .when lying in bed .I haven't seen [Resident 1] on the bed turning and repositioning .</p> <p>During an interview on 9/18/24 at 12:09 p.m. with Treatment nurse (TN) 1, when asked what was her expectation from the LNs and CNAs on wound prevention and decline, TN 1 stated There are precautions that need to be performed .turn and reposition every two hours .monitor the wound daily .do health teaching for prevention .turning and repositioning and make sure that they are done and documented .</p> <p>During a concurrent interview and record review on 9/18/24 at 1:48 p.m. with the Informatics Nurse (IN), Resident 1's Skin/Wound Interventions dated 8/28/24 to 9/18/24 were reviewed. The IN verified and confirmed there were gaps on the documentation on the turning and repositioning and did not indicate which side Resident 1 was lying.</p> <p>During an interview on 9/18/24 at 2:02 p.m. with the Director of Staff Development (DSD), the DSD stated, I did educate [the CNAs] with the importance of turning and repositioning .my expectation is they should be documenting them on the patient's chart .</p> <p>During an interview on 9/18/24 at 2:23 p.m. with the Director Of Nursing (DON), the DON stated, It has not been a practice to document or a requirement to document the Q2 hours turning and positioning .It is not a regulation to document turning and repositioning .I have not seen it documented anywhere in the chart .</p> <p>During a review of the facility's policy and procedure (P&P) titled, [Name of Facility] Turning and Repositioning, dated 8/2023, the P&P indicated, .The frequency of turning and repositioning will be documented in the resident's plan of care .</p> <p>2. Resident 2 was admitted to the facility in the middle of 2024 with diagnoses which included hip fracture, hyponatremia (low sodium level), and depression.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated the Resident 2 had no memory impairment, needed maximal assistance with rolling left and right, had unhealed unstageable pressure ulcers, and used pressure reducing device in bed.</p> <p>During a review of Resident 2's WCN, dated 8/24/24 at 2:36 p.m., the WCN indicated Resident 2 had multiple [pressure] wound locations.</p> <p>During a review of Resident 2's Skin Risk CP, dated 8/31/24, the CP indicated, Potential for Skin Breakdown . Positioning .Specialty mattress (LAL) .</p> <p>During an observation on 9/18/24 at 11 a.m. in Resident 2's room, Resident 2 was seen lying in bed, awake and alert and verbally responsive, with the LAL bed pump turned off.</p> <p>During a concurrent observation and interview on 9/18/24 at 11:10 a.m. with LN 2, LN 2 verified the LAL bed pump was turned off, and stated, .I don't know why it is turned off .it should always be turned on when the patient is on the bed . LN 2 verified the LAL order in the electronic medical record and stated, .I know, it should always be turned on.</p> <p>During an interview on 9/18/24 at 11:43 a.m. with CNA 2, CNA 2 stated, .specialty bed [LAL] is already on and always on .</p> <p>During an interview on 9/18/24 at 12:27 p.m. with TN 2, TN 2 stated, [Resident 2's] bed should always be turned on .</p> <p>During an interview on 9/18/24 at 2:23 p.m. with the DON, when asked about Resident 2's bed pumped being turned off, the DON stated, .glitch in the system .</p> <p>The P&P for LAL was requested but not provided.</p> <p>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: .Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement treatment, disease prevention, or rehabilitative regiment .ordered by and within the scope of licensure of a physician .as defined by Section 1316.5 of the Health and Safety Code. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing 1997 State of California Department of Consumer Affairs. pp. 5)</p>		