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	08/09/2024

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 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. 36624 Based on interview and record review, the facility failed to ensure a person-centered care plan was developed for 5 sampled Residents (Resident 22, Resident 32, Resident 186, Resident 189, and Resident 191) and was not updated for one resident (Resident 1) for a census of 39. These failures decreased the facility's ability to meet the goals and address the medical, physical, mental and psychosocial needs of the residents. Findings: During a record review of Resident 32's Face Sheet (FS), the FS indicated, Resident 32 had diagnoses which included urinary tract infection (UTI, an infection in any part of the urinary system). During a record review of Resident 32's Physician's Order (PO) dated 8/3/24, the PO indicated, Augmentin (a combination of two antibiotics - amoxicillin and clavulanate) 500-125 mg (milligram, unit of measurement) one tablet, oral, three times a day [medication administration time ranges] from 05:00 a.m. to 07:00 a.m., 12:00 noon to 14:00 [2:00] p.m., and at 20:00 [8:00] p.m. to 22:00 [10:00] p.m. for UTI x 7 days. During a record review of Resident 32's medical record on 8/8/24 at 9:10 a.m., there were no evidence in the records that a person-centered care plan for UTI was developed. During a concurrent interview and record review, on 8/8/24 at 9:17 a.m., with the Minimum Data Set (MDS, an assessment tool) Nurse (MDSN), the Physician's Order (PO) was reviewed. The PO indicated, Augmentin 500-125 mg, one tablet, oral, three times a day for UTI x 7 days.The MDSN validated Resident 32 was started on Augmentin antibiotic for UTI on 8/3/24. The MDSN confirmed there was no person-centered care plan developed for Resident 32's antibiotic use for UTI. The MDSN stated there should be a person-centered care plan developed to monitor the antibiotic effectiveness and any adverse side effects. A review of the facility's policy and procedure (P/P) titled, COMPREHENSIVE CARE PLAN, updated 7/23, the P/P indicated, The care plan should reflect the individual's goals and choices, and identify individual-specific interventions. It should include a time-frame in which goals might be achieved and parameters for monitoring progress. (continued on next page)

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
	555913	A. Building B. Wing	08/09/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48140 A review of Resident 22's Facesheet indicated Resident 22 was admitted to the facility in July 2024 with diagnoses including sepsis (a life-threatening complication of an infection), stomach cancer and a urinary tract infection. A review of Resident 22's Physician's Order Report (POR) indicated the following orders with their start dates: 1. 7/31/24: Start PICC (peripherally inserted central catheter, a thin tube that is inserted through a vein in your arm and passed through to the larger veins near your heart) line for blood draw. 2. 8/1/24: Quetiapine (a psychotropic medication used to treat schizophrenia, bipolar disorder and depression) for agitation associated with depression. A review of Resident 22's Care Plan indicated the facility did not include interventions for Resident 22's PICC line or the use of a psychotropic medication. A review of Resident 186's Facesheet indicated Resident 186 was admitted to the facility in August 2024 with diagnoses including ataxia (loss of muscle control) and syncope and collapse (fainting, or a sudden temporary loss of consciousness). During a review of Resident 186's POR there was no indication Resident 22 had been receiving tube feedings or IV fluids while admitted to the facility. During a review of Resident 186's Care Plan, the interventions for nutrition indicated Resident 186 received tube feedings (liquid nutrition through a flexible tube that goes in through your nose or directly into your stomach) and IV (intravenous, a soft, flexible tube placed inside a vein) fluids. A review of Resident 189's Facesheet indicated Resident 189 was admitted to the facility in August 2024 with diagnoses including cerebral infarction (lack of blood flow to the brain) and endocarditis (an infection of the heart's inner lining). During a review of Resident 189's POR there was no indication Resident 189 had been receiving tube feedings or IV fluids while admitted to the facility. Further review of Resident 189's POR did indicate an order for a PICC line. During a review of Resident 189's Care Plan, Resident 189's care plan for nutrition included interventions that indicated Resident 189 received tube feedings and IV. Resident 189's Care Plan did not include interventions for the care and treatment of a PICC line. A review of Resident 191's Facesheet indicated Resident 191 was admitted to the facility in August 2024 with diagnoses which included cutaneous abscess (localized collection of pus in the skin) in the abdomen and schizophrenia (a serious mental health condition that affects how people think, feel and behave). During a review of Resident 191's POR, Resident 191's POR indicated the following orders: (continued on next page)

