STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
American River Center	3900 Garfield Avenue Carmichael, CA 95608

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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. Based on observation, interview, and record review, the facility failed to follow the professional standards of food service safety for a census of 98 residents, when: 1. Two thermometers, one manual and one digital, were not in good working condition; and 2. Weekly thermometer calibration was not done and not documented in the thermometer log binder. These failures had the potential for inaccurate thermometer readings and the time/temperature control for food safety not accurately monitored and increased the risks of food-borne illnesses. During a concurrent observation, interview, and record review on 4/8/26 at 9:30 a.m., the kitchen thermometers used for food preparation were inspected. [NAME] 1 (CK 1) demonstrated how to calibrate the thermometers. CK 1 indicated, two thermometers, one manual and one digital were not in good working conditions. The thermometer log binder did not indicate the thermometers were calibrated weekly. During a concurrent observation, interview, and record review on 4/8/26 at 9:35 a.m. with the Certified Dietary Manager (CDM), the CDM confirmed thermometer calibration was not documented weekly, and two thermometers were not in good working conditions. The CDM stated thermometer calibration was important to ensure accurate temperature readings to prevent food borne illness caused by undercook food. The CDM confirmed regular or weekly calibration corrected errors caused by daily thermometer use, drop or extreme food temperature shifts, ensured consistent quality cooking and food safety compliance. During an interview on 4/8/26 at 9:40 a.m. with CK 1, CK 1 stated calibrating the thermometers were done to ensure the temperature of the food was correct. CK 1 stated accurate temperatures were essential to ensure food was cooked or stored at safe levels, and inaccurate readings allowed bacterial growth. During an interview on 4/10/26 at 10:28 a.m. with the Registered Dietician (RD), the RD stated her expectation was for the kitchen staff to calibrate the thermometers weekly and calibration readings were recorded. The RD stated not regularly calibrating the thermometers would not give the correct or accurate readings. The RD stated food temperature shifts, too high and too low, and not properly monitored temperatures increased safety risks primarily caused by rapid bacterial growth. The RD stated all thermometers should be in good working conditions. A review of the facility's policy and procedure (P&P) titled, Food Preparation, revised 2/25, the P&P indicated, Thermometers in use should be tested and calibrated at least once a week for accuracy.

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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(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 observation, interview, and record review, the facility failed to provide care and services in accordance with acceptable professional standards of quality for two of 24 sampled residents (Residents 22 and 72), when: 1. Resident 72 was not observed during the entire medication pass to ensure medications were completely administered; and 2. Nursing staff did not use multiple strategies to administer Humalog KwikPen (a fast-acting insulin to treat diabetes) for Resident 22. These failures resulted in Resident 22 and Resident 72's not receiving their medications and had the potential to result in worsening of their clinical conditions.Findings: 1. During a medication pass observation on 4/7/26 at 8:41 a.m. with Licensed Nurse 2 (LN 2), LN 2 prepared eleven medications for Resident 72 including ClearLax (a medication used to treat constipation). LN 2 measured the ClearLax powder, poured it into a plastic cup, poured approximately 6 ounces lemonade into it and mixed until the powder dissolved. During the same medication pass observation on 4/7/26 at 8:48 a.m. with LN 2, LN 2 entered Resident 72's room and handed her the prepared pills and the cup that contained the ClearLax lemonade mixture. Resident 72 took all the pills with sips of ClearLax in between. Once Resident 72 had finished taking all the pills, approximately half of the ClearLax mixture remained in the cup. LN 2 exited the room before Resident 72 had finished consuming the remaining half of the ClearLax solution, leaving her with the medication in hand. Resident 72 did not consume the rest of the medication During an interview on 4/7/26 at 3 p.m. with LN 2, LN 2 stated he did not recall leaving Resident 72 with the ClearLax solution half drunk. During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines, dated 10/2017, the P&P indicated, Procedures.B. Administration.15) The resident is always observed after administration to ensure that the dose was completely ingested. 