STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

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F 000	INITIAL COMMENTS	F 000	POC Received 6/3/24 POC Approved 6/4/24 BIC = 5/21/24 per DB	
	The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. Representing the Department of Public Health: Health Facilities Evaluator Nurse (HFEN), 47197 HFEN, 32096 HFEN, 45882 HFEN, 46872 HFEN, 50619 HFEN, 50633 The facility census was 38. The sample size was 15. One (1) facility reported incident #CA00899626 was investigated during the Recertification Survey. The Department was unable to substantiate a violation of the regulations for facility reported incident #CA00899626.			
F 583 SS=C	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583	The Administrator reviewed with the Dietary Manager and no other traycards were found to have been discarded in the trash. On 5/21/2024 the Dietary Services Supervisor completed an in-service of all dietary staff on the propert discarding and shredding of used meal tickets. The Dietary Services Supervisor will conduct weekly rounds to ensure proper disposal of traycards.	5/21/24

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

Dustin Murray | Administrator | 6/3/2024

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.

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F 583	Continued From page 1	F 583		

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure residents' rights to personal privacy and confidentiality of his or her personal medical information, when meal tray tickets were found thrown into the general trash.

This had the potential to compromise resident privacy and confidentiality for the 38 residents residing in the facility.

Findings:

During a concurrent observation and interview on 5/14/24, at 9:13 a.m., with Kitchen Aide (KA) 2 in the kitchen, KA 2 was observed throwing away residents' meal tickets into a garbage can.

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F 583	Continued From page 2 Resident meal tickets listed residents' names, diet, and room number. KA 2 stated meal tickets that are left on meal trays are thrown into the kitchen garbage can and the garbage can is then later emptied into the outside garbage bin. During an observation on 5/14/24, at 10:06 a.m., in the kitchen, KA 1 was observed removing residents' meal tickets from meal trays and throwing them away into the kitchen garbage can. During a concurrent observation and interview on 5/14/24, at 10:13 a.m., with the Dietary Supervisor (DS), the DS confirmed there were residents' meal tickets in the kitchen garbage can and staff was not following policy. The DS stated kitchen staff are expected to collect residents' meal tickets for shredding to protect resident's confidential information. The DS stated, "[Residents' meal tickets] Should not be in garbage can ...has patient info." During a review of the facility's policy and procedure (P&P) titled, "Confidentiality of Information and Personal Privacy," revised 10/17, the P&P indicated, "Our facility will strive to ensure privacy in matters related to patient care ...Access to resident personal and medical records will be limited to authorized staff ..."	F 583		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677	Resident 232 and resident 23 fingernails were cleaned and trimmed immediately.	6/3/24

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F 677	Continued From page 3	F 677	The fingernails of all Residents in the facility were checked and no other residents were found to be affected by deficient practice. All Nurses and CNAs were in-serviced on providing nail care at least weekly and as needed to all residents. Medical Records will Audit weekly that nail care has been completed. DSD to do random observations of nail care each week to monitor compliance. Results of the audits and observations will be reviewed during monthly QA meeting for compliance.	

Based on observation, interview, and record review, the facility failed to ensure two out of 15 sampled residents (Resident 232 and Resident 23) were assisted with nail care as part of their Activities of Daily Living (ADLs- normal daily functions required to meet basic needs) when Resident 232 and Resident 23 had long fingernails with blackish substance underneath the fingernails.

This failure had the potential for Resident 232 and Resident 23 to sustain injury and/or for the residents to acquire an infection.

Findings:

1. A review of Resident 232's clinical record indicated Resident 232 was admitted April of 2024 and had diagnoses that included chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and need for assistance with personal care.

A review of Resident 232's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/29/24, indicated Resident 232 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 11 out of 15 which indicated Resident 232 had a moderate impairment of cognition. A review of Resident 232's MDS Mood Status, dated 4/29/24, indicated Resident 232 had problem like feeling down, depressed, or hopeless for half or more of the days in two weeks. A review of Resident 232's MDS Functional Abilities and Goals, dated 4/29/24, indicated Resident 232 required setup or

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F 677	Continued From page 4	F 677		

clean-up assistance with personal hygiene and eating.

During a concurrent observation and interview on 5/13/24 at 9:55 a.m. with Resident 232, in Resident 232's room, Resident 232 had fingernails that were long and with blackish substance underneath the fingernails. Resident 232 stated he wanted his fingernails to be cleaned and trimmed.

During a concurrent observation and interview on 5/13/24 at 10 a.m. with Certified Nurse Assistant (CNA) 3, in Resident 232's room, CNA 3 confirmed that Resident 232 had long fingernails and with blackish substance underneath the fingernails. CNA 3 stated she would expect that Resident 232's fingernails to be trimmed and cleaned for infection control.

During a concurrent interview and record review on 5/14/24 at 3:34 p.m. with Licensed Nurse (LN) 4, Resident 232's clinical records were reviewed. LN 4 confirmed that Resident 232 had no care plan of refusing personal hygiene care and had no documented refusals of nail care. LN 4 stated Resident 232 had no issues like declining the trimming or cleaning of his fingernails.

During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated, "It is important to keep resident's fingernails clean and short for infection control...to avoid skin cuts or tears."

A review of Resident 232's care plan intervention, undated, indicated, "Provide assistance with ADLs as indicated."

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F 677	Continued From page 5	F 677		

A review of Resident 232's care plan intervention, dated 5/14/24, indicated, "The resident [Resident 232] needs their [sic] nails kept short to reduce risk of scratching or injury from picking at skin."

A review of the facility's policy and procedure titled, "Activities of Daily Living (ADLs), Supporting", revised 3/2018, indicated, "...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently...in accordance with the plan of care, including appropriate support and assistance with...a. hygiene (...grooming...)".
2. Review of Resident 23's Admission Record indicated the resident was a long-term resident in the facility with diagnoses that included muscle weakness and need for assistance with personal care.

During the initial pool observation and interview on 5/13/24 at 9:10 a.m., Resident 23 was lying in bed and complained that he had long fingernails and would like them to be trimmed and be cleaned. The resident was observed to have long overgrown fingernails with black substance underneath the distal edges of the fingernails. The resident stated, "I don't like long fingernails...I can't cut them by myself, and someone has to help." The resident stated his long fingernails were getting caught in the blankets and clothes and that was inconvenient.

