STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555459	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gramercy Court	2200 Gramercy Drive Sacramento, CA 95825

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40841 Based on observation, interview, and record review, the facility failed to promote dignity for one of 30 sampled residents (Resident 27), when Resident 27 was wearing a gown while sitting in a wheelchair with her back and side of body exposed. This failure decreased the facility's potential to maintain residents' dignity and privacy. Findings: A review of Resident 27's Admission Record, indicated Resident 27 was admitted to the facility in January 2024 with a diagnosis of left hip fracture. A review of Resident 27's Minimum Data Set (MDS, an assessment tool), dated 10/22/24, indicated Resident 27 had a brief interview for mental status (an assessment tool for cognitive status) scored 12 out of 15 with moderate memory impairment. Resident 27 required substantial to maximal assistance (helper does more than half the effort) with dressing clothes. A review of Resident 27's [Activities of Daily Living] Self-Care Performance Deficit care plan, dated 7/18/24, indicated staff had to promote dignity by ensuring privacy during care . During an observation on 12/3/24 at 9:27 a.m., Resident 27 wheeled herself into the hallway while wearing one gown with her back exposed. Other residents and staff were walking in the hallway and staff did not cover Resident 27's back. During a concurrent observation and interview on 12/4/24 at 1:06 p.m. with Certified Nursing Assistant 2 (CNA 2) inside Resident 27's room, Resident 27's back and side of body were exposed while she was sitting in her wheelchair. Resident 27 was sitting by the door's entrance and other staff and residents were walking beside the room. CNA 2 confirmed Resident 27's back and side of body were exposed to the public and stated it should have been covered with another gown or shirt. During a concurrent observation and interview on 12/4/24 at 1:09 p.m. with CNA 3, CNA 3 confirmed Resident 27's back and side of body were exposed and stated it should have been covered by another gown. CNA 3 also stated Resident 27 would feel embarrassed if her back and side of body were exposed to staff and other residents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 9:03 a.m. with the Director of Nursing (DON), DON stated Resident 27 would feel embarrassed when exposing her body and back and expected staff to provide a second gown to cover her. A review of the facility's policy titled, Dignity, dated 2/2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 40841 Based on interview and record review, the facility failed to ensure an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was obtained for the use of psychotherapeutic drug (a medication to control a resident's behavior) for one of 30 sampled residents (Resident 43), when Resident 43 was prescribed three psychotherapeutic drugs without an informed consent. This failure had the potential for Resident 43 to receive unnecessary medications. Findings: A review of Resident 43's Admission Record, indicated Resident 43 was admitted to the facility in January 2020 with a diagnosis of anxiety. A review of Resident 43's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/13/24, indicated Resident 43 had a brief interview for mental status (an assessment tool for cognitive status) scored 15 out of 15 with intact cognition. A review of Resident 43's Order Summary Report, dated 12/4/24, indicated orders for buspirone (an anti-anxiety medication) 20 milligrams (mg, a unit of measure) by mouth three times a day for anxiety disorder, duloxetine (anti-depression medication) delayed release 60 mg by mouth one time a day, and lorazepam (anti-anxiety medication) one mg by mouth every 12 hours as needed for anxiety manifested by restlessness and agitation until 12/6/24. A review of a facility's document titled, Consultant Pharmacist's Medication Regimen Review [MRR], dated 2/24 to 11/24, indicated there was no MRR for buspirone, duloxetine and lorazepam from 2/24 to 11/24. During a concurrent interview and record review on 12/5/24 at 9:42 a.m. with Medical Record (MR), Resident 43's medical record was reviewed. MR confirmed there were no informed consents for lorazepam, duloxetine, and buspirone. During an interview on 12/5/24 at 1:42 p.m. with the Assistant Director of Nursing (ADON) and Director of Nursing (DON), both DON and ADON stated an informed consent needed to be obtained every six months for psychotherapeutic drugs. A review of the facility's policy titled, Informed Consents, dated 11/2017, indicated, The use of psychotherapeutic drugs . shall be initiated when the facility is able to verify that the resident or resident representative has given informed consent. The policy further stipulated, The resident's physician shall obtain further informed consent when material circumstances or risk change and . medication increase if it is outside of the range the original informed consent was obtained.