2. During a medication pass observation on 4/7/26 at 11:40 a.m. with LN 2, LN 2 prepared Humalog KwikPen for Resident 22. LN 2 entered Resident 22's room, measured the resident's blood sugar, and stated it was 177 milligrams per deciliter (mg/dL, a unit of measurement). During the same medication pass observation on 4/7/26 at 11:48 a.m. with LN 2, LN 2 prepared Humalog 10 units at the medication cart. While LN 2 prepared the medication, Resident 22 was heard yelling in her native tongue in an agitated tone. LN 2 entered the resident's room with the insulin and stated to her that he was going to administer it in her abdomen. Resident 22 was seated in a wheelchair when LN 2 bent over and reached down to lift Resident 22's sweater. Resident 22 pushed his hand away. LN 2 stood up and stated she had refused the medication and made no further attempts to administer Resident 22's insulin. He stated if the resident was wearing a short sleeve shirt he would have tried to inject it in the back of her arm. LN 2 stated he would take the resident to the dining room and wheeled her out of her room. During an interview on 4/7/26 at 2:45 p.m. with the Assistant Director of Nursing (ADON), the ADON stated nursing staff were expected to obtain a translation device that was available for staff to use with residents whenever there was a language barrier. The ADON stated a resident pushing the nurse's hand away was not considered a refusal of medication. The ADON stated the nurse should have made additional attempts to administer Resident 22's medication by getting another staff member to help calm the resident because it was a very important medication. During an interview on 4/7/26 at 3:05 p.m. with LN 2, LN 2 stated he was aware of the translation device but stated he did not choose to use it. He confirmed he did not make any additional attempts to administer Resident 22's insulin after the earlier observation. During an interview on 4/8/26 at 2:06 p.m. with LN 2, LN 2 stated when a resident resisted medication administration, other strategies such as trying a different environment or a different time or a familiar face could help a resident feel at ease to take their medications. During an interview on 4/8/26 at 2:44 p.m. with the ADON, the ADON stated nursing staff were expected to make more than one attempt to administer medication if a resident was resistant. She stated nursing staff were expected to explain the risks and benefits of a medication to a resident to help them be more compliant with medication administration. During a review of the facility's P&P titled, Preparation and General (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Guidelines IIA2: Medication Administration- General Guidelines, dated 10/2017, the P&P indicated, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices. During a review of the facility's P&P titled, Requesting, Refusing, and/or Discontinuing Care or Treatment, revised 11/2025, the P&P indicated, Policy Interpretation and Implementation. 9. Documentation pertaining to a resident's request, discontinuation, or refusal of treatment includes at least the following. c. The resident's response and stated reason(s) for request, discontinuation, or refusal. e. That the resident was informed (to the extent of their ability to understand) of the purpose of the treatment and the potential outcome of not receiving the medication/or treatment f. The resident's condition and any adverse effects due to the request.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure medications for disposal were not rendered unusable, irretrievable, and were not securely stored when red sharps containers with open lids were used to dispose of medication in 2 of 2 medication carts inspected; and medications with discontinued orders were not removed from facility drug supply and destroyed in a timely manner. These failures had the potential to result in medication errors and adverse events from residents receiving discontinued medications and the potential for diversion (the illegal transfer, theft, or misuse of medications) from medications not being disposed of timely.Findings: 1. During an inspection on 4/7/26 at 10:27 a.m. of Station 1 Medication Cart 2 alongside Licensed Nurse 1 (LN 1), a red sharps container with the lid open filled with whole tablets was observed. LN 1 stated nursing staff were to dispose of dropped or refused doses of non-narcotic medication in the sharps container. LN 1 agreed the medications could be easily removed from the container and were not irretrievable. During an inspection on 4/7/26 at 10:58 a.m. of Station 2 Medication Cart 2 alongside LN 2, a red sharps container (identical to the container in Station 1 Medication