STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555344	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bruceville Terrace - D/P Snf of Methodist Hospital	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was treated with respect and dignity when Resident 1's request to have family present during direct care was not acknowledged by Certified Nurse Assistant 1 (CNA 1). This failure had the potential for Resident 1 to not to receive care based on her needs and preferences. A review of Resident 1's clinical record indicated Resident 1 was admitted in Middle 2025 with diagnosis of Type 2 Diabetes Mellitus (a condition where your body either doesn't make enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 7/22/25 indicated Resident 1 had a Brief Interview for Mental Status (BIMS, tests cognition) score of 13 out of 15 indicating Resident 1 was cognitively intact. A review of Resident 1's care plan, titled . Alteration in Communication r/t [sic, related to] language barrier. dated 7/16/25, indicated, . Language(s) spoken: Spanish . The box next to .Resident will be able to communicate his/her basic needs utilizing the communication devices provided. was not checked. During a concurrent observation and interview on 7/22/25 at 1:47 p.m. in Resident 1's room with family representative present, Resident 1 was observed receiving care when surveyor and family representative were in room with Certified Nurse Assistant 1 (CNA 1). CNA 1 was asked to allow family representative and surveyor to observe care due to language barrier, CNA 1 did not respond. CNA 1 was asked again at 1:48 p.m. and 1:49 p.m. to allow surveyor and family representative to observe care, CNA 1 stated she was providing patient care and did not allow surveyor and family to enter. CNA 1 then opened the curtain and was asked how CNA 1 communicated with Resident 1 and CNA 1 pointed to a communication board. CNA 1 left the room and did not respond to surveyor questions further. Family representative and surveyor observed and interviewed Resident 1. Resident 1 was noted shaking with arms crossed, grimacing and stated she was scared of CNA 1 and wanted an interpreter to explain each step during provision of care. Family representative stated Resident 1 was now scared to receive wound care by staff due to fear of staff not explaining procedures and being too rough with her. Resident 1 stated she wanted an interpreter or family representative present during care. During a concurrent observation and interview on 7/22/25 at 1:50 p.m. with Treatment Nurse 2 (TN 2), the TN 2 acknowledged Resident rights to have family participate in care. TN 2 stated family members were allowed to participate in patient care with permission from Resident 1. TN 2 further stated the facility honors resident preferences and family members are able to help with translation for non-English speaking residents to help them feel more comfortable. During an interview on 7/22/25 at 2:00 p.m. with CNA 1, CNA 1 acknowledged she did not allow Resident 1's family representative and surveyor in the room during Resident 1's care. CNA 1 further stated she could communicate with Resident 1 using gestures and using the communication board. She further acknowledged she did not ask the resident if the family representative could come in during direct care. CNA 1 further stated she would not allow family in the room despite Resident 1's language barrier due to privacy concerns. During an interview on 7/22/25 at 4:33 p.m. with Director of Nursing (DON), the DON stated that the facility can ask family members to leave while providing care if it will interfere with Resident care. When asked about family member being present to help interpret in situation where there was communication barrier during care, the DON did not answer surveyor's questions surrounding Resident 1's preferences and stated the facility used communication boards and interpreter lines. A review of facility policy and procedure (P&P), titled .Bruceville Terrace: Resident Right., dated 5/22/25, the P&P indicated, . The resident has the right to exercise his/her rights as a resident of this facility.Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess one of four sampled residents (Resident 1's) skin for stageable pressure injuries (damage to the skin and underlying tissues caused by prolonged pressure on the body). This failure had the potential to result in worsening of Resident 1's skin breakdown.A review of Resident 1's clinical record indicated Resident 1 was admitted in Middle 2025 with diagnoses which included Type 2 Diabetes Mellitus (a condition where your body either doesn't make enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 7/22/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS, tests cognition) score of 13 out of 15 indicating Resident 1 was cognitively intact. During a review of Resident 1's initial skin assessment dated [DATE], the skin assessment indicated excoriation (skin damage) on sacral coccyx (bones at the base of spine) area. An image was included. During a Review of Resident 1's clinical record, the physician order dated 7/17/25 indicated, .Peri-rectal (surrounding the