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	05/07/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** Based on observation, interview and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food serve safety when:Staff did not clean two ice machines located in the hospital's main kitchen and the skilled nursing facility.Staff did not maintain several pieces of cookware in usable condition.Staff left opened packaged and prepared food items in the walkˆin refrigerator and dry storage area without required labels and dates.The metal coating of the can opener blade was worn off.Dietary staff did not follow proper refrigerator thawing procedures that allowed identification of when food was pulled from the freezer and when it should be used.Two cooks used masks instead of proper beard restraints and did not fully cover facial hair.One Nutrition Assistant (NA) could not verbalize the correct process for manual dishwashing using the 3ˆcompartment sink.These failures had the potential to cause foodˆborne illness and placed 155 of 163 medically vulnerable residents at risk.Findings:1. During a concurrent observation and interview on 5/4/26 at 11:45 a.m., Stationary Engineer (SE) 1 disassembled the top section of the ice machine in the hospital's main kitchen. He found orangeˆred slimy residue on the bottom of the evaporator unit, which felt rough and wiped off with a paper towel. SE 1 and the Chief Engineer (CE) confirmed the equipment was not clean. SE 1 reported he was not the usual person assigned to clean and sanitize the machines and that SE 2 held that responsibility. CE stated the engineering department performed monthly deep cleanings (cleaning and sanitizing the machinery parts on the top section of the ice machine and ice storage bin on the bottom section of the machine with chemical solutions designed to remove lime scale and mineral deposits and to remove algae and slime, then sanitize with chemical agent), changed water filters every six months, and the facility contracted an outside company to clean both ice machines monthly.A concurrent observation of the ice machine located in the kitchen at the skilled nursing facility and interview with SE 1 and Food-Nutrition Services Manager (FNSM) was conducted on 5/4/26 at 12:17 p.m. SE 1 disassembled the ice machine at the skilled nursing facility. He and the Foodˆ Nutrition Services Manager (FNSM) observed black slimy residue and orange buildup on the evaporator. Both substances came off with wiping and left grainy particles on the towel. FNSM confirmed the machine was not clean.During an interview with the outside company technician (OCT) on 5/5/26 at 9:10 a.m., OCT stated they got hired from the facility to do deep cleaning of the ice machines monthly. He stated he checked the ice machine at the main kitchen in hospital and found there were red/pink water marks at the evaporator unit. He verified those marks were biofilms (substances often appearing as slimy pink or black buildup, are bacterial clusters or mold that thrive in dark, moist, and cold environments within ice machines).During an interview with SE 2 on 5/5/26 at 2:15 p.m., SE 2 stated he followed manufacturer instructions to deep clean both machines and changed water filters every six months.A concurrent interview and record review on 5/5/26 at 3:46 p.m. showed work orders documenting the last deep cleans on 4/18/26 (main kitchen) and 4/12/26 (skilled nursing facility).A review of the undated facility's ice machine user manual, under Section 4: Maintenance, indicated all parts and interior surfaces of the ice machine should be clean and sanitize, includes: side walls, base (area (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	above water trough [a tray under the evaporator unit], evaporator plastic parts and bin or dispenser.According to 2022 FDA (Food and Drug Administration) Food Code, on section 4-602.11 Equipment Food-Contact Surface and Utensils, it stated equipment like ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms (a living thing that is so small it must be viewed with a microscope, such as bacteria or algae).In addition, on Section 4-202.11 Food-Contact Surfaces, it stated, .The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food-contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts. and .Multiuse Food-Contact Surfaces shall be: 1. Smooth; 2. Free of breaks, open seams, cracks, chips, inclusions, pits.2. During an observation and a concurrent interview with FNSM on 5/4/26 at 10:55 a.m., 4 of 5 cooking pans had black buildup and deep scratches. FNSM confirmed the surfaces were not smooth and stated they should be replaced.During an