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 40841 Based on observation, interview, and record review, the facility failed to ensure a self-medication administration assessment was completed for one of 30 sampled residents (Resident 43), when Resident 43's medications were accessible and left stored on top of bedside table. This failure increased Resident 43's potential to unsafely self-administer medications. Findings: A review of Resident 43's Admission Record, indicated Resident 43 was admitted to the facility in January 2020 with a diagnosis of anxiety. A review of Resident 43's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/13/24, indicated Resident 43 had a brief interview for mental status (an assessment tool for cognitive status) scored 15 out of 15 with intact memory. During a concurrent observation and interview on 12/2/24 at 9:32 a.m. with Resident 43 inside her room, Resident 43 had a plastic container filled with multiple anti-fungal, anti-itching, and antibiotic creams in packets and tubes placed at bedside table. Resident 43 stated the nurse and certified nursing assistant gave her the medications so she could keep it at bedside when needed. During an interview on 12/2/24 at 11:08 a.m. with the Assistant Director of Nursing (ADON), ADON confirmed there were antibiotic, anti-fungal, and anti-itching cream medications at Resident 43's bedside and stated it should have been kept locked in the medication cart. During a concurrent interview and record review on 12/4/24 at 4:20 p.m. with Medical Record (MR), Resident 43's medical record was reviewed. MR confirmed there was no Self-Medication Administration Assessment for Resident 43. During a concurrent interview and record review on 12/5/24 at 8:54 a.m. with the Director of Nursing (DON), Resident 43's medical record was reviewed. DON confirmed there was no Self-Medication Administration Assessment for Resident 43 and stated medications should not be left at bedside because other residents could possibly get the medications when left unlocked. A review of the facility's policy titled, Self-Administration of Medications, dated 2/2021, indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770 Based on interview and record review, the facility failed to ensure a discharge Minimum Data Set (MDS-a federally mandated resident assessment tool) was completed in accordance with the regulatory timeframe required for one of 30 sampled residents (Resident 76), when Resident 76's discharge assessment was not submitted within 14 calendar days of discharge. This failure decreased the facility's potential to complete residents' assessments in a timely manner. Findings: A review of Resident 76's Admission Record, indicated he was admitted to the facility on [DATE] and discharged to the hospital on 7/15/24. During a concurrent interview and record review on 12/4/24 at 10 a.m. with the Business Office Consultant (BOC), the facility's census of July 2024 was reviewed. BOC confirmed Resident 76 was admitted in the first week of July and was discharged 13 days after admission. During a concurrent interview and record review on 12/4/24 at 10:20 a.m. with the MDS Coordinator (MDSC), Resident 76's Progress Notes and MDS Assessments were reviewed. MDSC confirmed Resident 76 was discharged to the hospital, did not return to the facility, and a discharge assessment was not completed. MDSC stated the discharge assessment should have been done and submitted within 14 calendar days according to the resident assessment instrument (RAI) manual. During a concurrent interview and record review on 12/5/24 at 8:30 a.m. with the Director of Nursing (DON), Resident 76's MDS Assessments were reviewed. DON stated Resident 76's discharge assessment should have been completed immediately after the resident was transferred to the hospital. DON further stated she expected the staff responsible for resident assessments to schedule, complete and submit assessments accurately and on time. A review of the facility's policy titled, MDS Completion and Submission Timeframes, revised 2017, stipulated, Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. A review of a document titled, Assessments for the RAI, dated 10/23, indicated MDS completion date for discharge assessment must be completed no later than the discharge date plus 14 calendar days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48694 Based on interview and record review, the facility failed to develop a care plan for one of 30 sampled residents (Resident 254), when Resident 254 did not have a care plan for hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility). This failure decreased the facility's potential to meet Resident 254's hospice care needs. Findings: A review of Resident 254's Admission Record, indicated Resident 254 was admitted to the facility in November 2024 with multiple diagnoses including frequent falls, malnutrition (less than minimum foods or nutrients essential for