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	07/25/2025

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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure medication administration were followed in accordance with professional standards of practice for one of 13 sampled residents (Resident 24), when hold parameters were not added to the lispro insulin (a high-risk medication that affects blood sugar levels) administration order. This failure resulted in the medication not administered several times and had the potential to result in unstable blood sugar levels affecting the resident's highest practicable well-being. During a review of Resident 24's Face Sheet, dated 7/25/25 (print date), the Face Sheet indicated, Resident 24 was admitted to the facility in May of 2025 with diagnoses which included femur (thigh bone) fracture and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 24's Medication Administration Record (MAR) for July 2025, the MAR included the following orders:Order dates 5/30/25-7/22/25: insulin lispro solution subcutaneous injection of six units (amount of active medication) to administer with meals; andOrder dates 7/22/25-open ended: insulin lispro solution subcutaneous injection of six units to administer with meals and hold administration if NPO (nothing by mouth, resident is not eating). During a review of Resident 24's nursing progress note (NPN) entered by Licensed Nurse 4 (LN 4) on 7/22/25 at 3:33 p.m., the NPN indicated, Clarified with [physician] regarding patients (sic) Lispro order, per MD [medical doctor], Routine Lispro is given with meals, Hold if NPO. During a review of Resident 24's Medications Regimen Review (MRR, pharmacist's evaluation of provided medications), dated 6/27/25, the MRR indicated, Please consider adding hold parameters to insulin orders. Staff is sometimes holding dose due to low BG [blood glucose] but there is no parameter to follow in actual order. During an observation on 7/22/25 at 6:47 a.m. LN 4 was observed administering medications to Resident 24. LN 4 took a blood glucose (BG) reading, and the glucometer display read 76 mg/dL (milligrams per deciliter, unit of concentration). LN 4 did not administer 6 units of Insulin Lispro per physician's order. During an interview on 7/22/25 at 2:41 p.m. with LN 4, LN 4 confirmed that she did not administer 6 units of insulin lispro to Resident 24 that morning. LN 4 confirmed that the order did not provide specific BG reading or other hold parameters to specify when the administration should be held. LN 4 agreed that the parameters needed to be clarified with the physician. During a review of Resident 24's MAR and food intake record in July of 2025, the following dates and times were verified when meals were documented as consumed by Resident 24 and 6 units of insulin lispro were not administered: 7/1/25 at 5-6 p.m. BG of 103 mg/dl. Dinner consumed 76-100%;7/3/25 at 7-8 a.m. BG of 82 mg/dl. Breakfast consumed 26-50%;7/4/25 at 5-6 p.m. BG of 84 mg/dl. Dinner consumed 26-50%;7/5/25 at 7-8 a.m. BG of 106 mg/dl. Breakfast consumed 51-75%;7/6/25 at 7-8 a.m. BG of 84 mg/dl. Breakfast consumed 76-100%;7/8/25 at 7-8 a.m. BG of 90 mg/dl. Breakfast consumed 26-50%;7/10/25 at 7-8 a.m. BG of 80 mg/dl. Breakfast consumed 51-75%;7/10/25 at 5-6 p.m. BG of 76 mg/dl. Dinner consumed 51-75%;7/13/25 at 7-8 a.m. BG of 77 mg/dl. Breakfast consumed 76-100%.7/15/25 at 7-8 a.m. BG of 80 mg/dl. Breakfast consumed 76-100%;7/17/25 at 11 a.m.-12 p.m. BG of 118 mg/dl. Lunch consumed 25-50%;7/20/25 at 11 a.m.-12 p.m. BG of 81 mg/dl. Lunch consumed 76-100%;7/20/25 at 5-6 p.m. BG of 90 mg/dl. Dinner consumed 76-100%; and7/22/25 at 7-8 a.m. BG of 76 mg/dl. Breakfast consumed 76-100%. During an interview on 7/25/25 at 9:55 a.m. with the Director of Nursing (DON), DON confirmed that lispro insulin should have been given to resident 24 with food per MD order and hold parameters should have been included. The DON recognized that the MRR brought the issue to the attention of the facility before 7/1/25, and the NPO hold parameters were not added until 7/22/25. During a review of the facility's policy and procedure (P&P) titled, Medication Orders, updated 9/28/22, indicated, Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. The prescriber is contacted to verify or clarify an order if the patient has an allergy to the medication, there are contraindications to the medication, or the directions are confusing.During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require substantial amount of specific knowledge of the following: (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement treatment, disease prevention, or rehabilitative regiment , ordered by and within the scope of licensure of a physician, as defined