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	08/09/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Clozapine (a psychotropic medication for treatment-resistant schizophrenia) 2. Haloperidol (a psychotropic medication for the treatment of mental disorders) for Schizophrenia 3. Trazodone (a psychotropic medication for the treatment of depression) 4. Venaflexine (a psychotropic medication for the treatment of depression) During a review of Resident 191's Care Plan, the comprehensive care plan did not indicate the psychotropic medications listed above were included in Resident 191's comprehensive care plan. During a concurrent interview and record review on 8/8/24 at 9:08 a.m. with the DON, the DON reviewed the care plans for Resident's 22, 186, 189 and 191. The DON confirmed the care plans were not person centered or comprehensive. The DON stated care plans need to be person centered and updated or initiated when there are changes to the resident's care or condition. A review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plan, updated on 7/25/23, the P&P indicated, The facility will develop a comprehensive person-centered care plan .the care plan should be updated as needed . 34328 Resident 1 was admitted to the facility with diagnososes of Alzheimer's diseease (Alzheimer's disease is a brain disorder that gets worse over time, it causes the brain to shrink and brain cells to eventually die), and Dementia (Dementia is not a specific disease but rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities). On 8/6/23 at 9:30 a.m. during the initial pool tour of the facility Resident 1 was observed in her room. She was interviewable but was confused as to time and place. She answers when her name is called out. The resident stated she feels safe in the facility. Medication review of Resident 1's Physician's orders indicated the resident was prescribed rivastigmine (medication for the treatment of Alzheimer's disease) patch on 3/22/24. Review of resident's clinical records indicated the Resident had a base care plan completed 6/24/24. Further review of Resident 1's comprehensive care plans did not indicate the medication rivastigmine transdermal patch (a patch that attaches to your skin and contains medication which is absorbed through the skin) was included with the comprehensive care plans. On 8/7/24 at 9:45 a.m. interview with the Director of Nursing (DON) the DON confirmed after reviewing Resident 1's comprehensive care plan confirmed that there were no Alzheimer's medication treatment included in the care plans. The DON stated the comprehensive care plan must reflect the medications prescribed for Resident 1's treatment in use against Alzheimer's disease. The DON confirmed the Alzheimer's medications were not included in Resident 1's comprehensive care plan and was incomplete. (continued on next page)

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	08/09/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy and procedure version A1021 indicated: .3. The care plan should be updated as needed: i.e. as conditions change, goals are met, interventions are determined to be ineffective, or as specific treatable causes of problems are identified .5. A variety of interventions should be used to meet the individual's needs and patient's rights based on many factors.

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	08/09/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50121 Based on observation, interview, and record review, nursing staff failed to meet professional standards of quality for four of 17 sampled residents (Residents 22, 26, 392, and 537) when: 1. Nursing staff failed to administer digoxin (a medication to control heart rate) and midodrine (a medication to improve the heart's ability to pump and support low blood pressure) to Resident 26 based on the parameters (a fixed limit) set in the physician's order; 2. Nursing staff failed to follow manufacturer's specifications to rotate injection sites when administering Lovenox (a medication to prevent blood clots) to Resident 392; 3. Nursing staff failed to monitor the intravenous (I.V., catheter in the vein that delivers medication or fluids) site or obtain a physician order to change the dressing for the I.V. site for Resident 22; and 4. Nursing staff failed to obtain a physician order to flush (instill fluid to maintain patency) of an I.V. line for Resident 537. These failures had the potential to result in Resident 26 experiencing low heart rate or low blood pressure which could cause dizziness or falls, in Resident 392 not absorbing the full Lovenox dose resulting in an increased risk for blood clots and experiencing increased soreness at the injection site, in Resident 22's I.V. to become infected or infiltrated (fluid leaking out of the vein into surrounding tissue), and in Resident 537's I. V. site to become infected or occluded. Findings: 1. A review of Resident 26's admission record indicated she was admitted [DATE] after surgery to fix a broken femur (upper leg bone). Her medical history included previous heart problems and low blood pressure. During a medication pass observation on 8/6/24, at 7:59 a.m. with Licensed Nurse (LN) 1, LN 1 was observed preparing 12 medications for Resident 26, including digoxin (a medication used to control heart rate), 125 micrograms (mcg, a unit of measure), one tablet, and Midodrine (a medication used to support low blood pressure), 5 milligrams (mg, a unit of measure), two tablets, without taking Resident 26's heart rate or blood pressure. A review of Resident 26's medical record indicated the following physician's orders: - Digoxin tablet, 125 mcg, oral, once a day, special instructions: hold if apical pulse (heart rate counted over the heart through the chest wall) is less than 60, dated 6/25/24 - Midodrine tablet, 10 mg, oral; twice a day, special instructions: hold for systolic blood pressure (the upper number in a blood pressure reading) greater than 150 millimeters of mercury (a unit of measure), dated 7/18/24 (continued on next page)

