STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056177	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DOUBLE TREE POST ACUTE CARE CENTER	**7400 24TH STREET SACRAMENTO, CA 95822**

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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignity was provided for three of 27 sampled residents (Resident 88, Resident 10 and Resident 82), when: 1. Licensed Nurse 5 (LN 5) did not explain procedure and did not close the privacy curtain during a blood sugar check for Resident 88; and 2. A call light was not answered promptly by staff for Resident 10 and was out of reach for Resident 82. These failures had the potential to negatively impact the residents' quality of life and psychosocial well-being. Findings: 1. Resident 88 was admitted to the facility in the middle of 2018 with [DIAGNOSES REDACTED]. A review of Resident 88's Minimum Data Set (MDS, an assessment tool), dated 2/11/20, indicated she had no memory impairment. During a concurrent observation and interview on 3/10/20 at 12:23 p.m., LN 5 entered Resident 88's room and checked Resident 88's blood sugar but did not explain the procedure. LN 5 did not pull the privacy curtain and Resident 88's roommate watched the entire procedure. Resident 88 reacted and stated, I don't like where you poke my finger. It hurts. In an interview on 3/10/20 at 12:28 p.m., LN 5 stated, I did not pull the curtain for privacy when I took the blood sugar. In an interview on 3/11/20 at 1:39 p.m., when asked what the expectation was for the staff when providing care, procedures, giving injections or medication administration, the Director of Nursing (DON) stated, Privacy and dignity should be provided to each resident, and procedures should be explained before doing any procedure. A review of the facility policy and procedure titled, Quality of Life - Dignity, dated 8/09, indicated, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. A review of the facility policy and procedure titled, Resident Rights, dated 12/16, indicated, Employees shall treat all residents with kindness, respect, and dignity. 2. Resident 10 was admitted to the facility in late 2018 with [DIAGNOSES REDACTED]. In an interview on 3/10/2020 at 2:30 p.m., the Director of Nursing (DON) indicated there was no policy on call lights, and stated, I will try to look for one. Requests were made for the policy on call lights but none was provided. In an interview on 3/10/20 at 2:45 p.m., when asked about the call lights, LN 4 stated, I don't want to say anything about this (call lights) because this is an on-going issue. During an interview on 3/11/20 at 10:13 a.m., Resident 10 stated, I was in a lot of pain yesterday and it took 45 minutes after I turned on my call light to receive my pain medication. Resident 10 indicated his roommate went to the front desk and asked on his behalf and the roommate was told everybody was busy. In an interview on 3/11/20 at 1:39 p.m., when asked what the expectation was from the staff when answering all lights, the DON stated, Call lights should be answered immediately. 3. Resident 82 was admitted to the facility in the middle of 2011 with [DIAGNOSES REDACTED]. A review of Resident 82's MDS, dated [DATE], indicated Resident 82 had mild memory impairment and needed extensive assistance with ADLs. In an observation on 3/9/20 at 10:17 a.m., Resident 82's call light was found on the floor. In a concurrent observation and interview on 3/9/20 at 10:17 a.m., the MDS Coordinator verified that the call light was on the floor. The MDS Coordinator stated, The call light should be within reach.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, interview and record review, the facility failed to ensure a homelike environment was provided for five residents (Resident 35, 18, 71, 7 and 28) in a census of 117, when the residents' rooms were found bare, with no personal items, and scraped paint on the walls. This failure increased the potential for residents not attaining their highest practicable quality of life. Findings: 1. In a concurrent observation and interview on 3/9/20 at 9:06 a.m., Resident 35 was in bed, alert and awake. Certified Nursing Assistant 5 (CNA 5) stated, (Resident 35) gets up in the morning but he says he is not feeling well this morning. If he wants to get up I will get him up. Resident 35's room was bare, with no personal items, and the paint on the wall was scraped. Resident 35 stated, There is not much to the room. I feel like I don't live here. In a concurrent observation and interview on 3/9/20 at 9:15 a.m., Resident 18 was in bed, awake, alert and responsive. The room was bare, with no personal belongings or pictures. Resident 18 stated, I have been here for three months. I don't have anything in my room. Nobody offered me anything. It looks