rectal area) area skin excoriation; Cleanse with warm water, pat dry, apply zinc oxide paste [a skin barrier paste], cover with foam dressing daily.During a concurrent observation and interview on 7/22/25 at 1:47 p.m. in Resident 1's room with Treatment Nurse 2 (TN 2), observed wound care being performed on Resident 1's coccyx (tailbone) and gluteal (buttocks) fold area. During the observation of the wounds, Resident 1 was noted to have a dark red line running up the coccyx area, gluteal folds redness, skin breakdown and peeling. The wound appeared to have partial thickness skin loss of the top layer of the skin. Upon observation, interviewed TN 2 who stated Resident 1 did not have skin break down, only redness and she did not acknowledge Resident 1's skin breakdown and potential pressure injury. TN 2 further stated only when a wound had drainage was it classified as skin breakdown and pressure injury. During a concurrent interview and record review on 7/22/25 at 2:30 p.m. with Treatment Nurse 1 (TN 1), Resident 1's admission wound photograph dated 7/17/25 was reviewed. TN 1 reviewed the photo and stated Resident 1's wound looked like a stage 2 upon admission. During an interview on 7/22/25 at 4:33 p.m. with Director of Nursing (DON), the DON refused to answer specific questions regarding wound care staging. DON stated all wound nurses are wound care certified (specialized training in wound care and certification). During a review of facility policy and procedure (P&P) titled, Bruceville Terrace: Pressure Injury Prevention and Treatment., dated 5/1995, the P&P indicated, .The facility will.accurately stage pressure injuries according to standardized guidelines.A pressure injury is localized damage to the skin and underlying soft tissue.The injury can present as intact skin.Stage 1: Non-blanch erythema (redness) of intact skin. Stage 2: Partial thickness skin loss involving epidermis (top layer of skin) , and/or dermis (base layer of the skin). The injury is superficial and presents clinically as an abrasion.

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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. Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during wound care for one of four sampled residents (Resident 2) when licensed staff did not perform hand hygiene between changing gloves when performing wound care. This failure had the potential to result in cross contamination of the wound and spread of infection for Resident 2. A review of Resident 2's clinical record indicated resident 2 was admitted in July 2025 with diagnoses which included pressure injury (pressure sore, ulcer, or bedsore) of sacral (a triangular bone at the base of the spine) region. During a review of Resident 2's Minimum Data Set (MDS, an assessment tool) dated 5/27/25 indicated Resident 2 had a Brief Interview for Mental Status (BIMS, tests cognition) score of 0 out of 15 indicating Resident 2 had severely impaired cognition. During a review of Resident 2's clinical record, the physician treatment order dated 7/11/25 indicated, . Pressure injury Stage 4 [severe, deep wound that extends through the skin, fat, and muscle, potentially reaching the bone] . Cleanse with wound cleanser, pat dry pack with calcium alginate with silver [wound care product] and apply foam dressing.During a concurrent wound care observation and interview on 7/22/25 at 2:09 p.m. with Treatment Nurse 3 (TN 3), TN 3 stated during wound observation, Resident 2 is on enhanced barrier precautions and stated the surveyor didn't need to wear a gown. TN 3 was observed removing the old dressing from the pressure wound and did not perform hand hygiene. TN 3 cleansed the wound and changed gloves but did not perform hand hygiene in between changing the gloves. TN 3 packed wound and placed scissors used for dressings on white chuck (waterproof barrier pad) on Resident 2's bed. TN 3 changed gloves but did not perform hand hygiene. TN 3 applied additional foam dressing to wound. TN 3 placed scissors back on table, changed gloves but hand hygiene was not performed. TN 3 re-positioned resident 2, grabbed gloves and threw trash bag away with discarded dressings, and did not perform hand hygiene afterwards. TN 3 then changed gloves, put off loading boots back on resident 2. TN 3 acknowledged that scissors should have been cleaned prior to placing it together with residents' clean materials. TN 3 acknowledged not performing hand hygiene between glove changes. During an interview on 7/22/25 at 4:33 p.m. with Director of Nursing (DON), the DON acknowledged the expectation was for staff to perform hand hygiene between change of gloves. During a review of facility policy and procedure (P&P) titled, .Hand Hygiene. dated, 3/2024, the P&P indicated, .hand hygiene is a critical component in preventing transmission of microorganisms (tiny living things that are too small to be seen without special lens) between personnel and patients.Health care workers shall decontaminate hands using alcohol-based hand rub.Before and after patient contact.before donning. gloves.Before moving from a contaminated body site to a clean body site on the same patient.after removing gloves.