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on observation, interview, and record review, the facility failed to ensure one of five residents (Resident 31) was free of unnecessary medications when an antidepressant (a medication to improve mood) was administered without corresponding medical diagnosis or documented behavioral symptoms to justify its use. This failure had the potential to result in adverse reactions, functional decline, and chemical restraint for Resident 31.Resident 31 was admitted to the facility in the middle of 2025 with diagnoses which included anxiety disorder. During a review of Resident 31's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 6/11/25, the MDS indicated Resident 31had no diagnosis of depression, and had no symptoms and no behavioral symptoms of depression exhibited. During a review of Resident 31's Medical Doctor's (MD) New Admit Progress Note, dated 6/9/25, the progress note did not include major depression in the problem list, and the Resident 31's assessment/plan indicated, Major depression: Patient apparently was on escitalopram and buspirone, consent was given. The progress note indicated, Depression screening negative.During a review of Resident 31's Physician's Order (PO), dated 6/5/25, the PO indicated, escitalopram oxalate [medication used to treat depression], tablet; 10 mg [milligram, a unit of measurement]; amt [amount]: 30 mg; oral.Special Instructions: DX [Diagnosis]: Depression AEB [as exhibited by] verbalized sadness. During a review of Resident 31's PO, dated, 6/5/25, the PO indicated to monitor for, TARGET BEHAVIOR: (ESCITALOPRAM) & (VERBALIZED SADNESS). Indicate the number of times the behavior(s) occurred each shift.During a review of Resident 31's Treatment Administration History Record (TAHR) for the period of 7/1/2025 to 7/25/2025, the TAHR indicated the targeted behavior for verbalized sadness did not occur.During a review of the Resident 31's Medication Regimen Review (MRR), dated between 6/1/25 and 6/27/25, the MRR indicated, 1) Please review indication/behavior for the escitalopram order. Depression is not listed in [Resident 31's] problem list and in fact in the H&P [history and physical] it states depression screening negative.During a concurrent observation and interview on 7/25/25, at 8:51 a.m. in Resident 31's room, Resident 31 sat in a wheelchair at the bedside table, awake and dressed appropriately. Resident 31 stated he had a diagnosis of anxiety and had been treated for depression in another facility in the past. During an interview on 7/25/25 at 8:34 a.m. with the MDS Coordinator (MDSC), the MDSC indicated Resident 31 did not have a diagnosis of depression. The MDSC stated that Resident 31's MDS Section D indicated Resident 31's Mood Total Severity Score (measures severity of potential symptoms for depression with higher scores indicating greater severity) was zero, and did not exhibit any target behaviors.During an interview on 7/25/25 at 9:21 a.m. with Licensed Nurse 3 (LN 3), LN 3 stated the indication for Escitalopram was for depression. LN 3 indicated the expectation was to monitor for signs of depression through observation and by asking questions. LN 3 further stated if symptoms of depression were observed, they would document this behavior and notify the physician.During an interview on 7/25/2025 at 9:34 a.m. with the Director of Nursing (DON), the DON stated Resident 31 did not have a diagnosis of depression.During a review of an undated the facility's Policy and Procedure (P&P), titled Comprehensive Care Plan, the P&P indicated, .Based on information generated by the.MDS assessment, the interdisciplinary team will develop an individualized care plan with input from the patient and/or representative.A P&P for unnecessary medications was requested from the facility but not provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure medications were stored securely for a census of 40, when:1. The refrigerator used for storing controlled substances in the medication storage room was found unlocked and unattended; and 2. Medication cart #1 was found unlocked and unattended. These failures had the potential for unauthorized personnel to access medications, biologicals and controlled substances. 1. During a concurrent observation and interview on 7/22/25 at 6:33 a.m. with the Director of Staff Development (DSD), a medication storage room was inspected. The DSD opened the locked door to the storage room and no licensed staff was inside the room. The medication refrigerator was observed not locked and contained lorazepam (a controlled substance sedative medication). The DSD indicated that the refrigerator storing a controlled substance should be locked. During an interview on 7/25/25 at 9:55 a.m. with the Director of Nursing (DON), the DON confirmed that the medication room refrigerator used for storing controlled substances should be locked when not in active use to prevent unauthorized access. 2. During an observation on 7/22/25 at 6:21 a.m., medication cart #1 was observed unlocked and unattended. During a concurrent observation and interview on 7/22/25 at 6:27 a.m. with Licensed Nurse (LN) 1 and LN 2 at medication cart #1, LN 1 and LN 2 verified and confirmed medication cart #1 was unlocked and had been left unattended. LN 1 and LN 2 acknowledged the medication cart should be locked when unattended to ensure the safety and security of the medications. During an interview on 7/25/25 at 9:31 a.m. with the Director of Nursing (DON) the DON confirmed the medication cart should be locked when unattended to maintain medication and narcotic drug safety. During a review of the undated facility’s policy and procedure (P&P) titled, “Medication Storage, ” the P&P indicated, “The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications…Schedule II, III and IV controlled medications are stored separately from other medications under a double lock…Medications and biologicals are stored safely, securely, and properly…All drugs and biologicals are stored under locked compartments…Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.”