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	08/09/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/6/24 at 8:32 a.m. with LN 1, the LN 1 acknowledged that she did not check Resident 26's heart rate or blood pressure prior to medication administration. During an interview 8/7/24 at 10 a.m. with the Director of Nursing (DON), the DON stated when a medication order had a hold parameter the licensed nurse should check the resident's heart rate and blood pressure prior to administration of the medication. The DON stated a resident could have a change in blood pressure or heart rate at any point in time that would make it unsafe for the resident to receive the medication. During a review of the policy and procedure (P&P) titled, Administration of Medication, undated, the P&P indicated, Ensure that ancillary tasks such as blood pressure, apical pulse, etc., are performed with appropriate medications. 2. A review of Resident 392's admission record indicated she was admitted [DATE] after injury to and repair of an artificial knee joint. Her medical history included Chronic Obstructive Respiratory disease (COPD, a condition caused by damage to the airways or lungs that blocks airflow and makes it hard to breathe), and heart failure (a condition in which the heart muscle is not able to pump as well as it should to meet the body's need for blood and oxygen.) During a medication pass observation on 8/6/24 at 8:59 a.m. with LN 1, the LN 1 was observed administering Resident 392's Lovenox (a medication to prevent blood clots) injection into the left lower quadrant (LLQ) of her abdomen. A review of Resident 392's medical record indicated a physician's order for Lovenox syringe, 40 milligrams/0. 4 milliliters (units of measure), subcutaneous (under the skin) injection, once a day, dated 8/4/24. During a concurrent interview and record review with LN 1 on 8/6/24 at 11:18 a.m., Resident 392's Medication Administration Record (MAR) was reviewed. LN 1 stated she had administered Lovenox into Resident 392's LLQ and the MAR indicated the previous dose given on 8/5/24 was also administered in the LLQ of abdomen. LN1 stated she should have administered the dose in a different site, away from where it was previously administered. She stated that it was important to change sites for each injection, so the resident does not develop a bruise or scar tissue. During an interview on 8/7/24 at 10 a.m. with the DON, the DON stated nurses were expected to rotate injection sites and if sites were not rotated, it could cause discoloration and soreness at the injection site. She stated the site could harden which could lead to decreased medication absorption. During a review of the manufacturer's package insert, dated 4/2022, the package insert indicated, alternate injection sites between left and right anterolateral (an anatomical adjective that means in front of and to the side of another part of the body) and left and right posterolateral (an adjective that means located on the side and toward the back of the body) abdominal wall. During a review of Nursing Skills: Administration of Parenteral Medications, dated 2023, the resource indicated that nurses should select sites for administration that allow for rotation of subcutaneous injections. 48140 (continued on next page)

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	08/09/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 22's Facesheet indicated Resident 22 was admitted to the facility in July 2024 with diagnoses including sepsis (a life-threatening complication of an infection), stomach cancer and a urinary tract infection. During a concurrent observation and interview on 8/7/24 at 2:25 p.m. in Resident 22's room, Resident 22 was receiving fluids through a PICC (peripherally inserted central catheter, a thin, flexible tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava) line located on Resident 22's right upper arm. Resident 22 stated the PICC line was inserted at the end of July. A review of Resident 22's Physician's Order Report (POR) indicated an order for the PICC line to be placed on 7/31/24, due to dehydration (dangerous loss of body fluid) and for the PICC line to be flushed with 20 mL (milliliters, a unit of measurement) of normal saline (a mixture of sodium chloride and water) every shift. During a concurrent interview and record review on 8/7/24 at 3:03 p.m. with Licensed Nurse 2 (LN 2), Resident 22's POR was reviewed. LN 2 confirmed there were missing orders regarding the care and treatment of Resident 22's PICC line. LN 2 stated standard professional practice for the care and treatment of a PICC line included monitoring the IV site every shift and changing the dressing weekly or if soiled or dirty. During a concurrent interview and record review on 8/7/24 at 4:08 p.m. with the Director of Nursing (DON) Resident 22's POR was reviewed. The DON confirmed additional orders for the care and treatment of a PICC line included monitoring the IV site for signs and symptoms of infection and changing the dressing weekly, or if needed. The DON confirmed these orders were missing for Resident 22. A review of the facility's policy and procedure (P&P), titled Intravenous Therapy: Extended Peripheral (Mid-Line) Catheter Procedures, undated, the P&P indicated, If the site is covered with a transparent semi permeable membrane (TSM) dressing. Then TSM dressing will be changed at least weekly or immediately if the dressing is compromised in anyway. 34980 4. Resident 537 was admitted to the facility in 2024 with a diagnoses that included an infection of the right lower leg. A review of Resident 537's, Minimum Data Set (MDS, an assessment tool) dated 7/24/24 indicated, Resident 537 was cognitively intact. A review of Resident 537's, Medication Administration Record (MAR) dated 8/1/24 - 8/6/24, indicated an order for a port-a-cath (a device placed under the skin that goes into a large vein used to administer medications) accessed with a Huber needle (a type of needle used to access a port-a-cath). A review of Resident 537's, Care Plan dated 8/4/24, indicated to flush the port-a-cath per protocol. (continued on next page)