so bare. In a concurrent observation and interview on 3/9/20 at 9:21 a.m., CNA 5 confirmed there was nothing in the room, and indicated the walls had been scraped because of the bed going up and down. CNA 5 stated, There should be at least a picture on the walls for both residents. (Resident 35) has been here for a while and he lives here and it looks very undignified. In a concurrent observation and interview on 3/9/20 at 9:55 a.m., Resident 71's room was bare, with no personal items. CNA 6 agreed there was nothing in Resident 71's room, and stated, There are other rooms that are not homelike, no pictures in their rooms. In a concurrent observation and interview on 3/9/20 at 10:10 a.m., Resident 28 was seated in a wheelchair, awake and verbally responsive. Resident 28's room walls were bare, with no personal belongings or pictures at bedside. Resident 28 stated, I have been here for two years now. Nobody offered to decorate my room. In an interview on 3/9/20 at 10:45 a.m., the Activities Director (AD), who was in another resident's room, indicated she tried her best to make the rooms homelike, and stated, I need money to provide room decorations .I bought that frame on the wall for this resident, and it is expensive. A review of the facility policy and procedure titled, Quality of Life - Dignity, dated 8/09, indicated, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** Based on interview and record review the facility failed to issue written bed hold notices for 12 randomly selected residents (Resident 14, 37, 39, 58, 89, 97, 107, 170, 171, 172, 173, 174) who were transferred to the hospital in the last three months. This failure had the potential to cause confusion and psychological distress to the residents and/or responsible parties (RP). Findings: A review of clinical records for Residents 14, 37, 39, 58, 89, 97, 107, 170, 171, 172, 173, and 174 indicated each resident had at least one transfer to an acute care hospital since the beginning of 2020 and none received a written notice of bed hold. In an interview on 3/11/20 at 1:27 p.m., the Director of Nurses (DON) stated, We notify the RP of any change in condition and ask them about a bed hold and it should be in the progress notes .We only

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F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) have them sign a bed hold when they are admitted and upon return to the facility if 24 hours or more. In an interview on 3/11/20 at 2:45 p.m., Licensed Nurse 3 (LN 3) stated, I don't send anything to the RP or resident when they are transferred to the hospital. In an interview on 3/11/20 at 3:14 p.m., the DON stated, I will confirm that it is not our practice to give a written notice of bed hold when a person is transferred to the hospital. The RP is notified and it is documented in the nurses notes .but nothing in writing is provided to the resident or the RP. Review of a facility policy titled, Bed-Holds and Returns, revised 3/17, indicated, Upon admission, prior to transfers and therapeutic leaves, residents or resident representatives will be informed of the bed-hold and return policy .The facility will notify the resident and the resident representatives that explains in detail .The details of the transfer (per the Notice of Transfer) .
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure care plan development for one of 27 sampled residents (Resident 270) when there was no care plan for intravenous (IV) medication management. This failure had the potential to negatively impact the resident's physical well-being. Findings Resident 270 was admitted in the winter of 2019 with multiple [DIAGNOSES REDACTED]. Review of a facility document titled, Baseline Care Plan dated 3/7/20 indicated infection. Review of a facility document titled, Medication Review Report dated 3/7/20, indicated (Brand name for [MEDICATION NAME] - an antibiotic) Solution Reconstituted (IV antibiotic) 1 gram. Use 1000 mg (milligram) every 24hours IV bag infuse over 30 mins. In an observation on 3/11/20 at 9:09 a.m., an intravenously (IV) line pole with an empty bag of antibiotic was observed next to Resident 270's bed. In an observation on 3/11/20 at 9:09 a.m., an IV site on Resident 270's right forearm was dated 3/6/20 in place. During an interview on 3/11/20 at 10:16 a.m., Licensed Nurse 7 (LN 7) stated, I am not seeing an IV care plan in place for the admission orders [REDACTED]. Review of the facility's policy and procedure titled, Care Plans - Comprehensive Person-Centered. dated 12/16 indicated, Facility will assure that the resident's comprehensive, person-centered care plan includes objectives to meet and maintain their functional needs. The facility is responsible for assuring the development and implementation for each residents immediate needs.