interview with FNSD on 5/6/26 at 9:42 a.m., FNSD stated staff should check for wear and tear and replace equipment as needed. She agreed rough cooking surfaces were difficult to clean properly.According to 2022 FDA Food Code, on section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, it stated, (A) Equipment Food-Contact Surfaces and Utensils shall be clean to sight and touch. (B) The Food-Contact Surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.In addition, on Section 4-202.11 Food-Contact Surfaces, it stated, .The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food-contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. and .Multiuse Food-Contact Surfaces shall be: 1. Smooth; 2. Free of breaks, open seams, cracks, chips, inclusions, pits.3. A concurrent observation of walk-in refrigerator and interview with FNSM was conducted on 5/4/26 at 9:56 a.m. There was food items found opened package and prepared without labeling and dating which included: a metal container of diced carrot, a metal container of gravy, a metal container of prepared flour tortilla rolls in foil, and a block of yellow cheese in surround plastic wrap. FNSM confirmed and stated the opened package or prepared food items should have label with open or prepare date and use-by date.A concurrent observation of dry storage area and interview with FNSM was conducted on 5/4/26 at 10:19 a.m. There were three opened bags of dry pasta without open date and use-by date. FNSM confirmed and stated the staff should put the label with open and use-by dates. FNSM showed there was a label printer that the staff should use to make labels for open and use-by dates. The label showed the product name, and when the food item opened and when the food item was used by.A review of departmental policy and procedure titled, Food and Nutrition [NAME] (FNS): Food Handling, dated 8/1/24, indicated food items from refrigerator, freezer and dry storage areas should be with labels and with expiration dates visible.Foods removed from the original box must be covered, labeled and dated at all times.A review of departmental training document titled, Staff Training-Food and Nutrition Services-Part 1, dated 2025, showed the example of label for opened package, should have name of food items, open or production date and use-by date, and name or initial of staff prepared the label.4. During an observation and a concurrent interview with FNSM on 5/4/26 at 10:44 a.m., FNSM observed that one of the canˆopener blades was chipped and the metal coating wore off. He stated the blade needed replacement.During an interview with FNSD on 5/6/26 at 9:42 a.m., FNSD reported she and FNSM checked the can opener monthly but she was not previously aware of the worn blade. She confirmed replacement was necessary to prevent contamination.According to 2022 FDA Food Code, Section 4-202.15 Can Openers, it indicated, Once can openers become pitted or the surface in (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized. Can openers must be designed to facilitate replacement.In addition, Section 4-501.11 Good Repair and Proper Adjustment, it indicated, .(C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened.5. During a concurrent observation and interview with FNSM on 5/4/26 at 9:38 a.m. and 10:35 a.m., at the walk-in refrigerators, found there were food items were thawing but they did not have any indicator when the food items pulled out from the freezer and when they would be used by or discarded. The food items included as follows:2 pans of cooked porkA pan of plastic containers of portioned puree green bean4 boxes of cooked sliced beef5 boxes of cooked chicken breast filletsA pan of packs of Moroccan lentil soupA box of packs of vegetable soup and few packs of vegetable soup on a [NAME] box of cooked diced chickenA box of packs of butternut squash soup2 boxes of chicken breast vegan pattiesA pan of 6 bags of raw pot roast7 boxes of raw pork loin3 loaves of raw pork loin2 boxes of raw chicken breasts5 boxes of raw turkey breasts4 pans of chicken sausage3 boxes of French toastFNSM confirmed and stated the food items mentioned above were pulled out from the freezer for thawing in the refrigerator. He stated the practice for thawing food items was the staff should put a pulled-out date and a use-by date. FNSM agreed and stated if the thawing items were without any indicators, it would be hard to identify when the food items were pulled out from the freezer and when they would be used or discarded. FNSM showed their practice to monitor the thawing food with the label system Pull to Thaw which the label included date and time for thawing and date and time to be