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	02/27/2025

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 43247 Based on observation, interview, and record review, the facility failed to protect the privacy and confidentiality for 3 of 48 sampled residents (Resident 133, Resident 141, and Resident 314) when the Licensed Nurse (LN) left worksheets containing residents' identifiable health care information exposed to view during medication administration. This failure had the potential to result in Resident 133, Resident 141, and Resident 314's confidential information to be viewed by unauthorized staff, residents, and visitors. Findings: A review of Resident 133's Facesheet indicated Resident 133 was admitted to the facility in June 2024 with diagnoses including atrial fibrillation (irregular and very rapid heart rhythm) and cellulitis (skin infection). A review of Resident 141's Facesheet indicated Resident 141 was admitted to the facility in October 2024 with a diagnosis of alcohol induced neuropathy (chronic alcohol abuse damages the nerves leading to sensory and motor dysfunction). A review of Resident 314's Facesheet indicated Resident 314 was admitted to the facility in February 2025 with diagnosis of lower extremity (leg) cellulitis. During an observation on 2/25/25 at 7:57 a.m., observed LN 2 prepare Resident 133's medications on the medication cart in the hallway. Observed LN 2 cover computer screen, but did not cover or turn over worksheet when she left the medication cart to enter Resident 133's room to administer medications. During an observation on 2/25/25 at 8:16 a.m., observed LN 2 prepare Resident 141's medications on the medication cart in the hallway. Observed LN 2 cover computer screen, but did not cover or turn over worksheet when she left the medication cart to enter Resident 141's room to administer medications. During an observation on 2/25/25 at 8:26 a.m., observed LN 2 prepare Resident 314's medications on the medication cart in the hallway. Observed LN 2 cover computer screen, but did not cover or turn over worksheet when she left the medication cart to enter Resident 314's room to administer medications. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/25/25 at 8:47 a.m. with LN 2, LN 2 acknowledged she did not cover her worksheet left on the medication cart when she entered the rooms of Resident 133, Resident 141, and Resident 314, to administer medications. LN 2 stated, It was a HIPAA [Health Insurance Portability and Accountability Act-federal law that protects medical records and other personal health information] violation. Information needs to be protected. Should have turned it over. During an interview on 2/25/25 at 4:29 p.m. with the Nurse Manager (NM), the NM stated when nurses leave the medication cart to give the medications, they should cover the computer screen and should take the worksheet into the room with them. The NM then stated if left on the medication cart, the worksheet should be covered or turned over. The NM stated, If left open can be seen, HIPAA violation. During an interview on 2/27/25 at 11:01 a.m. with the Director of Nursing (DON), the DON stated that during medication administration the computer should be closed, and the worksheet should not be in view. The DON stated if the worksheet or computer screen can be viewed that is a privacy violation. A review of the facility's Policy and Procedure (P&P) titled Patient's Rights and Responsibilities, dated 12/3/18, indicated, .You have the right to: .Confidential treatment of all communications and records pertaining to your care and stay in the hospital . A review of the facility's P&P titled Privacy Program, dated 10/1/20, indicated, .It is the policy of [Name of corporation] to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable international, federal and state laws and regulations . [Name of corporation] is committed to carrying out its healthcare ministry in a manner . including adherence to established uniform organizational policies, standards, and processes that ensure privacy, information security, and confidentiality of Protected Health Information (PHI) . A review of the facility's P&P titled Disclosure of Protected Health Information to Family and Friends, dated 4/15/21, indicated, . [Name of corporation]'s policy and standard is to comply with the federal laws and regulations associated with the Health Insurance Portability and Accountability Act of 1996 .