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	08/09/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with Resident 537 on 8/6/24 at 10:14 a.m., Resident 537 had a port-a-cath accessed with a Huber needle located on the left upper chest wall. Resident 537 stated, The port had not been flushed for 2 weeks. During a concurrent interview and record review with Licensed Nurse 2 (LN2) on 8/8/24 at 10:13 a.m., LN2 verified and stated, Their was no order to flush the port-a-cath. LN2 further verified, no licensed staff had documented the port-a-cath had been flushed since admission. During an interview with the Nurse Consultant (NC) on 8/8/24 at 1:39 p.m., the NC stated, If the port-a-cath has been accessed with a needle it should have been flushed daily per the facility's policy. A review of the facility's policy titled, Implanted Injection Port Procedures undated indicated to, Flush daily with prescribed flush solution . During a concurrent interview and record review with the Director of Nursing (DON) on 8/8/24 at 2:02 p.m., the DON stated, The nurse should have obtained an order to flush the port-a-cath if none had been ordered. A review and verification of the MAR dated 8/1/24-8/6/24 had no order to flush the port-a-cath. The DON further stated, the port-a-cath should have been flushed daily per the facility's policy.

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	08/09/2024

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 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. 50121 Based on observation, interview, and record review, the facility failed to ensure controlled substance medications (those with high potential for abuse or addiction) were accurately accounted for on the medication administration records (MARs) and controlled drug record (CDR) for one of six randomly selected residents (Resident 3). This failure resulted in the facility not having accurate accountability of controlled medications, and the potential for abuse or misuse of these medications. Findings: During an interview on 8/7/24 at 10 a.m. with the Director of Nursing (DON), the DON stated the expectation was anytime a nurse needed to administer a controlled medication, they were expected to sign it out of the CDR and document on the resident's MAR. The CDRs for six randomly selected residents receiving as-needed controlled medications were requested for review during the survey. Resident 3 had the following physician orders for hydrocodone/acetaminophen (a medication to treat pain) 5/325 milligrams (mg, a unit of measure) tablets: - Hydrocodone/acetaminophen 5/325 mg: 1 tablet every 4 hours as needed for moderate pain, dated 7/16/24. - Hydrocodone/acetaminophen 5/325 mg: 2 tablets every 4 hours as needed for severe pain, dated 7/16/24. During a concurrent interview and record review on 8/7/24 at 1:16 p.m. with the DON, Resident 3's July 2024 MAR and CDR for hydrocodone/acetaminophen were reviewed. The DON acknowledged the following inaccuracies in the CDR for Resident 3: The CDR indicated on 7/22/24 at 1 a.m., hydrocodone/acetaminophen 5/325 mg one tablet was removed from the secured area of the medication cart. The MAR indicated late documentation by nursing staff at 5:22 a.m. (over four hours later) that the dose was administered at 1 a.m. on 7/22/24. The DON confirmed the lack of accurate documentation by nursing staff. The CDR indicated on 7/22/24 at 7:57 p.m., hydrocodone/acetaminophen 5/325 mg two tablets were removed from the medication cart. The MAR did not indicate the dose was administer at or around that time. The MAR indicated late documentation by nursing staff at 11:33 p.m. (over three hours later) that the dose was administered at 7:57 p.m. on 7/22/24. The DON confirmed the lack of accurate documentation by nursing staff. (continued on next page)

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	08/09/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CDR indicated on 7/25/24 at 9:45 a.m., hydrocodone/acetaminophen 5/325 mg two tablets were removed from the medication cart. The MAR did not indicate a dose was administered at or around that time. The DON confirmed the lack of documentation on the MAR to account for this removal. The CDR indicated on 7/30/24 at 7:02 p.m., hydrocodone/acetaminophen 5/325 mg two tablets were removed from the medication cart. The MAR did not indicate a dose was administered at or around that time. The MAR indicated late documentation by nursing staff at 2:47 a.m. the following day (approximately 8 hours later) on 7/31/24 that the dose was administered at 7:15 p.m. on 7/30/24. The DON confirmed the lack of accurate documentation on the MAR. During an interview on 8/7/24 at 1:50 p.m. with DON, DON stated the nurses did not follow policy and failure to document at the time of administration could result in harm to the resident if another dose was given based on lack of documentation of the dose previously given. During a review of the facility's undated policy titled, Electronic Medical Record Documentation, the policy indicated, The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.