In a concurrent observation and interview on 5/13/24 at 9:25 a.m., in the resident's room, LN 1 verified Resident 23 had long overgrown fingernails that were unsanitary. LN 1 stated LNs cut the resident's fingernails every Sunday and Resident 23's fingernails should have been trimmed then.

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two out of 15 sampled residents (Resident 233 and Resident 234) received treatment and care in accordance with professional standards of practice, and facility's policy and procedure (P&P) when: 1. Resident 233's physician's order for stage 3 pressure ulcer/injury (PU/PI- injury to skin and underlying tissue resulting from prolonged pressure which extends through the skin into deeper tissue and fat but do not reach muscle or bone) on the coccyx (area on the lower back where the bottom/base of the spine is) treatment was not followed; and, 2. Resident 233 and Resident 234's wound dressings was not labeled with the nurse initials, and time and date it was applied. These failures had the potential for Resident 's 233's coccyx wound to get worse, and Resident 233 and Resident 234 to not achieve their highest practicable well-being and to not receive appropriate wound care treatment.	F 684	Resident 233's coccyx wound was immediately dressed per orders. Resident 233 Occipital dressing was changed and it was labeled and dated per policy. Resident 234's left knee dressings were changed and they were labeled and dated per policy. Facility audited all residents with wound care requiring dressing changes to check if dressings were in place, labeled with nurse initials and dated. No other residents were found to be affected by deficient practice. All Licensed nurses were in-serviced on following physician orders for wound care and labeling dressing changes with their initial and date of the dressing change. Medical Records will audit the Treatment record weekly to monitor compliance with completing treatments per physician orders. DON will do random observations weekly of checking that	6/3/24

		dressings are in place and dressings are labeled and dated per policy. Results of audits and observations will be reviewed during the monthly QA meeting for compliance.	

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F 684 Continued From page 7 F 684

Findings:

1. A review of Resident 233's clinical record indicated Resident 233 was admitted April of 2024 and had diagnoses that included cutaneous abscess of right lower limb (a localized collection of pus in the skin), cutaneous abscess of head, and stage 3 pressure ulcer (PU/PI- injury to skin and underlying tissue resulting from prolonged pressure which extends through the skin into deeper tissue and fat but do not reach muscle or bone).

A review of Resident 233's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/22/24, indicated Resident 233 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 233 had intact cognition.

A review of Resident 233's physician's order, dated 4/24/24, indicated, "TX [treatment] : STAGE 3 PRESSURE ULCER TO COCCYX, CLEANSE WITH NS [normal saline- a mixture of water and edible salt commonly use in cleaning wounds, help with dry eyes, and used to treat dehydration], PAT DRY, APPLY CALCIUM ALGENATE (used to treat moderate to heavily exuding wounds) FOLLOWED BY DRY DRESSING [a dry piece of gauze used to cover a wound to protect the wound from injury, prevent introduction of bacteria, reduce discomfort, and assist with healing] QD [every day] AND PRN [as needed] IF SOILED/DISLODGED..."

During a concurrent observation and interview on 5/13/24 at 10:56 a.m. with Licensed Nurse (LN) 4, in Resident 233's room, LN 4 confirmed that

F 684 Continued From page 8

Resident 233 had no dry dressing covering his stage 3 PU on the coccyx. LN 4 stated he would expect Resident 233's stage 3 PU on the coccyx to be covered with a dry dressing as per the physician's order to help with wound healing.

During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated she would expect the dressing for Resident 233 to be on him because that's the physician's order.

A review of the facility's P&P titled, "Wound Care", revised 10/2010, indicated, "1. Verify that there is a physician's order for this procedure...Dressing material, as indicated (...gauze...) ..."

2a. A review of Resident 233's physician's order, dated 4/16/24, indicated, "TX: ...GROIN DRAIN: CLEAN WITH NS, PAT DRY, COVER WITH T-DRAIN SPONGE [a sponge with pre-cut T-slit that provides a snug fit around the drain tubing] FOLLOWED BY CLEAR/TRANSPARENT FILM DRESSING...ONCE A WEEK OR PRN [as needed] IF SOILED OR DISLODGED..."

A review of Resident 233's physician's order, dated 5/7/24, indicated, "TX: OCCIPITAL [back of the head] ABSCESS, CLEANSE WITH NS, PAT DRY, APPLY MEDIHONEY [medical-grade honey intended for wound care] FOLLOWED BY...DRY DRESSING QD AND PRN IF SOILED/DISLODGED..."

During a concurrent observation and interview on 5/13/24 at 10:56 a.m. with Licensed Nurse (LN) 4, in Resident 233's room, LN 4 confirmed that Resident 233 dry dressing on the back of his head and inner right thigh was not labeled with the initials of the nurse who applied the dressing,

F 684

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F 684 Continued From page 9

F 684

and the date and time it was applied. LN 4 stated, "It [dry dressing on Resident 233's head and inner right thigh] should be labeled [of the date and time when it was applied] to know when it [dry dressing] was last changed".

2b. A review of Resident 234's clinical record indicated Resident 234 was admitted May of 2024 and had diagnoses that included encounter for other orthopedic aftercare (a care provided after a surgery that involves bones, muscles, and joints), and need for assistance with personal care.

A review of Resident 234's "ADMISSION-NURSING ASSESSMENT", dated 5/10/24, indicated, "...Patient [Resident 234] is A&Ox4 [the patient is alert and oriented to person, place, time, and situation] and has the capacity to make medical decisions..."

A review of Resident 234's physician's order, dated 5/10/24, indicated, "TX: SURGICAL SITE ON LEFT KNEE: CLEANSE WITH NS, PAT DRY, APPLY XEROFORM [a medicated non-adherent primary dressing that promotes wound healing] ...AND COVER WITH DRY DRESSING DAILY AND PRN [as needed] IF SOILED OR DISLODGED..."