Cart 2) with the lid open filled with whole tablets was observed. LN 2 stated nursing staff were to dispose of dropped or refused doses of non-narcotic medication in that container. During an interview on 4/7/26 at 2:35 p.m. with the Assistant Director of Nursing (ADON), the ADON stated nursing staff disposed of dropped or refused doses of non-narcotic medication in the sharps containers stored in the medication carts. The ADON confirmed the medications were not non-retrievable using that method of disposal. During an interview on 4/8/26 at 11:33 a.m. with the Consultant Pharmacist (CP), the CP stated it was her understanding that nursing staff were to dispose of dropped or refused non-narcotic medications in a designated disposal container with a substance such as coffee grounds, hand sanitizer or soap in it to make it irretrievable. The CP acknowledged and confirmed the pills should have been disposed of in a manner that would have allowed staff or residents to have the ability to easily pour them out in their original form. During a review of the facility's policy and procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies, revised 1/2025, the P&P indicated, Procedures A. All medications are placed in the proper waste container per facility policy.Date of first use to be recorded on the waste container.C. Non-controlled medication destruction occurs in the presence of two licensed nurses. 3. During an inspection on 4/7/26 at approximately 11 a.m. of Station 2 Cart 2 with LN 2, one bubble pack containing clonazepam (a medication to treat anxiety) for Resident 14 was identified in the separately locked narcotics compartment. A review of Resident 14's medical record indicated a physician's order for clonazepam 0.5 milligram (mg, a unit of measurement), give 1 tablet by mouth at bedtime for anxiety manifested by inability to sleep, discontinued December 2025. During a concurrent interview and record review on 4/7/26 at 2:31 p.m. with the ADON, Resident 14's clonazepam order was reviewed. The ADON confirmed the medication was discontinued in December 2025. The ADON stated the expectation was once medication was discontinued, it was to be given to the Director of Nursing (DON). The ADON stated discontinued medications should not have been in the medication cart. During an interview on 4/8/26 at 11:37 a.m. with the CP, the CP stated nursing staff were expected to give discontinued controlled (those with high potential for abuse or addiction) medications to the DON at end of their shift. The CP stated as soon as the medication was discontinued and nursing staff saw it in the Medication Administration Record, the medication should be set aside and given to the DON. During a review of the facility's P&P titled, Disposal of Medications and Medication-Related Supplies, dated 10/2017, the P&P indicated, Procedures.E. Medication is destroyed within 90 days from the date the medication was discontinued.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure two of 24 sampled residents (Residents 50 and 76) were free of significant medication errors when: Resident 50 received dorzolamide (a medication to treat high eye pressure in glaucoma, a group of eye diseases that causes high fluid pressure inside the eye, leading to permanent vision loss or blindness if untreated) ophthalmic (eye) solution 18 times (doses) and latanoprost (a medication to treat high eye pressure) six times, past the expiration date; andResident 76 received fluticasone/salmeterol (a medication to chronic obstructive pulmonary disease (COPD), a progressive, long-term lung disease that makes it hard to breathe) 37 times, past the expiration date. These deficient practices had the potential for ineffective use of medications for Resident 50 and 76 resulting in complications and worsening of their clinical conditions such as permanent, irreversible vision loss leading to blindness and acute, life-threatening attacks and respiratory failure to long-term structural airway remodeling, chronic cough, and reduced lung function.Findings: 1. During an inspection on 4/7/26 at 10:09 a.m. of Station 1 Medication Cart 2 alongside Licensed Nurse 1 (LN 1), one bottle dorzolamide 2% ophthalmic solution and one bottle latanoprost 0.005% ophthalmic solution, both labeled discard 4/1/26, for Resident 50 were identified. LN 1 looked in the medication cart (med cart) to see if another vial of either eye drop was available for administration and stated, I don't see it. A review of Resident 50's medical record indicated the following physician's orders:Dorzolamide 2% ophthalmic solution: Instill 1 drop in both eyes three times a day for ocular hypertension, dated 3/2/26; and Latanoprost 0.005% ophthalmic solution: Instill 1 drop in both eyes at bedtime for glaucoma, dated 3/2/26. During a concurrent interview and record