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 42255 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 32) was administered pain medication before providing wound care. This failure resulted in Resident 32 having unnecessary pain during wound care. Findings: Resident 32 was admitted to the facility in mid-2024 with diagnoses which included stroke, hypertension (uncontrolled blood pressure), dementia (memory loss) and a stage IV pressure ulcer (full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). A review of Resident 32's most recent Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/29/24, indicated Resident 32's memory was severely impaired. During an observation on 2/27/25 at 8:41 a.m., in Resident 32's room, Resident 32 wound dressing change was being provided by the Wound Care Registered Nurse (WCRN). Resident 32 stated, this is painful. During an interview on 2/27/25 at 8:42 a.m., with Resident 32, Resident 32 stated, She [WCRN] never asked about pain. Yes, I have pain, this does not feel good. During an interview on 2/27/25 at 8:50 a.m., with the WCRN, the WCRN stated, I'm not sure if [Resident 32's] pain medication was given. She (Resident 32) will be ok. During a concurrent interview and record review on 2/27/25 at 8:52 a.m., with LN 2, LN 2 reviewed, the Medication Administration Record (MAR) for Resident 32 's last pain medication administered. The MAR indicated Resident 32 received tramadol (used to relieve moderate to moderately severe pain),Oral Tablet 25 MG on 2/26/25 at 7:33 a.m. LN 2 stated, She (WCRN) should have checked with [Resident 32], 30 minutes before her wound care to assess the need for pain medication. During an interview on 2/27/25 at 12:48 p.m., with the Director of Nursing (DON), the DON stated, My expectation is that the staff should assess the residents prior to any care for their comfort. The facility's policy and procedure (P&P) for Pain Management was requested, the policy was not provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50633 Based on observation, interview, and record review the facility failed to ensure food was prepared in a manner to conserve nutritive value and palatability for residents receiving a pureed diet when the pureed carrots were prepared without using a recipe. This failure had the potential of leading to poor intake and malnutrition for the residents receiving pureed meals. Findings: During a concurrent observation, interview, and recipe review on 2/25/25 at 9:45 a.m., in the food preparation area, with the Nutrition Service Worker 1-Cook (NSW 1-C), Lead [NAME] for the day, and Nutrition Service Worker 2- Trainee [NAME] (NSW 2-TC) 2), NSW 1-C was showing the puree recipes and discussed the options used for adjusting the texture of pureed dishes. NSW 1-C had stated using water is seldom used as well as thickener ingredients. NSW 2-TC was observed liberally pouring an unmeasured amount of hot water into both the carrot puree and sweet potato puree. Observed NSW 1-C attempting to remedy the very watery and runny textured purees by adding an unmeasured volume of puree thickening ingredient. During a concurrent observation and interview on 2/25/24 at 12:15 p.m., Nutrition Service Manager (NSM) brought two lunch test trays that contained one regular consistency meal and one pureed consistency meal to the conference room. The pureed meal was sampled, and while the puree carrots had a sweet flavor, the consistency was very thick and gummy indicating too much thickener was used during preparation. When asked about the carrot puree consistency, the NSM stated, The amount of thickening added [to pureed foods] should follow a recipe .consistency is too thick and gummy. During an interview on 2/27/24 at 9:30 a.m. with the Nutrition Service Director (NSD), the NSD Stated, Cooks should follow recipes and measure out ingredients. Not following the pureed recipe could alter the nutrition that residents receive . 51484

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50633 Based on observation, interview, and record review the facility failed to provide food storage and preparation in accordance with professional standards for food service safety when: 1. Food items in refrigerator, freezer, and dry food storage had food items that were not securely closed, did not have expiration date labels, or no label with opened date and use by date labels; 2. Clean stainless steel table pans were found stacked and stored wet on storage shelves; and 3. Two red cutting boards for meat and 1 green cutting board for vegetables had deep grooves. Theses failures had the potential of leading to food borne illness for 159 residents who are eating facility prepared foods. Findings: 1. During the initial kitchen tour on 2/24/2025, at 9 a.m., with the Nutrition Service Manager (NSM), the following was observed: The South walk-in Veg Box #2 refrigerator contained an open bag of spinach that had cellophane loosely wrapped around the spinach bag. An