During a concurrent observation and interview on 5/13/24 at 1:20 p.m. with Resident 234, in Resident 234's room, Resident 234 was observed to have 2 dry dressing on the left knee; one vertically placed on the left knee, and one placed on the outer side of the left knee. Both dry dressings on the left knee was not labeled with the initials of the nurse who applied the dressing, and the date and time it was applied. Resident

F 684	Continued From page 10 234 confirmed the observation. During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated, "...The [dry] dressings should be labelled properly...Label the date and time [on the dry dressing] to keep track if it [dressing change] was done as scheduled and if the [physician's] order is being followed..." A review of the facility's P&P titled, "Wound Care", revised 10/2010, indicated, "...11. Dress wound... Mark tape with initials, time, and date and apply to dressing..."	F 684		6/3/
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692	Resident 20 and 23 hydration/fluid intake status was calculated and evaluated immediately. Results of the hydration summaries were forwarded to the MD/NP. All other residents on fluid restrictions were audited to ensure hydration/fluid intake summary was completed per policy and no other residents were found to be affected by deficient practice. All Licensed nurses were in-serviced on Intake and Output monitoring protocol, including calculating 24hr fluid intake and a weekly summary of hydration/fluid status for all residents on fluid restrictions. Medical records will audit all residents on fluid restrictions to monitor for compliance of completing weekly hydration summary. Results of the audits will be reviewed during monthly QA meeting for compliance.	6/3/24

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SAYLOR LANE HEALTHCARE CENTER	**3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816**

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F 692	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess and evaluate the Intake and Output (I&O, the measurement of fluids entering and leaving the body) weekly summaries for two of 15 sampled residents (Resident 20 and Resident 23) when the residents were on fluid restriction. This failure placed the residents at risk for unnoted fluid overloads and/or dehydration as well as difficulty to gauge fluid balance of the residents to determine the effects of the treatment and the progress of the disease. Findings: Review of Resident 20's Admission Record indicated the resident was a long-term resident in the facility with diagnoses that included hemodialysis (a treatment to filter wastes and fluid from the blood using a dialysis machine, an artificial kidney), heart disease, lung problem with localized swelling issues. Review of Resident 20's medical record, Order Summary, indicated the resident was on fluid restriction of a total of 2000 ml (milliliter, 2 Liters) per 24 hours with the specification for, "Dietary Allotment 1200 ML; Nursing allotment 800 ML/24 Hrs, AM-350 ML, PM-350 ML, NOC [night shift]-100 ML... Record total amount of fluid intake in ML". Review of Resident 23's Admission Record indicated the resident was a long-term resident in the facility with diagnoses that included chronic kidney disease and was on an anticoagulant	F 692		

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SAYLOR LANE HEALTHCARE CENTER	**3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816**

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F 692	Continued From page 12 (blood thinner) therapy for heart problems. Review of Resident 23's Medication Administration Record (MAR) indicated the resident had a physician order for 1500 ml daily fluid restriction. The fluid quota specified for dietary allotment of 840 ml and nursing allotment of 660 ml, for AM 300 ml, PM 300 ml, and Noc 60 ml respectively with the start date of 7/5/23. Review of the facility's revised October 2010 policy and procedure, "Encouraging and Restricting Fluids," stipulated Licensed Nurse (LN) to "Record the amount of fluid consumed on the intake side of the intake and output record. Record fluid intake in mLs [milliliters]" for the resident who was on fluid restriction." The policy instructed, "The licensed nurses should complete a summary of fluid intake/hydration status at least once per week and notify the doctor if any signs or symptoms of fluid overload or dehydration." Review of Resident 20's and Resident 23's medical records indicated LNs recorded the residents' fluid intake each shift respectively in the MAR; however, there was no documented evidence that LNs summed up the residents 24-hour fluids intake totals or completed the weekly fluid intake summary for Resident 20 or for Resident 23. In a concurrent interview and medical record review on 5/15/24 at 11:13 a.m. at the nursing station, LN 2 stated LNs on Saturday PM shift were to complete the weekly I&O summary for the residents who were on fluid restrictions. LN 2 verified there was no weekly I&O evaluations for Resident 20 and Resident 23 and stated they should have the weekly I&O summaries as the	F 692		

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	**3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816**

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F 692	Continued From page 13 residents were on fluid restriction. LN 2 acknowledged the weekly I&O summary was important to determine the fluid balance and to evaluate the fluid restriction orders were effective for the residents. In an interview on 5/15/24 at 12:14 p.m., at the nursing station, the Director of Nursing (DON), with the Nurse Consultant (NC) present, stated all residents on fluid restrictions were I&O monitoring. The DON verified there was no weekly I&O evaluation for Resident 20 and Resident 23 and stated without the weekly or monthly I&O evaluations, it was hard to understand the accurate fluid status of the residents.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper handling and delivery of respiratory care consistent with the facility's policy and procedures (P&P) and the professional standards of practice for one out of 15 sampled residents (Resident 14) when:	F 695	An “oxygen in use” sign was placed on resident 14’s door frame immediately. Resident 14’s oxygen flow rate was immediately changed from 3L/min to 2L/min per physician orders. The facility audit all residents with continuous oxygen orders to check that oxygen flow rate was being administered per physician orders and “oxygen in use” signs placed on the door frame of the room and no other residents were found to be affected by deficient practice. Licensed nurses were in-serviced on Oxygen use protocol, including required signage for resident rooms and following physician orders. “Oxygen in use” signage placed on all resident rooms in the facility. Facility IDT will audit during weekly	6/3/24

		room rounds for appropriate signage on the doors for residents requiring oxygen. Results of the room round observations will be reviewed during monthly QA meeting for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

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F 695	Continued From page 14 1. Resident 14 had no "oxygen in use" sign placed on the outside of the room entrance door; and, 2. Resident 14's physician's orders for oxygen therapy was not followed. These failures had the potential to result in unsafe delivery of oxygen to Resident 14 and potential harm to all the residents in the facility. Findings: 1. A review of Resident 14's clinical record indicated Resident 14 was admitted April of 2024 and had diagnoses that included respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), chronic obstructive pulmonary disease (COPD- a group of diseases that causes airflow blockage and breathing-related problems, heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), and dependence on supplemental oxygen. A review of Resident 14's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/15/24, indicated Resident 14 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 14 had moderately impaired cognition. A review of Resident 14's MDS Health Conditions, dated 4/15/24, indicated Resident 14 had shortness of breath or trouble breathing with exertion such as when walking, bathing, or transferring and when lying flat, and was a current tobacco user. A	F 695	

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	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