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	08/09/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50121 Based on observation, interview, and record review, the facility had a 18.18% error rate when six medication errors out of 33 opportunities were observed during a medication pass for two of three Residents (Residents 26 and 392). These failures resulted in medications not given in accordance with the prescriber's orders and/or manufacturer's specifications, which resulted in residents not receiving the full therapeutic effect of the medications. Findings: 1a. During a medication pass observation on 8/6/24 at 7:59 a.m. with Licensed Nurse (LN) 1, the LN 1 was observed preparing 12 medications, including Macrobid (a medication to treat infection), and potassium chloride extended release (a medication to treat low potassium levels) for Resident 26. A review of Resident 26's medical record indicated the following physician's orders: - Macrobid 100 milligrams (mg, a unit of measure): 1 capsule every 12 hours, dated 8/2/24 - Potassium chloride capsule extended release 10 milliequivalents (mEq, a unit of measure): 1 capsule once a day, dated 7/11/24 During an interview on 8/6/24 at 11:24 a.m. with LN 1, LN 1 confirmed she gave Resident 26 both medications on an empty stomach. LN 1 stated, Breakfast wasn't delivered until 8:30 a.m. LN 1 stated she did not know Macrobid needed to be given with food, but did know that potassium chloride needed to be given with food. She stated if potassium was administered without food, it might upset the resident's stomach. During an interview on 8/7/24 at 10 a.m. with the Director of Nursing (DON), the DON stated nursing staff were to follow the special instructions to give with food or on an empty stomach when administering medication. The DON explained that if nursing staff were unfamiliar with a medication and there were no specifications with the order, the expectation was to check with the pharmacy consultant or refer to a drug reference book. During an interview on 8/7/24 at 4:10 p.m. with the Pharmacy Consultant (PC), the PC stated nurses should follow the provider's instructions and manufacturer's specifications when administering medications. The PC stated that failure to follow specifications could affect the resident's tolerance and absorption of the medication. According to UpToDate [NAME]-Drug, a drug information provider for health care professionals, administration of Macrobid indicated Administer with meals to improve absorption and decrease adverse effects. (continued on next page)

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	08/09/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to UpToDate [NAME]-Drug, a drug information provider for health care professionals, administration of potassium chloride extended release indicated Take with or right after a meal [and] with a full glass of water. 1b. On the same medication pass observation on 8/6/24 at 8:13 a.m. with LN 1, the LN 1 prepared to place a lidocaine patch (medication used to relieve pain by applying on the skin) on Resident 26. Another Lidocaine patch, dated 8/5/24, was already on Resident 26's flank. The LN 1 removed this patch and did not apply the new patch. LN 1 stated, The skin needed to be free from the patch for 12 hours before placing a new one. A review of Resident 26's medical record indicated physician's orders, dated 8/1/24, for lidocaine adhesive patch 5%, 1 patch applied to lower back daily, remove at bedtime. During an interview on 8/7/24 at 10 a.m. with the DON, the DON confirmed nurses were expected to administer medications according to the physician's order. She stated the nursing staff were expected to initial and date a medicated patch when it was applied and to document in the resident's record when it was removed. She stated by not removing a lidocaine patch after 12 hours, placed the resident at risk for lidocaine toxicity. During a review of manufacturer's package insert instructions for use, dated 11/18, the package insert indicated Application of patch for 12 hours (recommended maximum daily dose), once per day. 2a. During a medication pass observation on 8/6/24 at 8:59 a.m. with LN 1, the LN 1 was observed preparing 13 medications, including Lovenox (a medication to prevent blood clots) injection for Resident 392. LN 1 injected the medication into the left lower quadrant (LLQ) of Resident 392's abdomen. A review of Resident 392's medical record indicated physician's order, dated 8/4/2024, for Lovenox syringe, 40 milligrams/0.4 milliliters (mg/mL, a unit of measure), subcutaneous (under the skin) injection, once a day, dated 8/4/24. During a concurrent interview and record review on 8/6/24 at 11:18 a.m. with LN 1, Resident 392's Medication Administration Record (MAR) dated August 2024 was reviewed. LN 1 stated she had administered Lovenox into Resident 392's LLQ and the MAR indicated the previous dose given on 8/5/24 was also administered in the LLQ of abdomen. LN1 stated she should have administered the dose in a different site, away from where it was previously administered. She stated it was important to change sites for each injection so the resident would not develop a bruise or scar tissue from repeated injections into the same location. During an interview on 8/7/24 at 10 a.m. with the DON, the DON stated nurses were expected to rotate injection sites and if sites were not rotated, it could cause discoloration and soreness at the injection site. She stated the site could harden which could lead to decreased medication absorption. During a review of the manufacturer's package insert, dated 4/2022, the package insert indicated, Alternate injection sites between left and right anterolateral (in front of and to one side of another part of the body) and left and right posterolateral (on the side and toward the back of the body) abdominal wall. (continued on next page)