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** Based on observation, interview and record review, the facility failed to ensure physician's orders were followed in accordance with professional standards for four of 27 sampled residents (Resident 20, Resident 220, Resident 270, and Resident 10) when: 1. Resident 20's low air loss (LAL, designed to prevent and treat pressure wounds) mattress was unplugged; 2. Resident 220's prescribed medication was not administered for two days; 3. Resident 270's intravenous (IV, directly into a vein) medication was not administered as ordered; and 4. Resident 10's blood pressure medication was not administered for several days. These failures increased the risk for a decline in the residents' health status and well-being. Findings: 1. Resident 20 was admitted to the facility at the end of 2019 with multiple [DIAGNOSES REDACTED]. to pressure on it and lack of movement). Review of Resident 20's physician's order, dated 12/13/19, indicated, THERAPEUTIC BED TO AID PREVENTION OF PRESSURE SORE. MONITOR . Review of Resident 20's Minimum Data Set (MDS, an assessment tool), dated 12/19/19, indicated Resident 20 was alert and oriented, able to make his needs known. He required extensive assistance with bed mobility and turning side to side. Review of Resident 20's care plan titled, Resident at risk for development of pressure ulcer/skin breakdown due to: Frequent incontinence in bladder/ Bowel ., revised 2/11/20, indicated .Pressure relieving/reducing device in bed .THERAPEUTIC BED TO AID PREVENTION OF PRESSURE SORE . Review of Resident 20's care plan titled Presence of Pressure Ulcer on admit .Coccyx (tailbone)-Stage 4 (ulcerated down to the muscle and bone), revised 2/19/20, indicated, THERAPEUTIC BED TO AID PREVENTION OF PRESSURE SORE . Review of Resident 20's WEEKLY WOUND EVALUATION, dated 3/3/20, indicated a stage IV pressure ulcer with the measurements of 1.5 cm (centimeters, a unit of measurement) long by 0.5 cm wide by 0.9 cm deep and indicated it's response to treatment as deteriorated. During an interview with Resident 20 on 3/9/20 at 8:07 a.m., he mentioned the air was coming out of his (LAL) mattress. During a concurrent observation and interview with Resident 20 on 3/12/20 at 8:03 a.m., the LAL mattress was observed to be off and the mattress deflated. Resident 20 indicated, It was probably off all night because I didn't hear it making noise. During a concurrent observation and interview with Resident 20's Certified Nurses Assistant 4 (CNA 4) on 3/12/20 at 8:05 a.m., she verified Resident 20's LAL mattress was unplugged and not running. She also verified he had a pressure ulcer on his back. During an interview on 3/12/20 at 8:23 a.m. with the Director of Nurses (DON) she said, I believe there is monitoring every shift for nurses (to check the functioning of the LAL mattress). They should check it's functioning. 2. Resident 220 was admitted to the facility in early 2020 with [DIAGNOSES REDACTED]. A review of Resident 220's physician's order, dated 3/5/20, indicated, [MEDICATION NAME] Capsule (medication for the prevention of spasms of lung passages caused by [MEDICAL CONDITION]) 18 MCG (microgram, measure of weight) 1 capsule orally (by mouth) one time a day for breathing treatment for [REDACTED]. Review of Resident 220's care plan titled, Alteration in Respiratory status due to: DX (diagnosis): [MEDICAL CONDITION], dated 3/5/20, indicated, Implement measures to promote effective airway and improve breathing pattern. Medication/s as ordered. A review of Resident 220's Medication Administration Record [REDACTED]. A review of Resident 220's Progress Notes, dated 3/9/20 at 9:25 a.m., revealed Licensed Nurse 4 (LN 4) indicated waiting on supply/refill (of [MEDICATION NAME]). During a concurrent medication pass observation and interview on 3/10/20 at 7:53 a.m., LN 4 passed medications for Resident 220. LN 4 indicated the medication, [MEDICATION NAME], was ordered last 3/8/20, and stated, The medications is not available. I will call the physician and the pharmacist. A review of Resident 220's Progress Notes, dated 3/10/20 at 8:06 a.m., LN 4 indicated, waiting on supply (of [MEDICATION NAME]), will confirm with pharmacy request was sent; will notify MD (physician) and pt (patient). There was no documented evidence LN 4 notified the physician or pharmacist or an order received from the physician to hold the medication. A review of Resident 220's Minimum Data Set (MDS, an assessment tool), dated 3/11/20, indicated Resident 220 had mild memory impairment, and had a [DIAGNOSES REDACTED]. 