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F 695	Continued From page 15 review of Resident 14's MDS Special Treatments, Procedures, and Programs, dated 4/15/24, indicated Resident 14 had continuous oxygen therapy on admission and while he is a resident in the facility. A review of Resident 14's physician's order, dated 4/8/24, indicated, "OXYGEN D/T [due to] SOB [shortness of breath]/COPD at _2_L PER MIN [liters per minute/lpm- unit of measurement for oxygen administration] VIA NASAL CANNULA [a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils] CONTINOUS [sic]. every shift." During a concurrent observation and interview on 5/13/24 at 10:14 a.m. with Licensed Nurse (LN) 4, in Resident 14's room, LN 4 confirmed that there was no "oxygen in use" sign placed on the outside of Resident 14's room entrance door. LN 4 stated, "...I don't put those ["oxygen in use" sign] signs up..." During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated, "...We [facility staff] put the "oxygen in use" sign so we [facility staff] can prevent potential harm towards patient or staff...It's ["oxygen in use" sign] a precautionary reminder for everyone..." A review of the facility's P&P titled, "Oxygen Administration", revised 10/2010, indicated, "Steps in the Procedure. 2. Place an "Oxygen in Use" sign on the outside of the room entrance door." 2. During a concurrent observation and interview on 5/14/24 at 8:50 a.m. with Resident 14, in	F 695	

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SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

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F 695	Continued From page 16 Resident 14's room, Resident 14 was observed lying on bed and was using an oxygen delivered using a nasal cannula with oxygen concentrator set at 3 LPM. Resident 14 stated, "...No, it should be at 2 [liters per min] ..." During a concurrent observation and interview on 5/14/24 at 8:51 a.m. with Certified Nurse Assistant (CNA) 3, in Resident 14's room, CNA 3 confirmed that Resident 14 was using an oxygen delivered using a nasal cannula with oxygen concentrator set at 3 lpm. During a concurrent interview and record review on 5/14/24 at 3:34 p.m. with LN 4, Resident 14's clinical records were reviewed. LN 4 confirmed that Resident 14 had no documented notes that he needed more than 2 lpm of oxygen. LN 4 stated, "...He's not asking for more than 2 [lpm of oxygen] ...He should be at 2 lpm..." LN 4 further stated facility staff should follow the physician's order when providing oxygen therapy. During an interview on 5/15/24 at 1:51 p.m. with the DON, the DON stated she would expect the staff to follow the physician's order when administering oxygen therapy to a resident. The DON further stated, "...That's [administering 3 lpm instead of 2 lpm of oxygen] too much...there should be monitoring...It [administering 3 lpm instead of 2 lpm of oxygen] could cause hyperoxygenation [a condition in which the body is exposed to an unusual amount of oxygen causing respiratory and/or neurological problems]". A review of Resident 14's care plan intervention, undated, indicated, "OXYGEN SETTINGS: O2 [oxygen] via nasal cannula at 2L [liters]	F 695	

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	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

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F 695	Continued From page 17 continuously..." A review of the facility's P&P titled, "Oxygen Administration", revised 10/2010, indicated, "1...Review the physician's orders or facility protocol for oxygen administration...Steps in the Procedure. 6. Adjust the oxygen delivery device so that. the proper flow of oxygen is being administered."	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one out of 15 sampled residents (Resident 14) received dialysis care services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's order when: 1. Resident 14's post-dialysis weight was not consistently documented in the resident's chart; and, 2. Resident 14's the dialysis communication sheet was not consistently completed. These failures had the potential for Resident 14 to not achieve the highest practicable well-being and to not receive appropriate dialysis care treatment and services.	F 698	Resident 14's post-dialysis weight records were obtained from the dialysis center and EHR was updated accordingly with weight records. Dialysis center contacted to obtain dialysis communication sheets for 5/6/24 and 5/10/24. Dialysis center submitted requested forms and the forms were uploaded to facility EHR. All other residents requiring dialysis services were audited for post dialysis weight documentation and dialysis communication form completion and no other residents were found to be affected by deficient practices. Licensed Nurses in-serviced on following physician dialysis orders, including documenting post-dialysis weights and completing pre/post dialysis communication form. LN's also instructed to call the dialysis center immediately if resident does not return from dialysis with completed dialysis communication form. Medical records will audit required dialysis monitoring documentation 3 times per week. Results of the audits will be reviewed during the monthly QA meeting for compliance.	6/3/24

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	**3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816**

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F 698	Continued From page 18	F 698		

Findings:

1. A review of Resident 14's clinical record indicated Resident 14 was admitted April of 2024 and had diagnoses that included diabetes mellitus (a chronic condition causing too much sugar in the blood that can affect kidney function and breathing), stage 5 chronic kidney disease (a condition in which the kidneys are severely damaged and have stopped doing their job to filter waste from the blood), and dependence on renal dialysis (the process of removing excess water, particles, and toxins from the blood in people whose kidneys can no longer perform these functions naturally).

A review of Resident 14's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/15/24, indicated Resident 14 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 14 had moderately impaired cognition. A review of Resident 14's MDS Special Treatments, Procedures, and Programs, dated 4/15/24, indicated Resident 14 was on hemodialysis (a treatment to filter wastes and water from the blood) on admission and while he is a resident in the facility.

A review of Resident 14's physician's order, dated 4/8/24, indicated, "Document Post [after] dialysis weight in the evening every Mon [Monday], Wed [Wednesday], Fri [Friday]. PM SHIFT MUST COMPLETE..."

During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated,

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	**3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816**

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F 698	Continued From page 19	F 698		

"We [facility staff] refer it [post-dialysis weight] from the dialysis sheet...If they [dialysis center] don't write down anything we [facility staff] call them [dialysis center]". The DON further stated, "I expect nurses to document the post-dialysis weight always...so we [facility staff] can check if there's a significant weight change...That's the [physician's] order."

During a concurrent interview and record review on 5/15/24 at 3:23 p.m. with Licensed Nurse (LN) 4, Resident 14's clinical records were reviewed. LN 4 confirmed that there were no documented weights of Resident 14 on his electronic medical record on Wednesday, 5/1/24; Friday, 5/3/24; Monday, 5/6/24; Wednesday 5/8/24, and Friday 5/10/24. LN 4 stated the post-dialysis weight should always be documented in resident's chart.

2. A review of Resident 14's physician's order, dated 4/8/24, indicated, "Complete Dialysis Communication Sheet BEFORE and Upon Return from Dialysis two times a day every Mon [Monday], Wed [Wednesday], Fri [Friday]. PM SHIFT MUST COMPLETE FORM UPON RETURN..."

During an interview on 5/15/24 at 1:51 p.m. with the DON, the DON stated, "It [Dialysis Communication Sheet] should always be completed...if not, the nurse should call the dialysis center..."