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	08/09/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. On the same medication pass observation on 8/6/24 at 9:13 a.m. with the LN 1, the following medications were not observed as given to Resident 392: Trelegy Ellipta, (an inhaled medication used to treat breathing problems), inhaler, 1 puff, and Metamucil (a fiber-based medication to regulate bowel function), 1 packet, mixed with 6 oz. water. A review of Resident 392's medical record indicated the following physician's orders: - Metamucil powder, 1 packet oral, mix with 6 oz. water, once a day, dated 8/4/24 - Trelegy Ellipta blister with device (a mechanism to convert medication to an inhale-able form), 200/62.5/25 mcg, 1 puff, inhalation, once a day, dated 8/4/24 During an interview on 8/6/24 at 11:18 a.m. with LN 1, LN 1 stated Trelegy and Metamucil were not administered to Resident 392 because they were not available in the medication cart. During an interview on 8/7/24 at 10 a.m. with the DON, the DON confirmed nurses were expected to administer medications according to the physician's order. She stated she expected nursing staff to provide care as ordered by the provider. During a review of the policy and procedure (P&P) titled, Medication Orders, undated, the P&P indicated, Medications are administered only upon the clear, complete, and signed order, and an order must include duration (length) of therapy.

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	08/09/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43258 Based on observation, interview, and record review, the facility failed to ensure one of 17 sampled residents (Resident 15) was free of a significant medication errors when he received seven doses insulin lispro (a rapid-acting insulin, medication to lower blood sugar level) and four doses insulin glargine (a long-acting insulin) past their expiration dates. This deficient practice had the potential for ineffective use of insulin, resulting in uncontrolled high blood sugar for the resident. Findings: During an inspection of Medication Cart 2 on [DATE] at 1:31 p.m. alongside Licensed Nurse (LN) 2, one vial insulin lispro and one vial insulin glargine for Resident 13 were labeled with open dates of [DATE] were identified. LN 2 confirmed the insulins expired on [DATE]. A review of Resident 15's medical record indicated the following physician's orders: - Insulin lispro 100 units/milliliter (unit/mL, a unit of measurement): inject 5 units subcutaneously (under the skin) before meals, dated [DATE] - Insulin glargine: inject 20 units subcutaneously at bedtime, dated [DATE] During a concurrent interview and record review on [DATE] at 1:54 p.m. with LN 2, Resident 15's Medication Administration Record (MAR), dated [DATE] was reviewed. Resident 15's MAR indicated he was administered seven doses of expired insulin lispro: 3 doses on [DATE], 3 doses on [DATE], and 1 dose on [DATE]. The MAR indicated Resident 15 was also administered four doses expired insulin glargine: on [DATE], [DATE], [DATE], and [DATE]. LN 2 confirmed the findings and stated the expiration date of a medication should always be checked before administering it to a resident. During an interview on [DATE] at 10:18 a.m. with Director of Nursing (DON), DON stated nursing staff were expected to check the expiration date of all medications prior to administration. The DON stated insulin would not be effective in controlling a resident's blood sugar if administered after the expiration date. According to UpToDate [NAME]-Drug, a drug information provider for health care professionals, storage of insulin lispro and insulin glargine both indicated, Store in-use vials under refrigeration . or at room temperature . and use within 28 days. According to an online article from DiabetesStrong.com, the article indicated, The effectiveness of insulin degrades over time and it's impossible to predict how well expired insulin will work- or if it will even work at all! Insulin is a bit unusual in that it had two expiration dates; one is the expiration date if insulin is unopened and stored at the proper temperature. The second expiration date is the date the manufacturer suggests insulin is good for after opening and when kept at room temperature. Be sure to check both dates so you know if your insulin is still safe to use. (https://diabetesstrong.com/does-insulin-expire/; accessed [DATE]) (continued on next page)