3. Resident 270 was admitted to the facility in early 2020 with [DIAGNOSES REDACTED]. A review of Resident 270's care plan titled, Presence of Urinary Tract Infection, dated 3/7/20, indicated, Infection will be resolved after course of treatment. ABT (antibiotics) as ordered. A review of Resident 270's physician's order, dated 3/7/20, indicated, (Brand name for [MEDICATION NAME] - an antibiotic) Solution (antibiotic to treat infections) Reconstituted 1 GM (gram) .one time a day for UTI until 03/10/2020 0800 1000mg (milligram) every 24 hours IV bag infuse over 30mins (minutes). A review of Resident 270's MAR, dated 3/10/20, indicated (brand name for [MEDICATION NAME]) was not administered as ordered. During an observation on 3/11/20 at 6:48 a.m., Resident 270 was in bed, awake and alert, and an indwelling urinary catheter and IV saline lock (location for the introduction of IV medications) on the right arm were noted. During a concurrent observation and interview on 3/11/20 at 7:27 a.m., Resident 270's IV pole had an empty IV bag of (brand name for [MEDICATION NAME]) 1 gm dated 3/9/20. LN 7 confirmed and verified in the MAR indicated [REDACTED]. The IV medication should have been administered 3/10/20, as ordered. During a concurrent medication room observation and interview on 3/11/20 at 7:39 a.m., Resident 270's (brand name for [MEDICATION NAME]) IV medication was found with a due date to be administered for 3/10/20. The MDS Coordinator (MDSC) verified the IV bag was for Resident 270, and stated, The medication should have been administered yesterday. A review of Resident 270's MDS, dated [DATE], indicated he had moderate memory impairment and had urinary tract infection. A review of the facility policy and procedure titled, Administering Medications, dated 4/19, indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with the prescribed orders, including any required time frame. A review of the facility policy and procedure titled, Pharmacy Services Overview, dated 4/19, indicated, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services . 4. Resident 10 was admitted in late 2018 with [DIAGNOSES REDACTED]. A review of the physician's orders and care plan for Resident 10, dated 11/26/19, indicated, [MEDICATION NAME] (medication used to treat high blood pressure) 10 mg .for high blood pressure .Administer medications as ordered. In a record review of the progress notes by the Nurse Practitioner (NP), dated 2/17/20, 2/26/20, 3/2/20, 3/4/20, and 3/8/20, indicated, Continue [MEDICATION NAME]. Monitor blood pressure. A review of Resident 10's Medication Administration Record [REDACTED]. A review of the MDS, dated [DATE], indicated Resident 10 had mild memory impairment and needed extensive assistance with activities of daily living (ADLs). In a concurrent observation

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) and interview on 3/12/20 at 9 a.m., Resident 10 indicated he was not feeling well. LN 5 indicated Resident 10's blood pressure reading was 167/106. When asked if the blood pressure medication was administered, LN 5 stated, [MEDICATION NAME] was discontinued since 2/17/20. LN 5 verified there was no documented evidence that the blood pressure medication was discontinued by the physician. A review of the Resident 10's medical record on 3/12/20, indicated Resident 10 had high blood pressures (normal blood pressure is defined by the American Heart Association at the Internet website address: https://www.heart.org/en/health-topics/high-blood-pressure/understanding-blood-pressure-readings retrieved on 3/25/20 at 5:53 p.m., is less than 120 over less than 80, 120/80) on the following days: 3/3/20 at 156/103; 3/4/20 at 156/100; 3/8/20 at 151/96; 3/9/20 at 151/90; 3/10/20 at 162/98; 3/11/20 at 165/105; 3/12/20 at 161/ 90 and 167/106. In a concurrent interview and record review on 3/12/20 at 9:28 a.m., LN 5 verified Resident 10's blood pressure was trending high, and he did not receive the blood pressure medication since 2/17/20. LN 5 verified there were no nursing progress notes to show MD was notified of Resident 10's significant change of blood pressure since 3/3/20. In a concurrent interview and record review on 3/12/20 at 10 