opened bag of shredded cheddar cheese with cellophane loosely wrapped around it. An open plastic container with pre-sliced Monterey [NAME] Cheese which was not securely sealed. An open bag of remaining pureed carrots had cellophane loosely wrapped around it. None of these opened food items had labels with Opened Date and/ or Use by Date recorded on it. During the initial kitchen tour on 2/24/2025, at 9 a.m., the walk-in freezer #4 was observed containing an open box of frozen cheese enchiladas that was stacked in the box without any plastic bag or cellophane wrap, and not securely sealed. During the initial kitchen tour on 2/24/2025, at 9 a.m., the walk-in storage room [ROOM NUMBER] containing dry foods, canned foods, some emergency response food supplies and paper kitchen supplies (i.e., paper cups, paper plates) the following was observed: Three 102 oz cans of diced red sweet peppers without any expiration date label, Two boxes of Nutri Grain breakfast bars had an expiration date of [DATE], stamped on them, Two unopened, loosely stored bags of Low Sodium Country Gravy Mix stored on the shelf without use by dates labeled on them, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Three unopened, loosely stored bags of Classic Corn Bread stuffing mix packets on shelf without use by date label/stamp, An open bag of Dry Classic Corn Bread stuffing was loosely sealed with saran wrap stored on the shelf without a use by date label on it, One loose bag of Whisk and Serve cream soup & sauce package was on the shelf without a use by date and expiration date label on it. During concurrent interview on 2/24/25 at 9 am with the NSM, the NSM stated stored open food items should be tightly sealed with a label affixed to open food item with open and use by dates written on label. NSM stated when food items are not tightly stored, there is a risk for bacterial growth as well as risk for freezer burn to froze food items. For dry stored foods, NSM stated food items stored on shelf should have expiration date labeled on the item and/or use by date label. During an interview on 2/27/25, 9:30 a.m., with the Nutrition Service Director (NSD), who oversees all Kitchen and Nutrition operations, the NSD stated that all stored foods should be tightly sealed and have labels with open dates, and use by dates written on labels, as applicable and expiration dates should also be clearly visible for all food items. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services (FNS): Food Handling Standard Operating Procedure, effective 8/1/24indicated, General food storage guidelines are followed for all stored foods including refrigerated, frozen and dry storage foods. Items stored neat and orderly, with labels facing out and expiration dates visible. Food stored .Follow Hazard Analysis Critical Control Point (HACCP) procedures for refrigerated food storage. Regarding labels, the P&P indicated, Most products contain an expiration date. The word sell-by or use-by precede the date. The use-by date is the last date that a food can be consumed. 2. During the initial kitchen tour on 2/24/25, 9:43 a.m., two rectangular stainless-steel table pans, and 1 square stainless-steel serving container had water droplets on them and were stored on the storage shelf with other clean, dry stainless-steel serving trays and containers. During initial tour and concurrent interview on 2/24/2025, 9:43 a.m., with NSM, NSM stated, The kitchen equipment should be clean and dry before storing as wet containers can breed bacterial growth and make residents sick. During an interview on 2/27/2025, 9:30 a.m., with the Nutrition Service Director (NSD) who oversees all Kitchen and Nutrition operations, NSD stated she expects NSWs to ensure clean kitchen supplies are completely dry before storing as it can be a source for bacterial growth. A review of the US Food and Drug Administration's (FDA) 2022 Food Code, section 4-901.11, titled, Equipment, Utensils, Air-Drying Required, indicated, After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining . and (B) May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During concurrent initial kitchen tour and interview on 2/24/2025 at 10 a.m., two red cutting boards used for cutting meat and 1 green cutting board used for cutting fresh produce, were observed with multiple deep cut marks on both sides of the cutting boards. NSM stated the cutting boards should be replaced as the deep grooves in the cutting board were a concern for bacterial growth. A review of the US FDA 2022 Food Code, section 4-501.12 titled, Cutting Surfaces, indicated, Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and SANITIZED or discarded if they are not capable of being resurfaced.