health), and palliative care (a medical care helps people with serious illnesses live with comfort and dignity). During a concurrent interview and record review on 12/5/24 at 9:47 a.m. with Licensed Nurse 1 (LN 1), Resident 254's care plans were reviewed. LN 1 confirmed no hospice care plan had been developed for Resident 254. During a concurrent interview and record review on 12/5/24 at 10:25 a.m. with the Director of Nursing (DON), Resident 254's care plans were reviewed. DON agreed no hospice care plan was developed for Resident 254 and stated staff should have developed a hospice care plan to implement Resident 254's hospice care needs. A review of the facility's policy titled, Hospice Program, revised in July 2017, indicated, . Our facility is responsible for . obtaining the most recent hospice plan of care specific to each resident . and coordinating with the care and services provided by our facility .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48694 Based on observation, interview, and record review, the facility failed to provide services according to professional standards of quality for three of 30 sampled residents (Resident 254, Resident 255, and Resident 257), when: 1. Resident 254's physician order to admit to hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) was not transcribed to the order summary record (OSR); 2. Resident 255's physician's order of heparin sodium (a medication used to prevent blood clots in blood channels in the body) was incorrectly recorded in OSR; and 3. Resident 257 was not given metformin hydrochloride (metformin HCl-a medicine to treat high blood sugars) as prescribed by the physician. These failures increased the residents' potential to have unmet health needs. Findings: 1. A review of Resident 254's Admission Record, indicated Resident 254 was admitted to the facility in November 2024 with multiple diagnoses including frequent falls, malnutrition (less than minimum foods or nutrients essential for health), and palliative care (a medical care helps people with serious illnesses live with comfort and dignity). During a concurrent interview and record review on 12/5/24 at 9:47 a.m. with Licensed Nurse 1 (LN 1), Resident 254's OSR was reviewed. LN 1 confirmed Resident 254's physician's order to admit to hospice care was not transcribed in OSR. During a concurrent interview and record review on 12/5/24 at 10:25 a.m. with the Director of Nursing (DON), Resident 254's OSR and progress notes were reviewed. DON agreed physician's order to admit Resident 254 to hospice care on 11/19/24 was noted in the progress notes. DON also agreed an order to admit to hospice was missing in OSR and stated staff should have transcribed the physician's order to admit to hospice care to OSR on 11/19/24. A review of the facility's policy titled, Hospice Program, revised in July 2017, indicated, Our facility is responsible for . obtaining the most recent hospice plan of care specific to each resident . and coordinating with the care and services provided by our facility . 2. A review of Resident 255's Admission Record, indicated Resident 255 was admitted to the facility in November 2024 with multiple diagnoses including amputation at left knee level (a surgical removal of left lower leg at the knee) and long-term use of anticoagulants (medications used to prevent and treat blood clots in blood channels in the body). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 255's OSR, dated 11/17/24, indicated an order of heparin sodium 5,000 units per milliliter (ml- a unit of measure) inject one ml intramuscularly (IM - into the muscle) every 12 hours. During a concurrent interview and record review on 12/5/24 at 7:57 a.m. with LN 5, LN 5 reviewed an order of heparin sodium for Resident 255 in OSR. LN 5 confirmed an order of heparin sodium was entered to OSR on 11/17/24 to be given intramuscularly and stated heparin sodium given IM would cause muscular tissue damage. LN 5 also stated heparin order needed immediate correction for Resident 255's safety. During a concurrent interview and record review on 12/5/24 at 10:30 a.m. with DON, DON reviewed Resident 255's physician orders and OSR. DON confirmed the physician order was heparin sodium 5,000 units/ml inject one ml subcutaneously (under the layers of skin) every 12 hours on 11/17/24. DON agreed nurse recorded the heparin order incorrectly in Resident 255's OSR and stated heparin given IM could cause muscular tissue damage and abscess (a pus-filled pocket). DON also stated nurse should have recorded the heparin order correctly in Resident 255's OSR as prescribed by physician. A review of the facility's policy titled, Telephone Orders, dated February 2014, indicated, . Physician's orders . must be recorded correctly in resident's medical record . The entry must contain the physician's instructions . 