used. He agreed the dietary staff did not practice the thawing system properly. He further stated the staff needed to be re-trained.During an interview with FNSD at 5/6/26 at 9:42 a.m., FNSD acknowledged and stated the Pull to Thaw was the practice and the staff should follow. She further stated the staff needed to be re-trained regarding the thawing procedure.According to 2022 FDA Food Code, Annex 3, it indicated, .Food which is.thawed must be controlled by date marking to ensure its safety based on the total amount of time it was held at refrigeration temperature, and the opportunity for [bacteria] to multiply, before freezing and after thawing.6. During the initial kitchen and follow-up observations on 5/4/26 at 11:07 a.m., and 5/5/26 at 11:40 a.m., observed [NAME] (CK) 1 and CK 2 prepared food while wearing medical masks as beard restraints. Their facial hair remained exposed on both sides.During an interview with FNSM on 5/5/26 at 12:36 p.m., FNSM confirmed and stated the facial hair should be fully covered.During an interview with FNSD on 5/6/26 at 9:42 a.m., FNSD stated they did not have a policy and procedure for facial hair restraint, but she agreed the facial hair should not be exposed and should be fully covered.According to 2022 FDA Food Code, Section 2-402 Hair Restraints, 2-402.11 Effectiveness, it indicated, .Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.7. During an interview with Nutrition Assistant (NA) 1 on 5/4/26 at 1:53 p.m. regarding the process of manual dishwashing with 3-compartment sink, NA 1 explained the process. NA 1 stated she would start to scrape the food residue to the trash bin, then soaked and washed the dishes in the wash sink, then rinsed the dishes in the rinse sink, next to sanitize the dishes in the sanitize sink and the last step was to air-dry. She stated the water temperature for washing should be 160 degrees Fahrenheit (F) and the immersion time for sanitizing the dishes should be 10 seconds in the sanitizer. NA 1 reviewed the posted instruction poster titled, Scout Pot & Pan Wash Procedure, and she switched her answer of immersion time for sanitizing the dishes which should be one minute.A concurrent interview with FNSM, he stated the water temperature for washing should be 120 degrees F and the immersion time for sanitizing should be one minute. FNSM stated the new staff got hands-on training for manual dishwashing with the senior nutrition assistant, and there were competency tests for the staff to be sure their skills were updated and competent.During an interview with FNSD on 5/6/25 at 9:42 a.m., FNSD stated the dishwasher staff should have good (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	knowledge about the procedure of manual dishwashing. She stated there was an instruction on the bottom of the 3-compartment skin temperature and PPM (part per millions - a measure unit for sanitizer concentration) log which showed the wash water temperature should be at least 110 degrees F. She further stated the staff needed to be re-trained.A review of undated departmental document titled, Pot-Sink Temp Sanitizer Log, indicated, .the 1st (wash) sink temperature must be at a minimum of 110 degrees F.A review of departmental training material titled, Staff Training - Food and Nutrition Services - Part 1, dated 2025, indicated washing sink (with detergent) with minimum water temperature of 110 degrees F and the immersion time should be one minute for quaternary ammonium sanitizer.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive, personˆcentered care plan for two of 35 sampled residents (Resident 163 and 106), when:The facility placed Resident 163 on Enhanced Barrier Precautions (EBP- an infectionˆcontrol intervention used to reduce transmission of multidrugˆresistant organisms through targeted gown and glove use) and not initiate a care plan.Resident 106's care plan for EBP and for the use of Peripherally Inserted Central Catheter (PICC line- a long, flexible tube inserted into a large vein, typically in the upper arm, and threaded to a central vein above the heart, and is used for long-term intravenous treatments such as antibiotics) were not developed.These failures had the risks for Resident 163 and Resident 106 not to receive appropriate and needed care and have the potential for Resident 163 and 106 not to achieve their highest practicable well-being.Findings: During a review of Resident 163's clinical record, Resident 163 was admitted on [DATE] with the diagnosis that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), recurrent Methicillin-resistant Staphylococcus aureus (MRSA- a type of bacterium (staph germ) that has developed