During a concurrent interview and record review on 5/15/24 at 3:23 p.m. with LN 4, Resident 14's Dialysis Communication Sheet, dated 5/6/24, was reviewed. LN 4 confirmed that Resident 14's dialysis communication sheet, dated 5/6/24, was not complete and did not indicate Resident 14's

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SAYLOR LANE HEALTHCARE CENTER	**3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816**

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F 698	Continued From page 20 pre [before] and post [after] dialysis weights. During a concurrent interview and record review on 5/15/24 at 3:23 p.m. with LN 4, Resident 14's Dialysis Communication Sheet binder was reviewed. LN 4 confirmed that Resident 14's dialysis communication sheet on 5/10/24 was not in the binder. LN 4 stated, "The [Dialysis Communication Sheet] binder sometimes gets lost...All dialysis sheet is in there [Dialysis Communication Sheet binder] ...If it's not there...I don't know..." A review of Resident 14's care plan intervention, dated 5/13/24, indicated, "Complete Dialysis communication form pre and post dialysis, which includes VS [vital signs], changes in condition, nutritional status, access site..." A review of the facility's P&P titled, "Hemodialysis Access Care", revised 09/2010, indicated, "Documentation. The General medical nurse should document in the resident's medical record pre/post-dialysis as follows.... 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis."	F 698		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756	DRR recommendation for resident 23 was completed immediately. Expired vaccines in the medication room fridge were removed immediately. All other resident DRR recommendations were reviewed and no other residents were found to be affected by deficient practice. Medication room fridge was checked and no other expired medications were found. DON will make notations on all drug	6/3/24

		regimen review recommendations to indicate if recommendation was completed. The noted recommendations will be kept in the DRR binder for reference. The Pharmacist will document follow-up the following month with any recommendations that were not noted or carried out from the previous month. The Pharmacist will include on the monthly DRR an audit of medication storage, including medication room fridge storage. Noted DRR documents will be reviewed during the monthly QA meeting for compliance. Pharmacist medication storage audits will be reviewed during Monthly QA meeting for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 756	Continued From page 21 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide thorough drug regimen reviews (DRR) for one of 15 sampled residents (Resident 23) when the facility did not act on the facility pharmacist (FP) report on irregularities and the expired medications were mixed with other medications available for use in the medication storage room refrigerator.	F 756	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

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F 756 Continued From page 22

These failures resulted in unresolved irregularities of antipsychotic (to treat symptoms of psychosis) medication therapy for Resident 23 and increased the potential for medication errors.

Findings:

Review of Resident 23's medical record, Admission Record, indicated the resident was a long term resident in the facility with diagnoses that included unspecified memory problems with behavioral disturbance.

Review of Resident 23's medication administration record (MAR) for March, April, and May 2024 indicated the resident was on antipsychotic medication monitoring every shift as follows:

1. Monitor side effect of Antispychotic medication (Risperidone) episodes of facial/tongue movement, decreased mental status, inability to sit still, tremors, drooling, rigidity every shift with the order date of 8/8/23.

2. Monitor behavior for Antipsychotic (Risperidone) episodes of verbally aggressive outbursts every shift, order date of 8/8/23.

3. Monitor behavior for Antipsychotic (Risperidone) episodes of threats self harm every shift, order date of 8/8/23.

Review of Resident 23's medical record, Order Listing Report, indicated the residents had two physician orders for Risperidone that were discontinued on 3/25/24 as follows:

1. Risperidone 0.25 mg (milligram) 1 tablet by

F 756

F 756 Continued From page 23

F 756

mouth once a day for dementia with psychotic features until 3/28/24 as evidenced by threats self harm and verbally aggressive outburst with the order date of 2/29/24

2. Risperidone 0.25 mg 1 tablet by mouth twice a day for dementia with psychotic features until 3/14/24 as evidenced by threats self harm and verbally aggressive outburst with the order date of 2/29/24

Review of Resident 23 monthly DRR for 3/1/24 through 3/27/24 included the FP's report on the irregularities of the Risperidone therapy monitoring and recommended, "Since this patient [Resident 23] was DC [discontinued] off of Risperidone, you may remove any SE [Side Effect] or behavior monitoring associated with the order if no longer needed."

Review of Resident 23's medical record included no documented evidence that the facility did act upon the FP's March DRR recommendation, either discontinued the monitoring or documented the rationale for continuation of the monitoring pertinent to the Risperidone even though the medication was discontinued.

Review of Resident 23's monthly DRR for 4/1/24 through 4/21/24 included a FP's note, "The following is a list of residents [Resident 23 included] which were reviewed during the consultant pharmacist's visit, but did not require any recommendations" while the facility had not resolved the FP's recommendation in March and the irregularities continued in the absence of Risperidone administration.

Review of the facility's May 2019 policy and

F 756 Continued From page 24

F 756

procedure, "Medication Regimen Reviews," stipulated, the medication regimen reviews involved, "a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems...other irregularities..."

In an interview on 5/15/24 at 11:52 a.m. at the nursing station, the Director of Nursing (DON) stated the facility practice was to monitor residents for 72 hours after the discontinuation of antipsychotic medications and "drop the monitoring" if no issues noted and acknowledged Resident 23 had no issues post Risperidone monitoring period. The DON verified the FP's March DRR recommendation for Resident 23 and stated the facility should have acted on it to complete the DRR process. The DON verified there was no FP's recommendation in April DRR for Resident 23.

In a telephone interview on 5/15/24 at 2:15 p.m., the FP explained the monthly DDR process was for the FP reviewing each resident's medications and making recommendations if indicated and the facility was to act upon the FP's recommendation. The FP acknowledged the March 2024 recommendation for Resident 23 was not resolved and had the potential for confusion and miscommunication among the healthcare providers regarding the antipsychotic therapy for the resident. The FP stated the pharmacist who conducted the April DRR should have identified the irregularities for Resident 23 and made a re-recommendation for the facility to act on.

During the medication storage room observation on 5/13/24 starting at 2:45 p.m. with Licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 756 Continued From page 25

Nurse (LN 3), there were multiple identical boxes of pre-filled flu syringes stored in the medication refrigerator drawer available for use. Some of the boxes were open and some were not; two open boxes were 5 milliliter pre-filled Influenza Vaccine afuria® Quadrivalent for 2022-2023 and each box contained six and three syringes apiece, nine total, with the expiration date of 6/30/23. The expired syringes were mixed with Influenza Vaccine afuria® Quadrivalent 2023-22024 flu vaccines in the drawer.