3. A review of Resident 257's Admission Record, indicated Resident 257 was admitted to the facility in November 2024 with a diagnosis of diabetes mellitus type 2 (a chronic disease where body does not produce/use insulin properly and causing high sugar levels in blood). During a concurrent observation and interview on 12/3/24 at 9:50 a.m. with LN 5 and Resident 257, LN 5 was observed administering morning medications to Resident 257. LN 5 gave metformin HCl 500 milligrams (mg-a unit of measure) one tablet by mouth with water to Resident 257. Resident 257 stated he had breakfast around 8 a.m. LN 5 agreed breakfast was served in between 7:30 a.m. and 8 a.m. During a concurrent interview and record review on 12/3/24 at 2:17 p.m. with LN 5, LN 5 reviewed metformin HCl order in OSR for Resident 257. LN 5 confirmed physician ordered to give metformin HCl 500 mg one tablet by mouth with meals. LN 5 agreed he did not give a snack/food along with metformin HCl to Resident 257 as ordered by physician. During a concurrent interview and record review on 12/3/24 at 4:45 p.m. with DON, Resident 257's physician order of metformin HCl was reviewed. DON confirmed metformin HCl was ordered to be given with meals. DON stated LN 5 should have followed the physician's order as prescribed. DON further stated metformin HCl given without meal/food to Resident 257 could have caused low blood sugars and deteriorate Resident 257's health status. A review of the facility's policy titled, Administering Medications, revised on 4/2019, indicated, . Medications are administered in accordance with prescriber orders .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40841 Based on interview and record review, the facility failed to ensure two of 30 sampled residents (Resident 43 and Resident 30) received proper monitoring for psychotropic medications (drugs that impact the brain and nervous system to treat mental health conditions), when: 1. Resident 43 did not receive an annual gradual dose reduction (GDR, a stepwise tapering of a medication dosage) for psychotropic medications; and 2. Resident 30 was given an anti-anxiety medication as needed for more than 14 days. These failures increased the residents' potential for unnecessary psychotropic medication use. Findings: 1. A review of Resident 43's Admission Record, indicated Resident 43 was admitted in January 2020 with a diagnosis of anxiety. A review of Resident 43's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/13/24, indicated Resident 43 had a brief interview for mental status (an assessment tool for cognitive status) scored 15 out of 15 with intact cognition. A review of Resident 43's Order Summary Report, dated 12/4/24, indicated an order for buspirone (an anti-anxiety medication) 20 milligrams (mg, a unit of measure) total by mouth three times a day for anxiety disorder, an order for duloxetine (an anti-depression medication) delayed release 60 mg by mouth one time a day, and an order for lorazepam (an anti-anxiety medication) one mg by mouth every 12 hours as needed for anxiety manifested by restlessness and agitation until 12/6/24. During a concurrent interview and record review on 12/5/24 at 1:36 p.m. with the Assistant Director of Nursing (ADON), ADON confirmed Resident 43 was receiving buspirone, duloxetine, and lorazepam for more than a year and there was no GDR in 2023 for all psychotherapeutic drugs. ADON stated GDR should have been completed annually. A review of the facility's policy titled, Tapering Medications and Gradual Drug Dose Reduction, dated 7/2022, indicated, Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medications, the staff and practitioner shall attempt a GDR in two separate quarters . After the first years, the facility shall attempt a GDR at least annually . 45770 2. A review of an admission record, indicated Resident 30 was admitted to the facility in June 2020 with a diagnosis of dementia (a progressive state of decline in mental abilities) with agitation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 30's Order Summary Report, indicated an order dated 2/17/24 for lorazepam one mg to be given every four hours as needed (PRN), with no stop date. A review of Resident 30's Medication Administration Record, indicated the PRN order for lorazepam was administered from 2/17/24 to 7/23/24. During a concurrent interview and record review on 12/4/24 at 11:02 a.m. with the Director of Nursing (DON) and ADON, Resident 30's Medication Regimen Review for February 2024 and progress notes were reviewed. Both DON and ADON confirmed that the doctor's order did not include a rationale/reason to continue Resident 30's order for lorazepam from February 2024 to July 2024. During an interview on 12/5/24 at 1 p.m. with the DON, DON confirmed Resident 30's lorazepam PRN order did not have a stop date and was given more than 14 days. DON stated a doctor's note with a rationale should have been obtained for Resident 30's continued use of lorazepam. A review of the facility's policy titled, Psychotropic Medication Use, revised on 7/2022, indicated, Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition . PRN orders for psychotropic medications are limited to 14 days.