resistance to many common antibiotics) bacteremia (the presence of bacteria in the bloodstream), venous ulcer (slow-healing, open wounds). During a review of Resident 163's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 4/13/26, Resident 163 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 163 had intact cognition. During an interview on 5/5/26 at 11:40 a.m. with Infection Preventionist (IP), the IP confirmed resident 163 was on EBP. During an interview on 5/7/26 at 8:57 a.m. with Licensed Nurse Manager (LN) 6, LN 6 confirmed that Resident 163 was not care planned for EBP. LN 6 stated that residents placed on EBP are supposed to have this intervention included in their care plan. During an interview on 5/7/26 at 9:04 a.m. with the Director of Nursing (DON), the DON stated residents on EBP should be care planned for it. During a review of the facility's policy titled, Interdisciplinary Care Plan, dated 2/28/19, the policy stipulated, . The admission Nursing Evaluation and the Initial Resident Care Plans will identify specific resident problems and specific interventions. and will also identify basic, standard nursing interventions as appropriate. Continued and prompt documentation shall be made in the Care Plan, as needs or changes of conditions are identified. The Care Plan is to be a reflection of the current and ongoing identified resident needs. 2. A review of Resident 106's clinical record indicated Resident 106 was previously admitted in June of 2020 and had diagnoses that included neutropenia (condition characterized by an abnormally low count of white blood cell, which is essential for fighting bacterial infection), and stage 4 pressure ulcer (a severe, full-thickness wound involving extensive tissue loss with exposed muscle, tendon, or bone, requiring urgent, specialized medical care.) A review of Resident 106's MDS Cognitive Patterns, dated 4/22/26, indicated Resident 106 had a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BIMS score of 14 out of 15 which indicated Resident 106 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 106's Skin Conditions, dated 4/22/26, indicated Resident 106 had an unhealed stage 4 pressure ulcer. A review of Resident 106's active physician's order, dated 4/28/26, indicated, may have [company name] insert a . PICC line. A review of Resident 106's active physician's order, dated 4/29/26, indicated, cefepime [a strong antibiotic used to treat moderate to severe bacterial infection] 2,000 mg [milligrams- unit of measurement], IV, Bag, q12hr [every 12 hours] Routine, Indication: .wound culture+ [positive] pseudomonas [a specific bacteria that causes infection on skin, ears, lungs, or wounds, particularly in hospitalized or immunocompromised individuals which require targeted antibiotics due to drug resistance] .for 10 Day . During a concurrent observation and interview on 5/5/26 at 9:35 a.m. with LN 1 in Resident 106's room, LN 1 confirmed that Resident 106 has a PICC line on her right upper arm and was on EBP. A review of the facility document titled, ENHANCED BARRIER PRECAUTIONS ., provided by the Infection Preventionist on 5/6/26, indicated Resident 106 was on EBP. During an interview on 5/6/26 at 9:03 a.m. with LN 4, LN 4 stated that if a resident has a PICC line and placed on EBP, both care plan for PICC line use and EBP should be developed and initiated because the plan of care would be the guide for staff on how to care for the resident. During a concurrent interview and record review on 5/6/26 at 9:15 a.m. with LN 3, Resident 106's medical records were reviewed. LN 3 confirmed that Resident 106 was on EBP but was not included in her care plan. LN 3 also confirmed that Resident 106 uses PICC line for IV antibiotic therapy but was not included in her care plan. LN 3 stated Resident 106 should have a care plan for PICC line use and EBP so staff would be aware and would follow Resident 106's plan of care. During an interview on 5/6/26 at 2:50 p.m. with the Nurse Manger/ Infection Preventionist (NM/IP), the NM/IP stated that PICC line use and EBP should have been a part of Resident 106's plan of care because these are essential part of the care given to Resident 106. During an interview on 5/6/26 at 3:04 p.m. with the DON, the DON stated that PICC line use and EBP should be part of a resident's plan of care. A review of the facility's policy and procedures titled, Bruceville Terrace: Interdisciplinary Care Plan, dated 2/28/19, indicated, E. The Care Plan shall indicate the care to be given, the goals/objectives to be accomplished and the professional discipline responsible for each element of care .Each Care Plan shall have approaches