In a concurrent interview on 5/13/224 starting at 2:45 p.m., LN 3 verified the name, quantity and the expiration date of the flu vaccines.

In a telephone interview on 5/15/24 at 2:15 p.m., the FP stated checking the medication storage room was a part of monthly DRR process and the expired medications should have been found during the DRR monthly visits.

F 756

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

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F 756 Continued From page 26 F 756

Based on interview and record review, the facility failed to provide thorough drug regimen reviews (DRR) for one of 15 sampled residents (Resident 23) when the facility did not act on the facility pharmacist's (FP) report on irregularities.

This failure resulted in unresolved irregularities of antipsychotic (to treat symptoms of psychosis) medication therapy for Resident 23.

Findings:

Review of Resident 23's medical record, Admission Record, indicated the resident was a long-term resident in the facility with diagnoses that included unspecified memory problem with behavioral disturbance.

Review of Resident 23's medication administration record (MAR) for March, April, and May 2024 indicated the resident was on antipsychotic medication monitoring every shift as follows:

a. Monitor side effect of Antipsychotic medication (Risperidone) episodes of facial/tongue movement, decreased mental status, inability to sit still, tremors, drooling, rigidity every shift with the order date of 8/8/23.

b. Monitor behavior for Antipsychotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

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F 756 Continued From page 27 F 756

(Risperidone) episodes of verbally aggressive outbursts every shift, order date of 8/8/23

c. Monitor behavior for Antipsychotic (Risperidone) episodes of threats self harm every shift, order date of 8/8/23

Review of Resident 23's medical record, Order Listing Report, indicated the resident had two physician orders for Risperidone that were discontinued on 3/25/24 as follows:

1. Risperidone 0.25 mg (milligram) 1 tablet by mouth once a day for dementia with psychotic features until 3/28/24 as evidenced by threats self harm and verbally aggressive outburst with the order date of 2/29/24

2. Risperidone 0.25 mg 1 tablet by mouth twice a day for dementia with psychotic features until 3/14/24 as evidenced by threats self harm and verbally aggressive outburst with the order date of 2/29/24

Review of Resident 23 monthly DRR for 3/1/24 through 3/27/24 included the FP's report on the irregularities of the Risperidone therapy monitoring and recommended, "Since this patient [Resident 23] was DC [discontinued] off of Risperidone, you may remove any SE [Side Effect] or behavior monitoring associated with the order if no longer needed."

Review of Resident 23's medical record included no documented evidence that the facility did act upon the FP's March DRR recommendation, either discontinued the monitoring or documented the rationale for continuation of the monitoring pertinent to the Risperidone even though the

F 756 Continued From page 28

F 756

medication was discontinued.

Review of Resident 23's monthly DRR for 4/1/24 through 4/21/24 included a FP's note, "The following is a list of residents [Resident 23 included] which were reviewed during the consultant pharmacist's visit but did not require any recommendations" while the facility had not resolved the FP's recommendation in March and the irregularities continued in the absence of Risperidone administration.

Review of the facility's May 2019 policy and procedure, "Medication Regimen Reviews," stipulated, the medication regimen reviews involved, "a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems...other irregularities..."

In an interview on 5/15/24 at 11:52 a.m. at the nursing station, the Director of Nursing (DON) stated the facility practice was to monitor residents for 72 hours after the discontinuation of antipsychotic medications and "drop the monitoring" if no issues noted and acknowledged Resident 23 had no issues post Risperidone monitoring period. The DON verified the FP's March DRR recommendation for Resident 23 and stated the facility should have acted on it to complete the DRR process. The DON verified there was no FP's recommendation in April DRR for Resident 23.

In a telephone interview on 5/15/24 at 2:15 p.m., the FP explained the monthly DDR process was for the FP reviewing each resident's medications and making recommendations if indicated and the facility was to act upon the FP's

F 756	Continued From page 29 recommendation. The FP acknowledged the March 2024 recommendation for Resident 23 was not resolved and had the potential for confusion and miscommunication among the healthcare providers regarding the antipsychotic therapy for the resident. The FP stated the pharmacist who conducted the April DRR should have identified the irregularities for Resident 23 and made a re-recommendation for the facility to act on.	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761	Expired vaccines were removed immediately from the medication room fridge. All other medications in the medication room fridge were checked and not other expired medications were found. Licensed nurses were in-serviced on removing any expired medications from “ready to use” medication storage. Designated Licensed nurses will audit medication room storage weekly, including medication fridge storage and will remove any discontinued or expired medication and place them in the storge area designated for medication destruction. Results of the medication room storage audit will be reviewed during the monthly QA meeting for compliance.	6/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

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F 761	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to discard expired medications for a census of 38 when the expired flu vaccines were mixed with non-expired flu vaccines in the medication refrigerator, available for use. This failure increased the potential for medication errors and placed the residents at risk for drug safety. Findings: During the medication storage room observation on 5/13/24 starting at 2:45 p.m. with Licensed Nurse (LN 3), there were multiple identical boxes of flu vaccines stored in the medication refrigerator drawer in the room. There were 5 milliliter pre-filled Influenza Vaccine afuria® Quadrivalent for 2022-2023 mixed with 2023-2024 flu vaccines; two boxes of 2022-2023 vaccines were open and each contained six and three pre-filled syringes apiece, a total of nine syringes, with the expiration date of 6/30/23. Review of the facility's March 2018 policy and procedure, Medication Storage in the Facility, stipulated, "Outdated...are immediately removed from stock, disposed of according to procedures for medication disposal..." In a concurrent interview on 5/13/224 starting at 2:45 p.m., LN 3 verified the name, quantity and the expiration date of the flu vaccines and stated night shift nurses were to discard the expired medication in the medication storage room and stated the expired flu vaccines should have been	F 761		

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F 761	Continued From page 31 disposed. LN 3 acknowledged storing expired medications with non-expired medications, especially when they were identical, increased the potential for medication errors.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food safety when food storage temperature logs and sanitization solution logs were not being consistently documented. This failure had the potential to lead to food borne illnesses for 38 residents eating facility prepared meals.	F 812	The Dietary Services Supervisor Found no other logs missing entries. The Dietary Staff were in-serviced on proper completion of all logs in the kitchen. The Dietary Services Supervisor will check the kitchen logs weekly to ensure proper completion. The Dietary Services Supervisor will report any trends of noncompliance at the Monthly QAA Committee meeting and take appropriate disciplinary action as needed with non non-compliance.	6/3/24