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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. 40841 Based on observation, interview, and record review, the facility failed to ensure medications were stored properly for a census of 107, when: 1. Staff stored personal belongings inside Hall C medication room; 2. Expired medications were found in two medication carts; 3. Two multi-dose liquid protein bottles without open dates and an expired inhaler were found in one medication cart; 4. Medication was left at Resident 404's bedside table; and 5. Treatment cart was left unlocked. These failures decreased the facility's potential to safely store medications. Findings: 1. During a concurrent observation and interview on 12/4/24 at 10:42 a.m. with Licensed Nurse 6 (LN 6), Hall C medication room was observed. LN 6 confirmed a lunch box, a water bottle, three jackets and a bag were found inside the medication room and stated these were her belongings and she placed them in the medication room. 2. During a concurrent observation and interview on 12/4/24 at 11:28 a.m. with LN 6, Hall C medication cart-1 was observed. 31 expired and discontinued pills of carvedilol (a medication used to treat high blood pressure) 12.5 milligrams (mg; a unit of measure) each in a bubble pack were found behind the bottom drawer of the medication cart. LN 6 stated expired and discontinued medications should not be stored in the medication cart. During a concurrent observation and interview on 12/4/24 at 11:53 a.m. with LN 7, W Hall medication cart-2 was observed. Two bubble packs with three pills in each were found behind the bottom drawer of the medication cart with old, partially ripped, and unreadable labels on them. LN 7 could not identify the name of medications and residents on both bubble packs. LN 7 agreed unidentifiable medications should not be stored in the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview on 12/4/24 at 12:18 p.m. with LN 8, W Hall medication cart-1 was observed. Two multi-dose bottles of liquid protein with no open dates and one expired albuterol sulfate inhaler (a medication that relaxes the muscles of the airways and improves breathing) were found. Both bottles of liquid protein were found opened and partially used with no open dates marked as instructed in the manufacturer's labels on the bottles. LN 8 agreed both bottles should have been marked with an open date when opened and stated she did not know when the bottles were opened. LN 8 also agreed the albuterol sulfate inhaler was marked with an open date 1/4/24 and expired on 2/4/24 (30 days after opening it) and stated expired medications should not be stored in the medication cart. 4. During a concurrent observation, interview, and record review on 12/2/24 at 4:28 p.m. with Resident 404 and LN 2, an unlabeled tube of menthol (pain relieving gel) was observed on the bedside table for Resident 404. Resident 404 stated the ointment was her medication from home. LN 2 reviewed Resident 404's physician's order of menthol ointment and confirmed physician ordered the menthol ointment for Resident 404. LN 2 also confirmed there was no order for self-administration and/or to be left at the bedside. LN 2 stated all residents' medications including home medications should be locked in the medication cart for safe use of medications. During an interview on 12/4/24 at 4:45 p.m. with the Director of Nursing (DON), DON stated LN 6 should have not stored her personal belongings in C. hall medication room to prevent cross contamination, nurses should have checked their medication carts every day and every shift to remove all expired and discontinued medications for safe use of medications, and multi-dose bottles of liquid protein should have been marked with open dates upon opening as instructed in manufacturer's labels on the bottles. DON also stated undated liquid protein should not be used, should have been disposed for residents' safety, and nurses should have not left the pain relieving ointment at Resident 404's bedside until the physician ordered that and the resident was assessed for self-administration. A review of the facility's policy titled, Medication Labeling and Storage, revised February 2023, indicated, . The nursing staff is responsible for maintaining medication storage areas in a clean, safe, and sanitary manner . If the facility has discontinued, outdated, or deteriorated medications . the dispensing pharmacy is contacted for instructions . or destroying these items . Medications or biologicals are locked when not in use . A review of the facility's policy titled, Medication Brought to the facility by Resident/family, dated April 2007, indicated, . Medications will be kept in the med cart unless evaluated to be safe to be kept at bedside and approved by physician . 