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food preparation in accordance with professional standards for food service safety were provided for a census of 40, when kitchen staff did not know how to calibrate thermometers to determine food time/temperature control during lunch tray line. This failure had the potential to cause food-borne illnesses in a vulnerable population.During a concurrent observation and interview on 7/24/25 at 12 p.m., in kitchen with Lead [NAME] 1 (LC 1), before the start of lunch tray line service, LC 1 was asked to demonstrate and explain the procedure for thermometer calibration. LC 1 placed a coffee cup, three-fourths full of water with cubed ice, on countertop. LC 1 was not able to verbalize the procedure for thermometer calibration and could not provide a policy for reference. LC 1 consulted Lead [NAME] 2 (LC 2) and Certified Dietary Manager (CDM), who were standing nearby, for assistance. LC 1 returned to the countertop and indicated the digital thermometers were inserted into an iced cup of water for less than 10 seconds for temperature reading. LC 1 and surveyor synchronized insertion of the digital thermometers into the same cubed ice coffee cup of water. LC 1 began counting out loud One alligator, two alligator, three alligator . LC 1 stopped counting at 17 alligator. LC 1's thermometer read 35.6 degrees (*), and the surveyor's thermometer read 32*. LC 1 decided to use another thermometer for a synchronized double check. LC 1 began counting out loud from one alligator, stopping at nine alligator. LC 1's thermometer read 37*, and the surveyor's thermometer read 32*. LC 1 and CDM decided to make a third attempt with another thermometer and synchronized the digital thermometers in the same cubed ice coffee cup of water. LC 1 began counting out loud from one alligator, stopping at six alligator. LC 1 thermometer read 20* and the surveyor's thermometer read 32*. LC 1, LC 2, and CDM acknowledged their inability to properly calibrate a thermometer before tray line.During a concurrent interview and record review, on 7/24/25 at 2 p.m., in the CDM's office with the CDM and the Registered Dietician (RD), the CDM presented a single sheet of paper, titled Emergency Procedure Calibration Thermometer Log, that showed documentation for two dates, 5/3/25 with a temperature reading 33.1, and 5/8/25 with a temperature reading 32.7. The CDM and the RD acknowledged kitchen staff's lack of education and training, that there was no record of in-services done, and no monthly temperature data related to thermometer calibration. The RD and the CDM indicated the expectation were for staff to have knowledge about the ice bath, proper timing and temperature for hot and cold foods to be served at proper temperatures, and the importance of education to prevent food borne illnesses for residents. During a review of the facility's policy and procedure (P&P) titled, Resource: Taking Accurate Temperatures, dated 2021, the P&P indicated, Choosing the Right Thermometer: Start with an accurately calibrated thermometer that is in good working condition.Calibrating the Thermometer.Thermometers should be calibrated at least monthly. Ice Point Method 1. Start with a container large enough to easily accommodate your thermometer. Fill it with ice (crushed is best).2. Put the thermometer probe into the ice water mixture. It is important to wait about 30 seconds.3.until the reading on the face of the dial reads 32 F (0 C).

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed ensure sanitary condition of the environment was maintained for a census of 40, when the kitchen waste fat in the indoor and outdoor refuse receptacles were not properly covered. This failure had the potential risk for the spread and transmission of diseases from pest or rodent activity in the kitchen and nearby outside dumpsters to a vulnerable population. During the initial kitchen tour observation on 7/22/25 at 6:20 a.m., in the Receiving Room, an approximately one-gallon uncovered silver pot, half-filled with a thick yellow liquid, was found on the floor near a garbage can. During the initial kitchen tour observation on 7/22/25 at 7 a.m. of the outside dumpsters, the dumpster doors were opened, and one moderately sized green, rigid plastic receptacle bin was found with lid open. Old, dried, yellow grease/waste fat was noted in large amounts adhered to the grated/grilled opening of receptacle bin and some of the grease food particles were wet in appearance. During the second kitchen tour observation on 7/23/25 at 7:25 a.m. of the outside dumpsters, the one green, rigid plastic receptacle bin was found with lid open, and the silver pot was turned upside down over the grated/grilled opening of the receptacle bin. During a concurrent observation and interview on 7/23/25 at 8:30 a.m. with the Certified Dietary Manager (CDM), the CDM verified the thick yellow liquid found in the silver pot was from the kitchen stove's grease trap drawer receptacle. The CDM stated the cooks emptied the grease drawer into the silver pot, the silver pot was kept in the Receiving Room for easy disposal to the outside grease garbage receptacle. The CDM confirmed in the outside garbage dumpster area the green receptacle bin with lid open, and the silver pot turned upside down over the grated opening. The CDM indicated that after the grease was drained, the silver bucket was brought back into the facility for cleaning & sanitizing through the kitchen's dishwasher. The CDM stated staff in-services had not been done related to grease/garbage disposal, or pest avoidance, and would need to speak with maintenance regarding a garbage/refuse disposal policy. The CDM further stated the expectation was for kitchen waste fat to be properly covered to avoid an infestation of pests and rodents, potentially causing harm to residents. During a review of the facility's Policy and Procedure (P&P) titled, Garbage and Refuse, updated 2021, the P&P indicated, .1. Containers are provided with tight-fitting lids.5. Garbage containers are maintained in a sanitary manner.7. Storage areas are maintained clean and sanitary.