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F 812	Continued From page 32 Findings: During a concurrent observation and interview on 5/13/24, at 8:21 a.m., with Cook (CK1), the Dry Food Storage Temperature Control Log was reviewed. CK1 stated the temperature for the dry foods' storage room was taken and documented twice daily, once on morning shift and once on evening shift. CK1 confirmed 4 entries were missing for the month of May 2024. CK1 stated it was not acceptable for entries to be missing and not monitoring the temperature could lead to food safety concerns. During a concurrent observation and interview on 5/13/24, at 8:24 a.m., with Kitchen Aid (KA) 2, the red bucket sanitizing solution was observed near the dishwashing sink. KA 2 tested the solution and stated the sanitizing solution is tested twice daily and results are written on a log. KA 2 showed the Quaternary Ammonium Log and confirmed there were 7 missing entries for the month of May 2024. During a concurrent observation and interview on 5/13/24, at 8:33 a.m., with CK1, the Cold Storage Temperature Control Log was reviewed. CK1 stated the temperature for the refrigerator and freezer are taken and documented twice daily, once on morning shift and once on evening shift. CK1 confirmed 14 entries were missing for the month of May 2024. CK1 stated not monitoring the temperature can potentially lead to spoiled food and was a safety concern for residents. During a concurrent observation and interview on 5/13/24, at 8:43 a.m., with the Dietary Supervisor (DS), the food storage temperature logs and sanitation solution log were reviewed. The DS	F 812		

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F 812	Continued From page 33 confirmed entries were missing on the Dry Food Storage Log, Cold Storage Temperature Log and Quaternary Ammonium Log. The DS stated kitchen staff were expected to complete the logs twice daily and not doing so could potentially lead to resident harm. During a review of the facility's policy and procedure (P&P) titled, "Preventing Foodborne Illness-Food Handling," revised 7/14, the P&P indicated, "Food will be stored ...so that the risk of foodborne illness is minimized ...refrigeration and food temperatures will be monitored at designated intervals throughout the day and documented ..." During a review of the facility's policy and procedure (P&P) titled, "Quaternary Ammonium Log Policy," dated 2023, the P&P indicated, "The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution ...concentration will be tested at least every shift ...staff will record the readings twice a day ..."	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842	Antipsychotic medication use behavior and side effect monitoring for residents 23 and 3 were discontinued immediately. Resident 20 and 23 Intake and Output hydration status summary was completed immediately to accurately reflect physician orders for Intake and output monitoring. Inaccurate weight documentation for resident 20 was corrected to reflect the accurate weight. EMAR administration documentation of prosource for resident 4 was corrected to reflect the refusal. All residents with antipsychotic medication use behavior and side effect monitoring orders were reviewed and no other residents were found to have monitoring in place without the use of antipsychotic medication administration.	6/3/24

All residents requiring intake and output monitoring were reviewed and no other residents were found to not have weekly hydration summaries documented. All resident weights in the facility were reviewed and no other residents were found to have inaccurate weights documented. All residents eMAR administrations were reviewed and no other documentation discrepancies were noted in resident charts.

Licensed nurses were in-serviced on expectation of accurate documentation, including how to correct documentation if it is identified as inaccurate.

Designated Licensed nurse will review/audit all physician orders and eMAR documentation on a monthly basis for accuracy. Medical records will audit on a weekly basis the Weekly Nursing Summary documentation to monitor for accurate documentation for residents that require Intake and Output monitoring. The RD will review weight documentation for all residents weekly and any weight discrepancies will be forwarded to the DON for review. Results of physician order audit, eMar documentation audit, Weekly Nursing Summary documentation, and Weight Documentation discrepancies will be reviewed during the Monthly QA meeting for compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

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F 842	Continued From page 34 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842	

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F 842 Continued From page 35

F 842

legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to maintain accurate, consistent, and complete medical records for three of 15 sampled residents (Resident 23, Resident 4 and Resident 20) and one randomly selected resident (Resident 3) for a census of 38.

These failures resulted in the residents' health and care status to be inaccurately reflected in the medical records and placed the residents at risk for inadequate care due to the potential miscommunication among the healthcare providers.

Findings:

1. a) Review of Resident 23's medical record, Admission Record, indicated the resident was a long-term resident in the facility with diagnoses that included unspecified memory problem with behavioral disturbance. Resident 23 was on fluid restriction due to a heart problem.

F 842 Continued From page 36

F 842

Review of Resident 23's medication administration record (MAR) for March, April, and May 2024 indicated the resident was on antipsychotic medication monitoring every shift for Risperidone (to treat symptoms of psychosis). The antipsychotic monitoring included the side effect of Risperidone and for the behavior manifestation of verbal aggression and threats to self-harm.

Review of Resident 23's medical record, Order Listing Report, indicated Risperidone therapy was discontinued as of 3/25/24.

In an interview on 5/15/24 at 11:52 a.m. at the nursing station, the Director of Nursing (DON) verified the MARs were inconsistent with Resident 23's antipsychotic medication therapy and acknowledged the inaccurate documentation did not reflect the resident's mental status correctly and stated it could create confusion among the healthcare providers.

b) Review of Resident 23's MAR indicated the resident was on a 1500 ml (milliliter) daily fluid restriction therapy with the specific fluid daily allotments for dietary 840 ml and nursing 660 ml respectively.

Review of the facility's revised October 2010 policy and procedure, "Encouraging and Restricting Fluids," stipulated residents who were on fluid restriction therapy: "The nurse should record the 24hr fluid intake at least once per day ...the licensed nurse should complete a summary of fluid intake/hydrations status at least once per week ..."

Review of Resident 23's medical record had no

F 842 Continued From page 37

F 842

weekly I&O evaluation.

In a concurrent interview and record review on 5/15/24 at 11:13 a.m. at the nursing station, Licensed Nurse (LN 2) explained Resident 23 had no weekly I&O evaluation because LNs inaccurately checked "no" in the I&O section in the LN weekly summary chart. LN 2 stated, otherwise the LN weekly summary would open the "task" screen where LNs to enter the summary of the resident's I&O weekly total. The most recent four LN weekly summaries, dated 5/11/24, 5/4.24, 4/27/24 and 4/20/24, were reviewed and noted all four summaries check marked that the resident was not on I&O monitoring.