5. During a concurrent observation and interview on 12/5/24 at 11:40 a.m. in the hallway, the treatment cart was left unlocked and unattended for 10 minutes while the Treatment Nurse (TN) was in the resident's room providing wound care, with door closed. TN confirmed the treatment cart should have been locked while providing care in the room and stated the unlocked treatment cart would create an opportunity for staff or residents to obtain the medications. A review of the facility's policy titled, Medication Labeling and Storage, dated 2001, indicated, The facility stores all medications and biological in locked compartment .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555459	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gramercy Court	2200 Gramercy Drive Sacramento, CA 95825

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45770 Based on observation, interview, and record review, the facility failed to provide weekly and alternate menus to three of 30 sampled residents (Resident 204, Resident 24, and Resident 38). This failure decreased the facility's potential to meet the residents' nutritional and cultural preferences. Findings: A review of Resident 204's Admission Record, indicated she was admitted to the facility in November 2024 with diagnoses including disorder of electrolyte and fluid imbalance. A review of Resident 204's Minimum Data Set (MDS, a federally mandated resident assessment tool), indicated her brief interview of mental status score was 13 out of 15 with intact cognition. During a concurrent observation and interview on 12/2/24 at 9:40 a.m., Resident 204 was up in her wheelchair with breakfast tray not touched. Resident 204 stated breakfast was always the same, she was unable to know what it was until been served, and there was no menu provided by the kitchen or dietician so she could choose her own food preference. A review of an admission record indicated, Resident 24 was admitted to the facility in September 2020 with a diagnosis of type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a concurrent observation and interview on 12/2/24 at 1:15 p.m., Resident 24 was sitting in his bed with an unfinished lunch tray on top of the table. Resident 24 stated he did not like what was served in his lunch tray, food was wasted daily because a menu was not provided to him, and he did not know what the next meal was to be served. Resident 24 also stated if he had a copy of the menu, then that would have helped him plan his meals. A review of Resident 38's Admission Record, indicated she was admitted to the facility in September 2020 with diagnoses including morbid obesity and DM type 2. During a concurrent observation and interview on 12/3/24 at 1 p.m., Resident 38 was observed putting her lunch tray to the side and stated she was not sure if she was going to eat it. Resident 38 also stated she kept asking staff daily about what was for lunch or dinner, was not given a menu or alternate menu to choose from, and most of the time she would eat her instant noodles provided by her conservator when she did not like the food. During an interview on 12/3/24 at 1:45 p.m. with the Dietary Supervisor (DS), DS stated that every week he prepared a menu with the dietician, made copies, and left it at each nurse's station so nurses would distribute to all residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 2:30 p.m. with Licensed Nurse 9 (LN 9), LN 9 confirmed DS provided copies of menus at the station, but nurses were not responsible for distributing it to the residents. LN 9 stated each resident should have a copy of the menu and alternate menu provided by the staff at the kitchen or the dietician. During a concurrent observation and interview on 12/4/24 at 3 p.m. with LN 10, inside Resident 38's room, LN 10 confirmed Resident 38 did not have a copy of the menu or alternate menu with her. During an interview on 12/5/24 at 8:30 a.m. with the Director of Nursing (DON), DON stated distribution of the menu/alternate menu should have been done weekly, a staff from the activities department should have distributed the menu to all residents and the dietician should have made sure residents had it. DON further stated she expected the dietician to explain to the residents that the facility honored their preferences while providing appropriate nutrition. A review of the facility's policy titled, Menus, revised on 10/2017, stipulated, Activities Department distributes menus to new admissions and residents . Dietician assures menu and alternate menu has been distributed to residents and explained.