STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555913	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 -** 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 interview and record review, the facility failed to ensure comprehensive care plans were developed for 1 resident (Resident 1) who was admitted with skin issues including purplish discoloration, rashes/redness, for a census of 39. This failure had the potential to result in inadequate care being provided for Resident 1. Findings: Resident 1 was admitted to the facility in early 2020 with [DIAGNOSES REDACTED]. Review of an undated document titled, Admission Assessment, for Resident 1 indicated a diagram with identified areas of concern. Body marks were indicated on the diagram which included, purplish discoloration, on the back left side of the body, and rashes/redness on the abdomen. There were no measurements completed for the documented body marks. Review of Resident 1's Progress Notes did not indicate the presence of purplish discoloration and rashes/redness found during skin assessment during Resident 1's initial admission. Review of Resident 1's Physician Orders did not indicate any monitoring and/or treatment orders for the presence of purplish discoloration and rashes/redness found during the admission skin assessment for Resident 1. Review of Resident 1's Care Plans revealed there were no care plans in place that addressed the purplish discoloration and rashes/redness found during the admission skin assessment for Resident 1. During an interview with the Clinical Nurse Manager (CNM) on 5/1/20 at 10:14 a.m., the CNM confirmed the Admission Assessment document was undated. The CNM also confirmed the skin concerns identified were not written in the Progress Notes and there were no Care Plans initiated regarding the purplish discoloration and rashes/redness for Resident 1. The CNM stated the Medical Doctor (MD) should have been made aware of the skin concerns and Care Plans should have been developed for Resident 1 to address the skin conditions. Review of the facility policy titled, Comprehensive Care Plan, dated 2/27/18, indicated, All items or services ordered to be provided or withheld shall be included in each resident's plan of care. The comprehensive care plan describes services furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure professional standards of quality were followed for one resident (Resident 1), for a census of 39, when: 1. There was no documented evidence skin checks/shower was done as ordered; and 2. The Medical Doctor (MD) was not made aware of identified skin concerns. These failures had the potential to cause skin issues to go untreated and for preventative measures to be put in place for future skin issues. Findings: Resident 1 was admitted to the facility in early 2020 with [DIAGNOSES REDACTED]. Review of Resident 1's medical records indicated forms titled, Weekly/Shower Sheet were completed on 2/6/20, 2/10/20, and 2/17/20. There was no documented evidence a Weekly/Shower Sheet form was completed on the following dates (Tuesdays and Saturdays): 2/1/20, 2/4/20, 2/8/20, 2/11/20, 2/15/20, 2/18/20, and 2/22/20. Review of Resident 1's medical records indicated a Weekly Oral and Skin Assessment was completed on 2/20/20. There was no other documented evidence of a Weekly Oral and Skin Assessment conducted on Saturday PM shift as ordered. Review of Resident 1's Physician Orders dated 2/27/20 indicated an order for [REDACTED]. COMPLETE A FOCUSED OBSERVATION TITLED WKLY (weekly) ORAL & SKIN ASSESSMENT . Once A Day on Sat (Saturday) EVE (evening) 14:00 - 22:00 During an interview with the Director of Nursing (DON) on 3/19/20 at 10:34 a.m., the DON confirmed the shower sheets they have were dated 2/6/20, 2/10/20, and 2/17/20. The DON further stated the shower sheets should have been completed and done every Tuesday and Saturday, except refusals, which still should have been completed. The DON further confirmed they only have the Weekly Oral and Skin assessment dated [DATE]. The DON further stated the Weekly Oral and Skin Assessment should have been done every Saturday. Review of the facility policy titled, Activities of Daily Living, dated 3/13/18, indicated, Activities of daily living include the patient's ability to bathe, dress, grooming, oral care . appropriate treatment and services are provided for all residents to help them maintain or improve their abilities to perform activities of daily living. 2. Review of an undated document titled, Admission Assessment, for Resident 1 indicated a diagram with identified areas of concern. Body marks were indicated on the diagram which included, purplish discoloration, on the back left side of the body, and rashes/redness on the abdomen. There were no measurements completed for the documented body marks. Review of Resident 1's Progress Notes did not indicate the presence of purplish discoloration and rashes/redness found during skin assessment during Resident 1's initial admission. Review of Resident 1's Physician Orders did not indicate any monitoring and/or treatment for [REDACTED]. During an interview with the Clinical Nurse Manager (CNM) on 5/1/20 at 10:14 a.m., the CNM confirmed the document was undated. The CNM also confirmed the skin concerns identified were not written in the Progress Notes. The CNM stated the Medical Doctor (MD) should have been made aware of the skin concerns identified. Review of an undated facility policy titled, Physician Notification, indicated, The licensed healthcare practitioner will be notified in a timely manner regarding any unusual occurence in relation to patients.

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

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.