review on 4/7/26 at 10:30 a.m. with LN 1, Resident 50's Medication Administration Record (MAR) dated April 2026 was reviewed. LN 1 confirmed the MAR indicated Resident 50 received doses of expired dorzolamide eye drops on the following dates: 3 doses on 4/1/26, 2 doses on 4/2/26, 3 doses on 4/3/26, 3 doses on 4/4/26, 3 doses on 4/5/26, 3 doses on 4/6/26, and one dose on 4/7/26. This was a total of 18 doses of expired dorzolamide. LN 1 confirmed the MAR indicated Resident 50 received doses of expired latanoprost eye drops on the follow dates: 4/1/26, 4/2/26, 4/3/26, 4/4/26, 4/5/26, and 4/6/26. This was a total of six doses of expired latanoprost eye drops. LN 1 stated expired medications were potentially not as effective and the resident could have had complications from them not treating the conditions they were prescribed for. She stated nursing staff were expected to check the expiration date of a medication when preparing it. 2. During the same med cart inspection on 4/7/26 at 10:09 a.m. with LN 1, one fluticasone/salmeterol 250/50 microgram (mcg, a unit of measurement) inhaler opened 2/20/26, for Resident 76 was identified. LN 1 reviewed the manufacturer's labeling on the package and confirmed it indicated to discard the inhaler one month after opening the foil container. LN 1 confirmed the inhaler expired 3/20/26. She inspected the cart and identified a second identical inhaler for Resident 76, however it was unopened. LN 1 confirmed the opened inhaler was the one nursing staff used to administer the medication to Resident 76. A review of Resident 76's medical record indicated a physician's order for fluticasone/salmeterol 250/50 mcg inhaler, inhale 1 puff orally two times a day for COPD rinse mouth after use, ordered 2/19/26. During a concurrent interview and record review on 4/7/26 at 10:39 a.m. with LN 1, Resident 76's MAR dated March and April 2026 were reviewed. LN 1 confirmed the MAR indicated Resident 76 received doses of expired fluticasone/salmeterol twice daily since it expired on 3/20/26. This was a total of 37 doses of expired fluticasone/salmeterol. During an interview on 4/7/26 at 2:22 p.m. with the Assistant Director of Nursing (ADON), the ADON stated nursing staff were expected to check expiration dates of medications as part of the medication preparation process. During an interview on 4/7/26 at 11:20 a.m. with the Consultant Pharmacist (CP), the CP stated medications may not have been 100% efficacious beyond their expiration date and could potentially result in adverse effects if used after they (medications) were expired. During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines IIA2: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Administration- General Guidelines, dated 10/2017, the P&P indicated, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices. During a review of the facility's P&P titled, Medication Storage in the Facility, dated 4/2028, the P&P indicated, Procedures.K. Medications requiring ?refrigeration'.are kept in a refrigerator with a thermometer to allow temperature monitoring.M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure opened multi-dose medications were dated with an open and discard date to ensure they were not used beyond the discard date, expired medications were not available for resident use, medications were stored according to manufacturer's labeling, and prescription medications were appropriately labeled with a pharmacy label. These deficient practices had the potential for residents to receive medications with unsafe and reduced potency from being used past their discard date, incorrect medications from inadequate labeling, and unsafe or ineffective medications from being stored outside of manufacturer's specifications.Findings: During a concurrent interview and inspection on 4/7/26 at 9:08 a.m. of Medication Storage room [ROOM NUMBER] with Licensed Nurse 3 (LN 3), six boxes hemorrhoidal suppositories (a small, torpedo-shaped medication designed to be inserted into the rectum to treat internal hemorrhoids) expired 11/2025 and one box expired 2/2025 were identified. Eight loose hemorrhoidal suppositories expired 11/2025, and four loose expired 2/2025 were also identified. LN 3 stated it was the unit manager's responsibility to check the medication storage room for expired medications, but the facility did not always have a unit manager. LN 3 confirmed the expired medications and stated they should have been removed from facility stock. During a concurrent interview and inspection on 4/7/26 at 9:50 a.m. of Medication Storage room [ROOM NUMBER] with LN 1, one vial Infuvite (an injectable multivitamin used to provide essential nutrients) with a pharmacy label that indicated Refrigerate was identified on the countertop. LN 1 confirmed the finding and stated the medication should have been