relevant to accomplishing the goal. The approaches shall reflect all professional disciplines responsible for assisting the resident in accomplishing the goal and the frequency of approach shall be stated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure biologicals were stored in accordance with the facility's policies and procedures (P&P), and accepted professional principles for a census of 163 when 11 packets of expired food thickeners (specialized powders or gels that instantly increase the viscosity of hot or cold liquids and foods primarily designed to achieve safe, consistent textures for individuals with difficulty swallowing) were found stored in D station medication cart 1.This failure created the potential for residents to receive biologicals that were expired or with unsafe or reduced potency which could have caused unwanted effects to the residents. Findings:During a concurrent observation and interview that began on 5/5/26 at 1:15 p.m. with Licensed Nurse (LN) 2, of the D station medication cart 1, 11 packets of expired food thickeners were found stored in the medication cart. LN 2 confirmed the finding and stated that expired food thickeners should not be stored in medication carts. LN 2 also stated they use food thickeners to thicken liquids for residents who would need thickened liquids for medication administration. LN 2 further stated the expired food thickeners could cause undesired effects or reactions to the residents like upset stomach, diarrhea, or vomiting.During an interview on 5/6/26 at 2:21 p.m. with the Facility Pharmacist (FP), the FP stated that expired food thickeners should not be stored in the medication carts and should be thrown out because they could have caused adverse effects if accidentally administered.During an interview on 5/6/26 at 3:04 p.m. with the Director of Nursing (DON), the DON stated the expired food thickeners should be thrown away and not stored in medication carts because they might get administered to the residents.A review of the facility's P&P titled, Medication Control & Storage Inspection, revised 4/25/24, indicated, .To insure [sic] the inspection of all medication storage areas (e.g. any areas in which medications are dispensed, administered or stored) on a monthly basis to ensure proper storage conditions, security, drug availability, expiration date and other safety factors are met .4. Outdated floor stock medications and IV's are to be returned to pharmacy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 163 when;1.A facility staff did not wear required personal protective equipment (PPE) when accessing and using the Peripherally Inserted Central Catheter (PICC line- a type of central line which is inserted into a large vein, typically in the upper arm, and threaded to a central vein above the heart, and is used for long-term intravenous treatments such as antibiotics) of Resident 130 who was on enhanced barrier precaution (EBP- also known as enhanced standard precaution/ESP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use);2.The facility did not communicate which residents were on EBP to all staff, and there was no EBP order for Resident^163; and,3. One glucometer (blood sugar monitor device that measures glucose levels) had a red smear on it and two glucometers were soiled with blue smears out of twelve glucometers.These failures had the potential to spread germs and cause infections for a census of 163. 1. A review of Resident 106's clinical record indicated Resident 106 was previously admitted in June of 2020 and had diagnoses that included neutropenia (condition characterized by an abnormally low count of white blood cell, which is essential for fighting bacterial infection), and stage 4 pressure ulcer (a severe, full-thickness wound involving extensive tissue loss with exposed muscle, tendon, or bone, requiring urgent, specialized medical care.) A review of Resident 106's Minimum Data Set (MDS– a federally mandated resident assessment tool) Cognitive Patterns, dated 4/22/26, indicated Resident 106 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 14 out of 15 which indicated Resident 106 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 106's Skin Conditions, dated 4/22/26, indicated Resident 106 had an unhealed stage 4 pressure ulcer. A review of Resident 106's active physician's order, dated 4/28/26, indicated, may have [company name] insert a .PICC line. During a medication administration observation which started on 5/5/26 at 9:22 a.m. with Licensed Nurse (LN) 1 in Resident 106's room, LN 1 was observed administering IV antibiotic to Resident 106 through her PICC line on her right upper arm. LN 