a.m., when asked about the process on the resident's change of condition, the DON stated, An SBAR (Situation Background Assessment Recommendation) note is generated on the progress note. A care plan is created on the change of condition. The MD and the Responsible Party (RP) is notified. Nurses follow the protocol for change of orders. The DON stated, There should be documents from the Primary Care Physician (PCP) to show the change of orders. The DON stated, There is no document to show in the electronic health record and the resident's chart that [MEDICATION NAME] is to be discontinued. The DON verified there was no nurse's progress note to show the MD was notified about the resident's high blood pressure. The DON verified that the progress notes of the NP indicated, Continue [MEDICATION NAME]. Monitor blood pressure. Review of the Nursing Practice Act Rules and Regulations revealed 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 a substantial amount of scientific knowledge or technical skill, including all 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 a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing 1997 State of California Department of Consumer Affairs. pp. 5.)
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain timely and appropriate pharmaceutical services for one out of 27 sample resident (Resident 220), when a prescribed medication was not available and administered as ordered. This failure increased the potential risk of Resident 220's needs not being met and decline in Resident 220's health condition. Findings: Resident 220 was admitted to the facility in early 2020 with [DIAGNOSES REDACTED]. A review of Resident 220's physician's order, dated 3/5/20, indicated, [MEDICATION NAME] Capsule (medication for the prevention of spasms of lung passages caused by [MEDICAL CONDITION]) . Review of Resident 220's care plan titled, Alteration in Respiratory status due to: DX (diagnosis): [MEDICAL CONDITION], dated 3/5/20, indicated, Implement measures to promote effective airway and improve breathing pattern. Medication/s as ordered. A review of Resident 220's Medication Administration Record [REDACTED]. A review of Resident 220's Progress Notes, dated 3/9/20 at 9:25 a.m., revealed Licensed Nurse 4 (LN 4) indicated waiting on supply/refill (of [MEDICATION NAME]). During a concurrent medication pass observation and interview on 3/10/20 at 7:53 a.m., LN 4 passed medications for Resident 220. LN 4 indicated the medication, [MEDICATION NAME], was ordered last 3/8/20, and stated, The medications is not available. I will call the physician and the pharmacist. LN 4 explained to Resident 220 the medication was not available. A review of Resident 220's Progress Notes, dated 3/10/20 at 8:06 a.m., LN 4 indicated waiting on supply (of [MEDICATION NAME]), will confirm with pharmacy. During an interview on 3/11/20 at 1:39 with the Director of Nurses (DON), when asked what her expectations were for following the physician order on missed or unavailable medications, the DON stated, I would expect the nurses to notify pharmacy about the needed medication and also the notify the physician to get orders, and document the reason for the missed or delayed medications. A review of the facility policy and procedure titled, Pharmacy Services Overview, dated 4/19, indicated The facility shall contract with a licensed consultant pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs .Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement medication storage and disposal practices according to the pharmaceutical policies and procedures for a census of 117, when: 1. Scattered loose pills and medications combined with resident-care equipment were found in the medication carts; 2. Expired medication was found in the narcotic drawer of medication cart 3; and 3. There was no thermometer in the refrigerator freezer in the medication room. These failures increased the potential risk for residents to receive ineffective medications and placed residents at risk for cross contamination. Findings: 1. During a concurrent inspection of medication cart 3 and interview on 3/10/20 at 10:23 a.m., an open bottle of [MEDICATION NAME] liquid medication (medication used to treat constipation) combined with personal equipment in one drawer, and several scattered loose pills below the bubble packs in two middle drawers were found. Licensed Nurse 5 (LN 