stored inside the refrigerator. During a concurrent interview and inspection on 4/7/26 at 10:09 a.m. of Station 1 Medication Cart 2 with LN 1, one bottle Geritussin (a medication to treat cough) was identified with a pink crusty substance dried on the outside. LN 1 stated nursing staff were expected to wipe the outside of bottles, so they did not get dirty. LN 1 stated it was important to do so for the medication cart (med cart) to stay clean and prevent cross contamination. One bottle of dorzolamide (a medication to treat high eye pressure) 2% eye drop expired 4/1/26, one bottle latanoprost (a medication to treat high eye pressure) 0.005% eye drop expired 4/1/26, and one fluticasone/salmeterol (a medication to treat asthma) 250/50 microgram (mcg, a unit of measurement) inhaler expired 3/20/26 were also identified. LN 1 confirmed the finding and stated they should have been removed from the medication cart. One Trelegy Ellipta (a medication to treat asthma) 200 mcg/62.5 mcg/25 mcg inhaler labeled opened 2/13/26 was also identified. LN 1 reviewed the manufacturer's labeling on the package and confirmed it indicated to discard six weeks after opening. LN 1 stated the inhaler expired 3/27/26 and confirmed it should have been removed from med cart. Two Anoro Ellipta (a medication to treat chronic obstructive pulmonary disease (COPD), a progressive, long-term lung disease that causes obstructed airflow, making it difficult to breathe) 62.5/25 mcg inhalers and two Trelegy Ellipta 200/62.5/25 mcg inhalers opened and unlabeled with an open date were identified. LN 1 confirmed the finding and stated nursing staff were expected to put an open date on inhalers with shortened expiration after first use. One Humalog KwikPen (a fast-acting insulin to treat diabetes) was identified inside a clear plastic bag without a pharmacy label affixed. LN 1 confirmed prescription medications in the med cart needed a pharmacy label and she was not sure why the Humalog KwikPen did not have one. Four aformoterol (a medication to treat COPD) 15 mcg/2 milliliters (ml, a unit of measurement) vials for nebulization (a process that turns liquid into a mist for direct inhalation) were observed inside a clear plastic bag outside of the manufacturer's foil pouch. LN 1 stated the medication was usually stored in the refrigerator, not in the med cart, and confirmed there was no date on the label to indicate when it was brought to room temperature. LN 1 reviewed the manufacturer's labeling and confirmed the vials (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have been stored inside the foil pouch. A review of the manufacturer's labeling for arformoterol, revised 12/2021, indicated, Store arformoterol tartrate inhalation solution in the protective foil pouch under refrigeration at 36 to 46 F (2 to 8 C). Protect from light and excessive heat. After opening the pouch, unused unit-dose vials should be returned to, and stored in, the pouch. Unopened foil pouches of arformoterol tartrate inhalation solution can also be stored at room temperature 68 to 77 F (20 to 25 C) for up to 6 weeks. If stored at room temperature, discard if not used after 6 weeks or if past the expiration date, whichever is sooner. During the same interview and inspection on 4/7/26 of Station1 Medication Cart 2 with LN 1, two vials ipratropium/albuterol (a medication to treat asthma) 0.5/3 milligram/3 ml for nebulization were observed inside clear plastic bags outside of the manufacturer's foil pouch. LN 1 reviewed the manufacturer's labeling and confirmed it indicated the vials were to be used within two weeks once removed from the pouch. LN 1 confirmed there was no date on the label to indicated when the vials were removed from the protective pouch. A box of single use dorzolamide/timolol (a medication to treat high eye pressure) opthalmic (eye) solution 2/0.5% vials was observed inside the med cart. In the box were multiple foil pouches that contained medication with one vial outside of the foil tucked behind the pouches. LN 1 reviewed the manufacturer's labeling on the box and confirmed it indicated to store the single use vials in the foil pouch to protect the medication from light. During a concurrent interview and inspection on 4/7/26 at approximately 11 a.m. of Station 2 Medication Cart 2 with LN 2, one opened Advair (a medication to treat asthma) 100/50 mcg Diskus inhaler was identified without an open date. LN 2 confirmed the inhaler did not have an open date. He reviewed the manufacturer's package labeling and confirmed it indicated to discard one month after opening or when the counter reached 0, whichever came first. During an interview on 4/7/26 at 2:22 p.m. with the Director of Nursing (DON), the DON stated nursing staff were expected to label inhalers with an open date and expiration date. She stated nursing staff