1 was observed handling and using Resident 106's PICC line while only using gloves. There was an EBP signage posted outside of Resident 106's room which indicated, STOP .ENHANCE BARRIER PRECAUTIONS .PROVIDERS AND STAFF MUST .Wear gloves and a gown for the following High-Contact Resident Care Activities .Device care or use: central line . During a subsequent interview on 5/5/26 at 9:35 a.m. with LN 1, LN 1 confirmed that she only wore gloves and did not wear gown while handling and using Resident 106's PICC line. LN 1 confirmed Resident 106 was on EBP. LN 1 stated she should have worn both gloves and gown when using and caring for Resident 106's PICC line to prevent possible transfer of microorganisms to Resident 106. A review of the facility document titled, ENHANCED BARRIER PRECAUTIONS ., provided by the Infection Preventionist on 5/6/26, indicated Resident 106 was on EBP. During a concurrent interview and record review on 5/6/26 at 9:15 a.m. with Licensed Nurse (LN) 3, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 106's medical records were reviewed. LN 3 confirmed that Resident 106 was on EBP but was not included in her care plan. LN 3 stated Resident 106 should have a care plan for EBP so staff would be aware and would follow Resident 106's plan of care. During an interview on 5/6/26 at 10:55 a.m. with the Infection Preventionist (IP), the IP stated they do not obtain a physician's order for residents who are on EBP. During an interview on 5/6/26 at 2:50 p.m. with the Nurse Manger/ Infection Preventionist (NM/IP), the NM/IP stated staff should be using both gloves and gown when caring and using the resident's PICC line to prevent possible infection of the resident. During an interview on 5/6/26 at 3:04 p.m. with the Director of Nursing (DON), the DON stated staff should be wearing the required PPE for residents who were on EBP for infection control. A review of the facility's policy and procedures titled, Bruceville Terrace: Enhanced Barrier Precautions, dated 2/25/25, indicated, 2. Initiation of Enhanced Barrier Precautions: .b. An order for enhanced barrier precautions will be obtained for residents with any of the following: .indwelling medical devices (.central lines .) .even if the resident is not known to be infected or colonized with a MDRO .3. Implementation of Enhanced Barrier Precautions: .b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room .4. 4. High-contact resident care activities include: .vii. Device care or use: central lines .PICC lines . 2. During a review of Resident 163's clinical record, Resident 163 was admitted on [DATE] with the diagnosis that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), recurrent Methicillin-resistant Staphylococcus aureus (MRSA- a type of bacterium (staph germ) that has developed resistance to many common antibiotics) bacteremia (the presence of bacteria in the bloodstream), venous ulcer (slow-healing, open wounds). A review of Resident 163's orders revealed there was no order for EBP. During an interview on 5/4/26 at 10:30 a.m. with LN 8, LN 8 stated they were unsure whether Resident^163 was on EBP. During an interview on 5/4/26 at 10:44 a.m. with the IP, the IP confirmed Resident^163 was on EBP and that EBP signs are posted outside the doors of residents on EBP. The IP confirmed resident 163's room did not have an EBP sign posted. The IP indicated that without the sign, staff may not know the resident is on EBP and may fail to gown and glove, which could lead to infection spread. During a follow up interview on 5/4/26 at 11:40 a.m. with the IP, the IP stated they do not obtain EBP orders for residents on EBP. During an interview on 5/7/26 at 9:04 a.m. with the Director of Nursing (DON), the DON stated the expectation is that EBP signs are posted on the doors of residents who are on EBP. During a review of the facility's policy titled, Enhanced Barrier Precautions, revised 2025, the policy indicated .the facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which resident require the use of EBP.An order for enhanced barrier precautions will be obtained for residents with. Multidrug-resistant organisms (MDRO- bacteria and other microorganisms, [including MRSA] that are resistant to at least three (continued on next page)

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	555344	A. Building B. Wing	05/07/2026