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	08/09/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to Consumermedsafety.org (a nationally recognized medication safety organization), it indicated, Safety Tips for Storing Insulin . Never use insulin if it is expired. The expiration date will be stamped somewhere on the vial, pen, or cartridge. Remember once the insulin is opened, the expiration date printed on the vial, pen, or cartridge does not apply. Opened insulin must be thrown away after 28 days . (https://www.consumermedsafety.org/insulin-safety-center/insulin-basics/storage-of-insulin; accessed [DATE]) During a review of the facility's policy and procedure (P&P) titled, Administration of Medication, undated, the P&P indicated, Procedure . 13. Check the card, bottle, etc. for expiration date of the medication. Discard expired meds immediately and obtain replacement. During a review of the facility's P&P titled, Medication Storage, undated, the P&P indicated, Procedure . 14. 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.

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	08/09/2024

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 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** 50121 Based on observation, interview, and record review, the facility failed to ensure: - Medication was stored at temperatures specified by manufacturer; - An inhaler was labeled properly with a pharmacy label to ensure it was used for the right resident; - Five opened biologicals, multi-dose eye medications, and inhalers were dated with an open and discard date, to make sure they were not used beyond the discard date; and - Six expired medications, including insulin vials (a medication used to lower elevated blood sugar levels) were not available for resident use. These deficient practices had a potential for residents to have inaccurate tuberculosis (a contagious disease affecting the lungs) or blood glucose testing results, and to receive medications with unsafe and reduced potency from being used past their discard date. Findings: 1. On 8/6/24 at 1:31 p.m. in the presence of Licensed Nurse (LN) 2, an inspection of Medication Cart 2 identified an opened vial of tubersol (a medication used to diagnosis tuberculosis) with a label stating it should be stored in the refrigerator. A review of the manufacturer's storage instructions for tubersol indicated Store intact bottles under refrigeration at 2 C to 8 C (36 F to 46 F) . Once opened, the container should be discarded after 30 days. LN 2 acknowledged tubersol should be stored in the refrigerator to maintain its effectiveness. During the same inspection of Medication Cart 2 in the presence of LN 2, an Evencare G3 vial of test strips (used to measure blood glucose levels with a drop of blood from the fingertip) was open and missing an opened date. A review of the manufacturer's storage and handling instructions on the outside of the Evencare G3 test strips with LN 2 indicated Use within 6 months after first opening . LN 2 confirmed the vial should have been dated when opened to know when the test strips expired and stated he was not sure they were still effective. During the same inspection of Medication Cart 2 in the presence of LN 2, two vials of insulin (glargine and lispro, medications to lower blood sugar levels) were labeled with an opened date of 7/5/24. A review of the manufacturer's storage and handling instructions for glargine and lispro insulin indicated Can store opened inulin at room temperature between 59 F and 86 F (15 C to 30 C) for up to 28 days after opening. LN 2 confirmed that the insulin vials should have been discarded after 28 days, on 8/2/24. (continued on next page)

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	08/09/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same inspection of Medication Cart 2 in the presence of LN 2, a Breo Ellipta 100/25 micrograms (mcg, a unit of measurement) inhaler (a medication used to treat certain lung conditions), was open and unlabeled with opened date. A review of the manufacturer's storage and handling instructions on the packaging indicated to throw away six weeks after you open the tray or when the counter reads '0', whichever comes first. LN 2 acknowledged the inhaler should have been labeled with the date when opened. LN 2 identified and confirmed additional medications on Cart 2: - 1 vial tubersol, expired 8/2/24 - 1 bottle Pepto Bismol (medication to treat upset stomach), expired 6/24 2. On 8/6/24 at 3:27 p.m. in the presence of LN 3, an inspection of Medication Cart 3 identified an Evencare G3 vial of test strips was missing an opened date. LN 3 confirmed she did not know when it was opened. During the same inspection of Medication Cart 3 in the presence of LN 3, a box containing two bottles of EvenCare G3 Control solutions (used to calibrate a medical device that checks blood glucose levels using a drop of blood), was observed opened 12/10/23. A review of the manufacturer's storage and handling instructions for Evencare G3 control solutions indicated Discard any unused control solution 90 days after first opening . LN 3 confirmed the control solutions were expired and should be discarded. During the same inspection of Medication Cart 3 in the presence of LN 3, one Arnuity Ellipta 200 mcg inhaler (a medication used to treat certain lung conditions) was open and unlabeled with opened date. A review of the manufacturer's storage and handling instructions for Arnuity Ellipta indicated to throw away six weeks after you open the tray or when the counter reads '0', whichever comes first. During the same inspection of Medication Cart 3 in the presence of LN 3, one vial Rocklatan (eye drops used to treat high pressures in the eye), was open and unlabeled with opened date. A review of the manufacturer's storage instructions for Rocklatan indicated Once the bottle is opened, the drug can be kept at a temperature of 36 F to 77 F (2 C to 25 C) for up to 6 weeks. During the same inspection of Medication Cart 3 in the presence of LN 3, one albuterol 90 mcg inhaler (medication used to help breathing), unlabeled pharmacy label or with patient name or open date, in a cup with labeled 135. LN 3 confirmed she did not know to which resident this belonged. LN 3 identified and confirmed one bottle acetaminophen 500 milligram tablets, expired 4/24. LN 3 acknowledged these medications should be discarded. During an interview on 8/7/24 at 10 a.m. with the Director of Nursing (DON), the DON stated nursing staff should check expiration dates on medications. She stated nurses know tubersol should be refrigerated but for some reason, it was left on the medication cart. She stated residents would be placed at risk if an expired medication was administered. She confirmed a room number was not an adequate label for a medication; It should have had a name on it. She confirmed staff should write opened dates on [NAME]-dose vials. (continued on next page)