were expected to keep medication bottles clean to prevent cross contamination in the med cart. DON stated nursing staff were expected to keep the nebulized solution vials in their foil pouch and to follow the manufacturer's instructions on storage for medications. The DON stated expired medications should have been discarded and not in the facility's stock and had the potential to not be as effective if used. During an interview on 4/8/26 at 11:20 a.m. with the Consultant Pharmacist (CP), the CP stated as soon as nursing staff opened a medication they were expected to label it with an open date. The CP stated nursing staff were expected to follow manufacturer labeling and any extra instructions from the manufacturer. The CP stated if they did not, the risk was having medications in the med cart that should not be there after a certain period. The CP stated expired medications may not be 100% efficacious beyond their expiration date. During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving From Pharmacy, dated 4/2014, the P&P indicated, Policy: Medications are labeled in accordance with facility requirements and state and federal laws.Procedures: A. Labels are permanently affixed to the outside of the prescription container.B. Each prescription medication label includes: 1. Resident's name 2. Specific directions for use, including route of administration.3. Medication name.4. Strength of medication.5. Prescriber's name 6. Date dispensed 7. Quantity of medication 8. Expiration date of medication 9. Name, address, and telephone number of dispensing pharmacy 10. Prescription number 11. Accessory labels.12. Container number and total number of containers.13. Initials of dispensing pharmacist 14. Lot number of medication dispensed. During a review of the facility's P&P titled, Medication Storage in the Facility, dated 4/2028, the P&P indicated, Procedures.K. Medications requiring ?refrigeration'.are kept in a refrigerator with a thermometer to allow temperature monitoring. M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. N. Medication storage areas are kept clean, well-lit, and free of clutter.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview, record review, the facility failed to ensure one out of 24 sampled residents (Resident 2) was free from unnecessary psychotropic medication (drugs that affects brain activities associated with mental processes and behaviors), when Resident 2's fluoxetine (a medication to treat depression) dose was increased without adequate documented clinical rationale and without target behavior monitoring for efficacy. This failure had the potential to result in the unnecessary use of psychotropic medication and increased the risk of exposure to side effects such as nausea, headache, insomnia, diarrhea, dry mouth, and fatigue.Findings: A review of Resident 2's medical record indicated he was admitted to the facility in January 2021 with diagnosis which included bipolar disorder (a chronic mental health condition characterized by intense, unusual shifts in mood, energy, activity levels, and concentration), anxiety, and major depressive disorder. A review of Resident 2's physician's orders indicated the following:- Fluoxetine 40 mg (milligram, unit of weight measure): Give 1 capsule by mouth one time a day for depression manifested by verbalizations of sadness and anger, dated 2/19/24 to 2/13/25; and- Fluoxetine 60 mg: Give 1 tablet by mouth one time a day for depression manifested by verbalizations of sadness and anger, dated 2/13/25 to current. During a concurrent interview and record review on 4/8/26 at 11:24 a.m. with the Assistant Director of Nursing (ADON), Resident 2's Progress Notes (PN) and Medication Administration Record (MAR) were reviewed. The ADON stated she expected to an increase in target behaviors exhibited by a resident documented in the clinical record prior to increasing their dose of psychotherapeutic medication. The ADON reviewed Resident 2's PN dated 1/2025 to 2/13/25 (the 6 weeks leading up to Resident 2's dosage increase) and confirmed nursing staff had only two notes, both dated 1/25/25, which indicated Resident 2 was irritable and irate. The ADON reviewed Resident 2's MARs dated 1/2025 and 2/2025 and stated the order for behavior monitoring during those months was nonspecific and only directed nursing staff to document yes or no. The ADON stated this made it difficult for them to monitor Resident 2 and document the behavior. The ADON confirmed the MARs indicated Resident 2 exhibited behavior twice, during the evening shifts on 1/15/25 and 1/25/25. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, undated, the P&P indicated, Policy Interpretation and Implementation.3. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes.c. adequate monitoring for efficacy and adverse consequences.Assessment and Evaluation of the Resident: 1. When determining whether to initiate, modify, or discontinue medication therapy the interdisciplinary team conducts and documents an evaluation of the resident. The evaluation includes the resident's: a. physical, behavioral, mental, and psychosocial status.c. expressions or indications of distress. e. resident complaints, behaviors, and symptoms.Dose, Duration and Duplicate Therapy: 1. The prescribed dose and duration are based on the resident's diagnoses, signs and symptoms, current condition. accepted standard of practice for dosing, and input from the IDT about the resident's goals and preferences.Monitoring and Adverse Consequences.2. Residents receiving psychotropic medication are monitored and the response to treatment is documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555450	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
American River Center	3900 Garfield Avenue Carmichael, CA 95608

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 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. Based on observation, interview, and record review, the facility failed to ensure one of 24 sampled residents (Resident 3) wound care treatment was followed as ordered, when the Treatment Nurse (TN) wrapped Resident 3's right lateral heel diabetic (chronic condition caused by increased blood sugar level and can delay wound healing) wound with a bandage (stretchable, reusable compression bandage made of cotton, polyester, and synthetic rubber, to support inured muscle and joint, reduce swelling) which was not ordered or indicated. This failure had the potential to delay the wound healing process and develop complications to Resident 3's right lateral heel diabetic wound. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted in early February 2026 with diagnoses which included peripheral vascular disease (PVD, a slow, progressive circulation disorder characterized by narrowed or blocked blood vessels outside the heart and brain, commonly affecting leg arteries) and chronic ulcer of right heel and midfoot. During a review of Resident 3's Physician's Order (PO) dated 3/13/26, the PO indicated, Right lateral heel eschar (a dry, dark scab or falling away of dead skin) diabetic ulcer, apply triad to peri wound, medi-honey to immediate wound, calcium alginate, cover with foam dressing. The PO did not indicate the use of any kind of bandage wrap to be applied on the wound. During a review of Resident 3's revised Care Plan (CP) dated 3/22/26, the CP indicated, At risk for skin breakdown related to PVD and right lateral heel diabetic ulcer. Provide wound treatment as ordered. During a review of Resident 3's Wound Surgical Consults (WSC) dated 3/13/26, 3/20/26, 3/27/26, and 4/3/26, the WSC indicated the goal was for the prevention of wound decline and creation of wound healing bed. The WSC indicated the wound fluctuates from increased to decreased in size with risk factors which included diabetes and limited mobility. The WSC indicated treatment included calcium alginate with honey and collagen and did not indicate to wrap the wound with bandage wrap. During a concurrent observation and interview on 4/9/26 at 9:38 a.m. with the TN, Resident 3 was in bed and her right lateral heel wound was wrapped with bandage wrap. The TN removed the wound bandage cleansed the wound with normal saline, wiped the wound dry and applied the triad to peri-wound, medi-honey to immediate wound, applied calcium alginate, covered with foam dressing and wrapped the wound with the same bandage wrap. During a concurrent interview and record review on 4/9/26 at 9:50 a.m., with the TN, Resident 3's PO for the wound was reviewed. The TN confirmed the treatment order did not indicate the wound should be wrapped with bandage wrap. The TN stated she did not clarify the order whether to use a bandage wrap after every treatment. The TN stated it was important to clarify every treatment order especially on wounds to ensure patient safety, prevent errors and treatment order was followed accurately. During a concurrent interview and record review on 4/10/26 at 9:44 a.m., with the Assistant Director of Nursing (ADON), Resident 3's clinical record was reviewed. The ADON stated LNs should always clarify PO to ensure the treatment was accurate including the use of bandage wrap. The ADON confirmed all orders should be followed and clarified when appropriate. During a review of the facility's Policy and Procedure (P&P), titled, General Policy Guidelines: Physicians order, dated 3/22/22, the P&P indicated, IV: A. Treatment orders will include the following: a description of the treatment, including the treatment site, if applicable, B. The frequency of treatment and duration of order, (when appropriate), and C. The condition / diagnoses for which the treatment is ordered.