5) verified the findings, and stated, The cart should be clean, and the medications are organized. During a concurrent medication room inspection and interview on 3/11/20 at 7:39 a.m., two medications, rectal suppository and eye lubricant, were found in separate cabinets combined with other house supplies. The Minimum Data Set Coordinator (MDSC) confirmed the findings, and stated, The medications should not be there. During a concurrent medication cart 4 inspection and interview on 3/11/20 at 10:32 a.m., scattered loose pills at the bottom of the drawers, a tablet pack and a bottle of liquid medications combined with resident-care equipment were found. LN 6 confirmed the findings, and stated, We should clean the cart more often, and organize the medications. 2. During a concurrent medication cart 3 inspection and interview on 3/10/20 at 10:23 a.m., a medication container labeled [MEDICATION NAME] (medication used to treat anxiety) 1 mg (unit of measurement) tab was found with an expiration date of 10/19/19, inside the narcotic drawer. LN 5 verified the medication was expired, and stated, The medication was from home, brought by the family .The medication should have been removed from the cart. During a concurrent interview and inspection of controlled medications on 3/11/20 at 1:39 p.m., the DON held a container of medication, [MEDICATION NAME] 1 mg with an expiration date of 10/19/19, and stated, We only have one medication handed to me yesterday. The DON confirmed the medications was expired. 3. During a concurrent medication room inspection and interview on 3/11/20 at 7:39 a.m., there was no thermometer found in the refrigerator freezer and there were resident's food and medications inside the freezer. The MDSC confirmed there was no thermometer inside the freezer. In an interview on 3/11/20 at 1:41 p.m., when asked what her expectation with the medication room and medication carts was, the DON stated, The nurses should make sure the cart is clean and organized, medications should be grouped together, expired medications should be disposed and discarded, and medications should not be mixed with other equipment. A review of the facility policy and procedure titled, Sanitation and Infection Control: Refrigerated Storage, dated 2018, indicated, The refrigerated areas will be managed so that proper time temperature is maintained .must have a thermometer that is easily visible . should be placed halfway into the refrigerator should be recorded twice a day . A review of the facility policy and procedure titled, Storage of Medications, dated 4/19, indicated, The facility stores all drugs and biologicals in a safe, secure and orderly manner. The nursing staff is responsible for maintaining medication storage and preparation in a clean, safe and sanitary manner. Discontinued, outdated, deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3)
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 review of facility documents, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for a census of 117 when: 1. Multiple foods had no use-by date; 2. A black mold-like substance was found in the inner section of the ice machine; 3. A thick dried yellow substance was on the ledge and bottom of a utensil drawer; 4. Multiple staff did not follow hand washing protocols; 5. A fan was found covered with heavy dust-like debris; and 6. No internal thermometer was found inside the reach-in refrigerator. These failures increased the risk for food borne illness. Findings: 1. During a concurrent observation of the kitchen and interview with Cook 1 on 3/9/20 starting at 7:42 a.m., she verified: Two medium containers of heavy cream, one visibly bloated, were outdated with a use-by date of 2/26/20 and available for use. A medium container of yogurt, received 3/6/20, had a split lid, the seal was broken, yogurt was showing through, there was no use-by date and it was available for use. Two bulk containers of cereal, received 2/21/20, had no use-by date and were available for use. One bulk container of food thickener with a received date of 3/1/20, had no use-by date and was available for use. During a concurrent observation and interview with the Cook 1 on 3/9/20 at 8:05 a.m., she verified the heavy cream and yogurt should have been checked and discarded. During a concurrent observation of the dry storage area and interview with the Dietary Manager (DM) on 3/9/20 at 8:38 a.m., a large bin of flour, dated 8/16/19, and a large bin of oatmeal, dated 2/28/20, had no use-by date. The DM said, There should be a use-by date on them. Review of the facility's policy and procedure titled, Sanitation and Infection Control: Usage and Storage of Leftovers and Pre-cooked Items, dated 2018, indicated, The food will be labeled properly and stored in a proper way . 