STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555913	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Sacramento	1411 Expo Parkway North Sacramento, CA 95815

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069 Based on interview and record review, the facility failed to ensure care was provided in accordance with professional standards for one of three sampled residents (Resident 1) when Resident 1 did not receive a medication as prescribed. This failure resulted in Resident 1 having had a burning sensation all over her back, neck, and shoulders and resulted in her shoulders appearing red, irritated, and very sensitive to touch. Findings: During a review of Resident 1's face sheet, the face sheet indicated she was admitted to the facility on [DATE], with diagnoses that included acute posthemorrhagic anemia (a condition when you lose a large amount of blood quickly), spinal stenosis (narrowing of spinal canal that causes pian or numbness in legs), chronic pain syndrome (persistent pain that lasts weeks to years). Review of Resident 1's Admission MDS (Minimum data set-an assessment tool), dated 7/25/24 described Resident 1 as able to make herself understood and able to understand others. Resident 1's Brief Interview for Mental Status (BIMS-a screening that aids in detecting cognitive impairment) score was 13 which indicated she was cognitively intact. The MDS described Resident 1 as having no signs or symptoms of delirium or behavioral symptoms. The MDS also described Resident 1 as dependent on staff for toileting, shower/bathing self and lower body dressing, as needing supervision or touching assistance with eating and oral hygiene, and as needing partial/moderate assistance with upper body dressing and personal hygiene. Review of Resident 1's physician orders contained an order, dated 7/16/2024, for Voltaren Arthritis Pain gel 1 % every 6 hours as needed for pain. During a review of Resident 2's Progress Notes (PN), dated 7/21/24 at 11:29 a.m., the PN indicated, At the start of shift, the patient was c/o (complained of) a burning sensation all over her back, neck and shoulders. Upon assessment, her back, neck, and shoulders appeared red and irritated, and very sensitive to touch. The patient explained that when she requested her Voltaren arthritis pain cream, the PM nurse [Licensed Nurse- LN 1] applied Bengay Extra Strength instead. This morning, the patient was offered a shower, but she declined and asked for a sponge bath. Staff provided a sponge bath, focusing on her back, neck and shoulders in an attempt to remove the Bengay as much as possible. Her back was thoroughly dried and Voltaren cream applied, per the patient's request. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The patient is resting quietly in her WC [wheelchair] at this time. She appears settled and comfortable, watching TV. Nursing is monitoring for any adverse reactions, and addressing any patient concerns as soon as they arise. Medication error care plan initiated. MD notified with new orders add ice to the affected area PRN pain/burning. During an interview on 7/29/24 at 10:41 a.m. with Resident 1, Resident 1 stated on Saturday evening (7/20/24) a Certified Nursing Assistant was helping her, when LN 1 yelled from the hallway for CNA to ask Resident 1 what mediations Resident 1 needed. Resident 1 stated she wanted her pain cream (Voltaren) and Oxycodone. LN 1 came in and started applying the cream to her neck. Resident 1 stated she knew immediately that it was not her regular medication (Voltaren). Resident 1 stated to the LN that it was burning, burning. Resident 1 asked LN 1 where she got the cream from and LN 1 replied, I grabbed whatever was in the cart. Resident 1 stated she was shocked and stated to LN 1, You're the med nurse you should know what you're doing. LN 1 responded she was busy and was running behind. Resident 1 confirmed she didn't see the cream before LN 1 applied it. Review of a facility document titled Medication Error Report, indicated on 7/20/24 a different ointment administered allegedly Bengay. Outcome to patient: Erythema [redness to the skin]. During a review of facility document titled, Personnel Action, dated 7/22/24 indicated, On 7/20/24 employee (LN 1) failed to follow MD orders as evidenced by 1) Failure to app the right ointment 2. Wound treatment not performed. Employee also falsified documentation when tx (treatment) was not performed. Employee failed to follow her scope of practice. During a concurrent interview and record review, on 7/29/24 at 9:16 a.m., with the Director of Nursing (DON), she stated she was informed of the medication error on 7/21/24. LN 1 applied Bengay instead of Resident 1's prescribed Voltaren cream. Resident 1 had skin irritation and redness on the areas where the Bengay was applied. The DON reviewed Resident 1's medical record and confirmed Resident 1 did not have an MD order for Bengay. The DON confirmed Resident 1 had an order for Voltaren gel and review of Resident 1's eMAR (electronic Medication Administration Record) revealed no documentation that LN 1 applied Bengay or Voltaren gel on 7/20/24. The DON also stated she was unable to identify to which resident in the facility the Bengay belonged. The DON confirmed there was no documentation, by LN 1, in Resident 1's medical record or in facility documents regarding the medication error on 7/20/24. During a review of the facility's policy and procedure (P&P) titled, Administration of Medication undated, indicated, Licensed personnel, in accordance with professional standards of practice, will appropriately administer prescribed medications. Compare the prescription label to order on the eMAR .Verify the 6 Medication Administration Rights: 1. Right Patient 2. Right Drug, 3. Right Dose, 4. Right Dosage Form, 5. Right Route 6. Right Time.