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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. 42255 Based on observation, interview, and record review the facility failed to ensure infection control practices were maintained for one (Resident 32) of 48 sampled Residents when: 1. Resident 32's room, with Enhanced Barrier Precautions (wearing gowns and gloves during close-contact care activities with residents with open wounds or medical devices to stop the spread of tough-to-treat infections), trash bin did not have a lid and was overflowing with used Personal Protective Equipment (PPE - items, such as gowns and gloves, worn to minimize exposure that can cause serious illnesses and healthcare workers wear to prevent contact with infectious agents or body fluids), and 2. Wound Care RN (WCRN) did not perform hand hygiene during Resident 32's wound care. These failures had the potential to spread harmful germs to patients, leading to increased risk of infections, including those resistant to antibiotics (medicines to treat bacterial infections), and potentially causing serious illness to Resident 32. Findings: 1. During a concurrent observation and interview on 2/27/25 at 10:55 a.m., with Licensed Nurse/ Infection Preventionist (LN/IP), the LN/IP confirmed the PPE trash bin was overflowing and without a lid. The LN/IP stated, They should not be that way. I don't know why the lid is missing. I will look into it .the lids prevent infection from spreading. During an interview on 2/27/25 at 12:48 p.m., with the Director of Nursing (DON). The DON stated, all rooms should have trash cans with lids. Not sure how the lid is missing. I would never expect the trash to be overflowing with PPE and the trash cans need the lids to control the spread of infection. During a review of the CDC's website, https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html, resulted on 3/3/25 at 2:33 p.m., the CDC guidance indicated, Facilities should remember to have an appropriate disposal container available in the resident room to allow for removal of PPE inside the room. 2. Resident 32 was admitted to the facility in mid-2024 with diagnoses which included stroke, hypertension (uncontrolled blood pressure), dementia (memory loss) and a stage IV pressure ulcer (full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). A review of Resident 32's most recent Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/29/24, indicated Resident 32's memory was severely impaired. During a concurrent observation and interview on 2/27/25 at 8:41 a.m., at Resident 32's bedside the WCRN was observed using the same gloves after adjusting the bedrail, positioning the resident and taking off the old wound dressing. The WCRN then used the same gloves and picked up the clean wound dressing supplies. The WCRN confirmed that she should not have used the same pair of gloves and stated, We are supposed to hand sanitize and change our gloves. (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 2/27/25 at 12:48 p.m., with the DON, the DON stated, Would expect the staff to follow hand hygiene for wound care at all times. During review of a facility policy and procedure (P&P) titled, Hand Hygiene, dated 1/2023, the P&P indicated, Health care workers shall decontaminate hands using alcohol-based hand rub or washing with soap .and water under the following circumstances. After contact with patient's intact or non-intact skin, mucous membranes, wound dressings or other objects likely to be contaminated.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 50633 3/1Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for 1 of 48 sampled residents (Resident 143) for 2 consecutive days, This failure decreased the potential for the residents to get assistance from staff in a timely manner when needed and increased potential safety risk. Findings: Resident 143 was admitted to facility in 2025 with a diagnosis of congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently) and Myocardial Infarction (a heart attack -heart muscle begins to die due to lack of sufficient blood supply and oxygen). The Admission Minimum Data Set (MDS-a standardized evaluation tool used to assess health and functional status of a resident) indicated Resident 143 was dependent with bathing, toileting, dressing, bed mobility and transfers. The MDS indicated Resident 143 was incontinent with bowel and bladder functions and had a stage 3 pressure ulcer (full-thickness loss of skin wound). The MDS assessment triggered care plan risk areas for care providers to monitor including nutrition, dehydration, impaired physical mobility, pain management, self-care deficit. During observation on 2/25/25 at 11:44 am, Resident 143's room was located down the hall from the nurse's station and around the corner at the end of the hall, in the last room on the right side. During a concurrent observation and interview, on 2/25/25 at 11:45 a.m., Resident 143 was awake lying in bed. Resident 143's call light was observed on the floor. When Resident 143 was asked if he required assistance from staff on a daily basis, Resident 143 stated he needs help with toileting and bathing and that he is incontinent. He stated that he needs assistance to sit up and when going from his bed to wheelchair. The call light remained on floor and the Surveyor activated the call light. Certified Nursing Assistant (CNA) 5 arrived in less than 5 minutes and stated the call light should be within resident's reach and not on the floor. During concurrent observation and interview the following day on 2/26/25, at 11:45 a.m., with Resident 143, Resident 143 was lying in bed and call light was observed hanging off the side of bed not within reach. Resident 143 requested to sit up. Surveyor activated Resident 143's call light for care provider assistance. In a concurrent observation and interview with CNA 2 on 2/26/25, at 11:55 a.m., in Resident 143's room, CNA 2 stated her expectation regarding patient call lights is that it should be within patient's reach to ask for assistance when needed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25, 12:00 p.m. with Licensed Nurse (LN) 1, who was caring for Resident 143, LN 1 stated her expectation for location and availability of the call light for residents was to be within reach to call for help when needed. LN 1 stated Resident 143 was dependent on assistance for all care.