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	classes of antibiotics). 3. During a concurrent observation and interview with LN 7 and the Director of Staff of Development (DSD), on 5/6/26 at 9:55 a.m. at Nursing Station B, one glucometer had a red smear at the top. LN 7 disinfected the red smear, and the DSD stated it was most likely blood and not cleaned properly. During a concurrent observation and interview on 5/6/26 at 10 a.m. at Nursing Station C, two glucometers had blue smears on the top. LN 6 at Nursing Station C verified the blue smears were on the top of the glucometers and stated it was the control solution (control solution is to ensure the accuracy of the blood glucose monitoring system, confirming that the meter and strips are performing within designated ranges). During an interview on 5/6/26 at 10:20 a.m. with the IP, the IP stated staff are supposed to clean the glucometers after every use, and after the control solution is used. The IP further stated that the consequences of not cleaning can be an infection. During a review of the facility's policy and procedure (P&P) titled, Bruceville Terrace: Glucometer Disinfection, dated April 2025, the P&P indicated, The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure that staff delivered intravenous (IV) therapy (administration of fluids or medications into the vein) was consistent with standards of practice and the facility's policy and procedures (P&P) for one out of 35 sampled residents (Resident 106) when Resident 106's Peripherally Inserted Central Catheter (PICC line- a long, flexible tube inserted into a large vein, typically in the upper arm, and threaded to a vein above the heart, and is used for long-term intravenous treatments such as antibiotics) hub (the external plastic junction connecting the catheter to extension tubes) was not scrubbed with antiseptic pad before use.This failure created the potential for unsafe IV therapy delivery, possible infection, and prevented Resident 106 from achieving the highest practicable well-being.Findings:A review of Resident 106's clinical record indicated Resident 106 was previously admitted in June of 2020 and had diagnoses that included neutropenia (condition characterized by an abnormally low count of white blood cell, which is essential for fighting bacterial infection), and stage 4 pressure ulcer (a severe, full-thickness wound involving extensive tissue loss with exposed muscle, tendon, or bone, requiring urgent, specialized medical care.)A review of Resident 106's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 4/22/26, indicated Resident 106 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 14 out of 15 which indicated Resident 106 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 106's Skin Conditions, dated 4/22/26, indicated Resident 106 had an unhealed stage 4 pressure ulcer.A review of Resident 106's active physician's order, dated 4/28/26, indicated, may have [company name] insert a . PICC line.A review of Resident 106's active physician's order, dated 4/29/26, indicated, cefepime [a strong antibiotic used to treat moderate to severe bacterial infection] 2,000 mg [milligrams- unit of measurement], IV, Bag, q12hr [every 12 hours] Routine, Indication: .wound culture+ [positive] pseudomonas [a specific bacteria that causes infection on skin, ears, lungs, or wounds, particularly in hospitalized or immunocompromised individuals which require targeted antibiotics due to drug resistance] .for 10 Day .During a medication administration observation which started on 5/5/26 at 9:22 a.m. with Licensed Nurse (LN) 1, LN 1 was observed administering cefepime IV antibiotic to Resident 106 through her PICC line on her right upper arm. LN 1 did not scrub Resident 106's PICC line hub with antiseptic pad before flushing the line with 10 ml [milliliters- unit of measurement] saline flush [a salt and water solution used to clear IV catheters, maintaining patency and preventing blockages or infections] and reconnecting the cefepime IV antibiotic to Resident 106's PICC line. During a subsequent interview on 5/5/26 at 9:35 a.m. with LN 1, LN 1 confirmed that she did not scrub Resident 106's PICC line hub with antiseptic pad before flushing the line with 10 ml saline flush and reconnecting the cefepime IV antibiotic to Resident 106's PICC line. LN 1 stated she should have wiped Resident 106's PICC line hub before using it to disinfect the hub and prevent introduction of microorganism to the line which could cause infection or other complications.During a concurrent interview and record review on 5/6/26 at 9:15 a.m. with LN 3, Resident 106's medical records were reviewed. LN 3 confirmed that Resident 106's use of PICC line was not care planned. LN 3 stated Resident 106 should have a care plan for the use of PICC line so staff would be aware about it and would have a plan of care to follow.During an interview on 5/6/26 at 2:50 p.m. with the Nurse Manger/ Infection Preventionist (NM/IP), the NM/IP stated that nurses should always clean the PICC line hub every time they access and use the PICC line to prevent possible infection or other complications. During an interview on 5/6/26 at 3:04 p.m. with the Director of Nursing (DON), the DON stated the PICC line hub should always be scrubbed with antiseptic before accessing and using it to prevent possible infection issues.A review of the facility's P&P titled, Bruceville Terrace: Care and Maintenance of Central Venous Catheter, undated, indicated, 9. Scrub the hub (i.e. [in example] cap) of all access ports prior to use. Scrub for at least 5 seconds using antiseptic pad (chlorhexidine-based, povidone-iodine, or alcohol pad).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices were followed when the facility's medication error rate was more than 5% (percentage- number or ratio that expressed as a fraction of 100) for a resident census of 163. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of two errors out of 30 opportunities which resulted in a facility wide medication error rate of 6.67% in one out of 9 residents (Resident 125) observed for medication administration.These failures had the potential for unsafe and ineffective medication therapy of Resident 125 and had the potential to negatively affect the residents' medical conditions.Findings:During a medication administration observation which started on 5/5/26 at 10:41 a.m. with Licensed Nurse (LN) 5, LN 5 administered a total of five pills to Resident 125 which included 1 capsule of docusate sodium (a medication utilized for managing and treating infrequent or difficult bowel movements) 100 mg (milligrams- unit of measurement), and 1 tablet of naloxegol (a medication used to treat medication-induced constipation) 12.5 mg.A review of Resident 125's active physician's order, dated 8/15/23, indicated, Docusate (docusate sodium) 100 mg, PO (by mouth), Cap (capsule), BID (twice a day) Routine, Indication: constipation .A review of Resident 125's active physician's order, dated 8/14/23, indicated, Naloxegol .12.5 mg, PO, tab [tablet], qAM [every morning], Indication: constipation .A review of Resident 125'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 May 2026 indicated Resident 125's morning dose of docusate sodium and naloxegol were scheduled at 8 a.m., and were both signed as administered at 10:50 a.m.A review of Resident 125's nursing progress notes, dated 5/5/26, indicated, Patient [Resident 125] last BM [bowel movement] noted on 5/3/26 .During an interview on 5/5/26 at 1:07 p.m. with LN 5, LN 5 acknowledged that the observed medication administration of docusate sodium and naloxegol to Resident 125 were late. LN 5 stated Resident 125 was constipated. LN 5 also stated medication administration should be an hour before or after the scheduled time of administration to maintain therapeutic level (concentration of a medication in the body that is high enough to produce the desired medical effect without causing significant side effects) of medication in the resident.During a concurrent interview and record review on 5/6/26 at 2:21 p.m. with the Facility Pharmacist (FP), Resident 125's clinical records were reviewed. The FP confirmed that Resident 125's docusate sodium and naloxegol were administered late. The FP stated nurses should administer medication within the time frame of the scheduled administration in order for the medication therapy to be effective.During an interview on 5/6/26 at 3:04 p.m. with the Director of Nursing (DON), the DON stated that nurses should administer medications to residents within the time allowance of the scheduled administration time.A review of the facility's policies and procedures titled, Medication Management: Administration, dated 110/2017, indicated, 25. Non-time-critical scheduled medications .have a different timewindow for administration. a. Medications prescribed for daily, weekly or monthly administration may be within 2 hours before or afterthe scheduled dosing time, for a total window that does not exceed 4 hours. b. Medications prescribed more frequently than daily but no more frequently than every 4 hours may be administered within 1 hour before or after the scheduled dosing time, for a total window that does not exceed 2 hours.A review of the facility's Medication Administration Schedule, dated 8/22/19, indicated, .Facility schedule for the administration of medications .Daily .0800 [8 a.m.] BID .0800 .1700 [5 p.m.] .A review of the facility's Medication Administration Schedule, dated 8/22/19, indicated, .Facility schedule for the administration of medications .Daily .0800 [8 a.m.] .BID .0800 .1700 [5 p.m.] .