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 45770 Based on observation, interview, and record review, the facility failed to ensure one of 30 sampled residents (Resident 46) was provided with necessary adaptive equipment (special eating equipment) for meals as ordered. This failure decreased the facility's potential to meet the resident's nutritional needs. Findings: A review of an admission record indicated Resident 46 was admitted to the facility in July 2020 with a diagnosis of type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 46's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 10/4/24, indicated a brief interview of mental status score of three out of 15 with memory problems. During an observation on 12/2/24 at 12:25 p.m., inside Resident 46's room, a lunch tray was given to her. The food consisted of chopped meat, chopped vegetables, and mashed potato. All food was served in one plate. Resident 46 was observed transferring food to a cup before eating then stated it was easier for her to eat in a smaller dish. A review of Resident 46's Order Summary Report, dated 7/25/24, indicated an order recommended by the occupational therapist to serve Resident 46's food in bowls. During a concurrent observation, interview, and record review on 12/2/24 at 12:30 p.m. with Licensed Nurse 8 (LN 8), inside Resident 46's room, Resident 46's Order Summary Report and tray card were reviewed. LN 8 confirmed Resident 46's lunch was served in one plate and should have been put in a small bowl to help her finish the food as ordered by the doctor. During a concurrent interview and record review on 12/5/24 at 8:30 a.m., with the Director of Nursing (DON), Resident 46's Order Summary Report and tray card were reviewed. DON confirmed Resident 46's order indicated to serve all food in bowls and stated staff should have followed the doctor's order to appropriately care for the resident. A review of the facility's policy titled, Assistance with Meals, revised on 3/2022, indicated, Adaptive devices will be provided for residents who need them . Assistance will be provided to ensure residents can use and benefit from special eating equipment and utensils.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45770 Based on observation, interview, and record review, the facility failed to properly store food in accordance with professional standards for food safety for a census of 107, when: 1. Two expired food products were stored in the spice shelf; 2. One box of expired food was stored in the dry storage area; 3. A 12 pack box of expired lactose free drink was stored in the walk-in refrigerator; and 4. Undated food products were stored in the walk-in refrigerator and dry storage area. These failures increased the potential for food-borne illnesses among the residents. Findings: 1. During a concurrent observation and interview on [DATE] at 8:30 a.m. with the Dietary Supervisor (DS) during the initial kitchen tour, two spice bottles were found on the spice shelf past their use by date. The powdered ginger had a use by date of ,d+[DATE] and the ground nutmeg had a use by date of [DATE]. DS confirmed both bottles were expired. 2. During a concurrent observation and interview on [DATE] at 8:30 a.m. with DS during the initial kitchen tour, a box of expired dried beans was stored in the dry storage area. The dried beans had a use by date of [DATE]. DS stated the box of dried beans was out of date and should have been tossed to the garbage. 3. During a concurrent observation and interview on [DATE] at 8:30 a.m. with DS during the initial kitchen tour, a 12-pack box of lactose free drink was stored in the walk-in refrigerator. The lactose free drink had a use by date of ,d+[DATE]. DS stated the box of drink was out of date. 4. During a concurrent observation and interview on [DATE] at 8:30 a.m. with DS during the initial kitchen tour, two opened and undated loaves of bread were stored in the dry storage area. An opened and undated block of cheese and a container of cooked sliced turkey were kept in the walk-in refrigerator without the preparation date. DS stated the bread in the dry storage area, and the block of cheese and sliced turkey in the walk-in refrigerator should have been dated after been opened to make sure they were still safe to be consumed. During an interview on [DATE] at 1 p.m. with the Director of Nursing (DON), DON stated she expected kitchen staff to consistently check and clean their storage area including the refrigerators to make sure food was stored in a sanitary condition. DON further stated food should not be used after its use by date because this could endanger the residents' health and safety. A review of the facility's policy titled, Food Receiving and Storage, revised on ,d+[DATE], stipulated, Foods shall be received and stored in a manner that complies with safe food handling practices.