2. During a concurrent observation of the ice machine and interview with the Maintenance Supervisor (MS) on 3/9/20 at 8:26 a.m., he verified there was black mold-like substance on the right and left seal of the upper compartment, and a dime sized black flake on the right wall. Review of the facility policy and procedure titled, Sanitation and Infection Control: Cleaning Ice Machine, dated 2018, indicated, Follow the manufacturer recommendations . An observation of the outside of the ice machine revealed undated instructions which revealed, CLEAN ALL INTERNAL SURFACES AND AREAS WHERE LIVE SCALE HAS COLLECTED . 3. During a concurrent observation and interview with Cook 1 on 3/10/20 at 8:17 a.m., a thick dried yellow substance was seen on the ledge and bottom of a utensil drawer. Cook 1 was asked about it and said, Probably the blender spilled this morning. 4. During a lunch preparation observation on 3/10/20 at 11:23 a.m., Cook 3 pushed her sweater up her arm with her bare hand, walked across the kitchen and gathered clean utensils from the dishwashing area without washing her hands. During a concurrent observation and interview with Cook 2 on 3/10/20 at 11:32 a.m., she held 5 thermometers with the metal prongs gripped in her ungloved hand and used them to check temperatures of individual foods on the steam table. When asked about the contact of bare hands with the prongs that were put in cooked food, Cook 2 verified the observation and said, You shouldn't touch the metal (prongs). During a tray line observation on 3/10/20 at 12:05 p.m., Dietary Aid 1 (DA 1) touched a kitchen door knob with her gloved hand and pushed the food cart to the hallway. DA 1 did not change her gloves and continued her work at the tray line. During an observation on 3/10/20 at 12:08 p.m., Certified Nurses Assistant 3 (CNA 3) came into the kitchen to ask for additional ketchup. DA 1 handed a large number of individual ketchup packets to CNA 3 who reached for them and placed her bare hands around DA 1's gloves to receive them. DA 1 went back to plating food without washing her hands or changing her gloves. During a subsequent interview with the Registered Dietician Consultant (RDC) on 3/10/20 at 12:20 p.m., she was asked what her expectations were, and said, If they (dietary staff) touch their clothing, they should wash their hands. Staff should put ketchup in a container and pass it to non-kitchen personnel without hand-to-hand contact. Staff should change gloves after touching door handles or use their elbow to open a lever-type door. Anything that comes in contact with food should be handled with gloved hands. 5. On a concurrent observation and interview with Cook 1 on 3/11/20 at 9:40 a.m., a fan, covered with heavy dust-like debris, was found underneath the counter. Cook 1 verified the fan was dirty and said, They use this fan at night when they mop the floor. During a concurrent observation and interview with the DM, on 3/11/20 at 9:45 a.m., DM verified that the fan was dirty and indicated the dirty fan should be cleaned so dust would not blow into the clean area. During an interview on 3/11/20 at 9:50 a.m., the MS indicated he did not have a log for cleaning the fan. 6. During a concurrent observation and interview with Cook 1 on 3/11/20 at 9:25 a.m., she verified there was no internal thermometer inside the reach-in refrigerator and said, The refrigerator is new .The internal thermometer must have been removed when they cleaned this refrigerator. Review of the facility's policy and procedure titled, Sanitation and Infection Control: Refrigerated Storage, dated 2018, indicated, The refrigerated areas will be managed so that proper time temperature is maintained .must have a thermometer that is easily visible . should be placed halfway into the refrigerator should be recorded twice a day . Review of the facility's refrigerator temperature monitoring log, dated 3/20, indicated external thermometer temperatures were monitored but not the internal thermometer temperatures.