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	08/09/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/7/24 at 4:10 p.m. with the facility's Pharmacy Consultant, Consultant stated You never want to give medications past their expiration dates. During a review of the facility's policy and procedure (P&P) titled, Injection Safety, undated, the P&P indicated Multi-dose vials are dated by healthcare worker when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Note this is different from the expiration date printed on the vial. During a review of the facility's policy and procedure (P&P) titled Medication Storage, dated 9/28/22, the P&P indicated, All multi-dose bottles must be dated upon opening . Medications requiring 'refrigeration' or temperatures between 2 C (36 F) and 8 C (45 F) are kept in a refrigerator . 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 . Medication storage conditions are monitored on a monthly basis and corrective actions taken if problems are identified.

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	08/09/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50121 Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program designed to provide a safe and sanitary environment to prevent the spread of infection when: 1. Licensed Nurse 1 (LN 1) did not perform hand hygiene (cleansing hands with soap and water or hand sanitizer) during medication preparation and administration in accordance with facility policy and procedure. 2. The pill cutter was not sanitized and disinfected after use. These failures placed 39 residents at increased risk of infections and had the potential to spread infection to other residents, visitors, and staff. Findings: 1. During a medication pass observation on 8/6/24, at 7:59 a.m. with LN 1, LN 1 was observed administering medications to Resident 26. After administering the medications, LN 1 donned gloves without performing hand hygiene. During a medication pass observation on 8/6/24 at 8:59 a.m. with LN 1, LN 1 was observed administering medications to Resident 392. After administering the medications to Resident 392, LN 1 donned gloves without performing hand hygiene. During an interview on 8/6/24 at 11:18 a.m. with LN 1, LN 1 stated it was not her practice to perform hand hygiene before or after wearing gloves to provide care to residents. During an interview on 8/7/24 at 9:28 a.m. with the Infection Preventionist (IP), the IP stated staff were expected to perform hand hygiene between residents, before treatment, and before and after glove use. The IP stated hand hygiene was taught on new employee orientation, was reviewed annually during the employee evaluation, and periodically at in-services if an issue was identified. During an interview 8/7/24 at 10:00 a.m. with the Director of Nursing (DON), the DON stated staff were expected to perform hand hygiene before and after resident contact, after contact with body fluids, and before and after gloving. The DON stated, Gloves are not a substitute for hand hygiene. The DON stated failure to perform hand hygiene could result in infections spreading among residents. During a review of the facility policy and procedure (P&P) titled, Hand Hygiene Policy: Handwashing, dated 11/3/23, the P&P indicated, Handwashing will occur at the following times . before applying and removing gloves. 2. During the same medication pass observation for Resident 392, LN 1 was observed wiping white powder from a pill cutter with a gloved hand before use. After using the pill cutter, LN 1 did not clean or disinfect it and placed it back on the medication cart. (continued on next page)

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	08/09/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/6/24 at 11:18 a.m. with LN 1, LN 1 stated, I should have wiped the pill cutter with disinfecting wipes. During an interview on 8/7/24, at 9:28 a.m. with the IP, the IP stated the pill cutter should have been disinfected after each use by wiping with a disinfecting wipe. She stated if pill cutters were not cleaned after use, medication could be mixed with remnants of the previously cut medication which could cause harm to the resident. During an interview 8/7/24 at 10 a.m. with the DON, the DON stated the pill cutter should have been wiped after every use. The DON stated, The residue could contain a substance that the resident had allergy to. During a review of the P&P titled, Medication Storage, undated, the P&P indicated, Equipment for the administration of medications is thoroughly cleaned and properly stored after each use.