F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program for a census of 117 when: 1. A Certified Nursing Assistant (CNA) did not sanitize hands when serving meal trays in between residents; 2. A resident was touching another resident's utensils and food during meal time; and 3. Licensed Nurses (LNs) did not disinfect resident-care equipment before use. These failures increased the potential risk for the transmission of communicable diseases and infections in a vulnerable population. Findings: 1. During a concurrent dining room observation and interview on 3/9/20 at 12:16 p.m., CNA 7 served meal trays to residents and did not clean or sanitize hands between residents. When asked if she sanitized her hands before serving the meal tray, CNA 7 stated, I did not sanitize my hands between the residents. CNA 7 stated, You should sanitize hands in between. A review of the facility policy and procedure titled, Handwashing/Hand Hygiene, dated 8/15, indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .Before and after eating or handling food; before and after assisting resident with meals. 2. During dining room observation on 3/9/20 at 12:27 p.m., Resident 92 was seated at the same table with Resident 66 during meal time. Resident 92 assisted and touched Resident 66's spoon, fork, plates and food items. Resident 92 touched Resident 66's hands and arms and encouraged her to eat. In an interview on 3/9/20 at 12:47 p.m., when LN 3 was asked about Resident 92 assisting Resident 66 during meals, LN 3 indicated it happened every day, and stated, I will check if there has been an education on (Resident 92's) way of touching (Resident 66's) food and utensils while helping her eat. In an interview on 3/9/20 at 12:50 p.m., CNA 6 stated, It happens every day. (Resident 92) helps (Resident 66) to eat everyday .I know it is not appropriate that he is touching the other resident's utensils or food when she is eating but we don't know what they have instructed him to do. In an interview on 3/9/20 at 1:07 p.m., LN 3 stated, On the situation on (Resident 92 and Resident 66), there is no policy and procedure for that, but the situation has been care planned. In an interview on 3/9/20 at 3:36 p.m., the Minimum Data Set Coordinator (MDSC) stated, I know that (Resident 92 and Resident 66) are friends .There is a care plan that (Resident 92) is non-compliant with giving assistance and food to other residents. In an interview on 3/10/20 at 12:35 p.m., Resident 92 stated, The (MDSC) just talked to me yesterday on how I should and should not do when assisting the resident eating. It's not for my own good but for (Resident 66). We don't know what to expect when I am assisting her during meals. 3. During a concurrent medication pass observation and interview on 3/10/20 at 7:33 a.m., LN 4 picked up the blood pressure apparatus on top of the medication cart, entered resident's room, and used the equipment. When LN 4 was asked if the equipment was sanitized before use, LN 4 confirmed she did not clean the equipment before use. During a concurrent medication pass observation and interview on 3/10/20 at 12:16 p.m., LN 5 picked up resident-care equipment, entered a resident's room and checked the resident's blood sugar. When asked if LN 5 cleaned the device before use, LN 5 confirmed she did not sanitize or clean the equipment, and stated, We need to clean before and after we use the equipment. A review of the facility policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 10/18, indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected .Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident .Reusable resident care equipment will be decontaminated and/or sterilized between residents . A review of the facility policy and procedure titled, Infection Prevention and Control Program, dated 10/18, indicated, An infection prevention and control program (IPCP) is established to provide a safe, sanitary and comfortable environment to help prevent the development of communicable diseases and infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056177	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DOUBLE TREE POST ACUTE CARE CENTER	**7400 24TH STREET SACRAMENTO, CA 95822**

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	(continued... from page 4)