In an interview on 5/15/24 at 12:14 p.m., the DON, with the Nurse Consultant present, verified Resident 23's LN weekly summaries were inaccurate. The DON stated the resident should have been evaluated for weekly I&O and acknowledge the resident's medical record was incomplete.

2. Review of Resident 4's Admission Record indicated the resident admitted to the facility recently for aftercare of neck surgery.

During the medication administration observation on 5/14/24 starting at 8:59 a.m., Licensed Nurse (LN 4) administered Resident 4's morning medications including a 30-milliliter cup of 15-gram liquid protein supplement. Resident 4 took all her morning medications but refused the liquid protein and didn't take it.

Review of Resident 4's 5/14/24 AM medications was reconciled with the MAR. The MAR reflected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842 Continued From page 38

F 842

that the liquid protein was administered to the resident with other morning medications. There was no documented evidence LN 4 noted the resident refused the liquid protein in the progress note or notified the DON or the RD (Registered Dietician).

In a concurrent interview and record review on 5/15/24 at 10:50 a.m., LN 4 stated it was a "typo" that the protein liquid was administered to Resident 4 the previous morning and stated it should have been coded "2" for the medication refusal and progress note should have been created for the resident's refusal. LN 4 explained it was the facility practice to let DON know when the resident refused prescription medications two to three times and to document in the progress notes for the reason of the resident's refusal. LN 4 stated when resident refused other supplements or over-the-counter medications, LNs do not notify the DON or the physician.

In an interview on 5/15/24 at 12:06 p.m., the DON stated it was her expectation LNs to notify the RD (Registered Dietician) when residents refused supplements and notify the DON for all medication refusal not only prescription medications, but vitamins and over-the-counter medications as well.

3. a) Review of Resident 20's Admission Record indicated the resident was a long-term resident in the facility with diagnoses that included hemodialysis (a treatment to filter wastes and fluid from the blood using a dialysis machine, an artificial kidney) and had an above knee amputation recently. Resident 20 was on fluid restriction due to hemodialysis treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842 Continued From page 39

F 842

Review of Resident 20's weight variance from 1/12/24 through 5/13/24 indicated the resident had a 12.2 lb. (pound) weight loss for less than half a month period from 131.6 lbs. (2/23/24) down to 119.4 lb. (3/12/24). Since March 2024, the resident continued exhibited insidious weight loss and on 4/24/24 the resident weight was down to "50.7 lb.".

In a concurrent interview and record review on 5/15/24 at 10:11 a.m. at the nursing station, the RD explained Resident 20 was on hemodialysis and frequently exhibited weight fluctuation up to 10 lbs. in a short period of time. The RD stated "50.7 lb." on 4/24/24 was inaccurate and explained it was "a typo" that must have been "kilograms" and not pounds.

b) Review of Resident 20's MAR indicated the resident was on a 2000 ml daily fluid restriction therapy with the specific fluid daily quota for 1200 ml dietary and 800 ml nursing respectively.

Review of the facility's revised October 2010 policy and procedure, "Encouraging and Restricting Fluids," stipulated residents who were on fluid restriction therapy were to be evaluated for the resident's intake hydration status every week (weekly I&O summary).

Review of Resident 20's medical record included no documented evidence of the weekly I&O summary evaluation.

In a concurrent interview and record review on 5/15/24 at 11:32 a.m. at the nursing station, LN 2 stated Resident 20 had no daily I&O total summary or weekly I&O evaluation summary. LN 2 reviewed the most recent four weeks of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842 Continued From page 40

F 842

weekly summaries and stated they were inaccurate in that LNs documented Resident 20 was not on I&O monitoring. LN 2 stated without the weekly I&O summary, LNs were not able to know whether the resident's intakes were met with the doctor's order and had the potential for unnoted fluid overload, dehydration or skin integrity.

In an interview on 5/15/24 at 12:14 p.m., the DON, with the Nurse Consultant present, verified Resident 20 was on fluid restriction and therefore should have been evaluated weekly for the intake/hydration status. The DON acknowledge the resident's medical record was inaccurate and incomplete.

4. Review of Resident 3's Admission Record indicated he was a long-term resident in the facility with diagnoses that included a mood disorder.

Review of Resident 3's April and May 2024 MAR indicated LNs monitored the resident for the side effect of an antipsychotic medication, Abilify, for facial/tongue movement, drooling, rigidity, decreased mental status, tremors, and inability to sit still. In addition, the resident was being monitored for his behaviors in relation to Abilify therapy, for verbal aggressive outburst in the absence of Abilify administration which was discontinued on 4/19/24.

Review of the facility's policy and procedure, revised July 2017, "Charting and Documentation," stipulated, "The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care...Documentation in the medical

F 842	Continued From page 41 record will be...complete, and accurate." In an interview on 5/15/24 at 11:52 a.m., the DON verified the Abilify therapy monitoring had been continued in the absence of the Abilify administration for Resident 3. The DON acknowledged the resident's medical record was inaccurate and inconsistent with the care provided and it could mislead the healthcare providers on the resident's health status.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880	Staff in the rehab gym were instructed on adhering to Enhanced Barrier Precautions(EBP) while providing Mobility care to residents 233 and 234 while inside the rehab gym. A clean bag was provided to 14 to place the nasal cannula tubing in when not in use. All other residents that require EBP were not found to have mobility care inside the rehab gym. All residents requiring oxygen use were audit/observed to check if clean bags were available to use if oxygen tubing is not in use and no other residents were found to be affected by deficient practice. All Licensed nurses were in-serviced on oxygen use protocol, including storage of nasal cannula tubing when not in use. Rehab gym staff were in-serviced on EBP policy, including adhering to EBP for residents the require EBP during high-contact activities, such as mobility and transfer exercises. Facility IDT will audit during weekly room rounds to check for clean bag availability for when oxygen tubing is not in use. Infection Preventionist will perform random EBP compliance observations in the rehab gym on a weekly basis. Results of room round	6/3/24

		audits and EBP compliance audits will be reviewed during the monthly QA meeting for compliance.	

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	055417	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYLOR LANE HEALTHCARE CENTER	3500 FOLSOM BOULEVARD SACRAMENTO, CA 95816

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F 880	Continued From page 42 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880	

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F 880 Continued From page 43

F 880

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 38 residents when:

1. A facility staff did not wear required personal protective equipment (PPE) when assisting Resident 233 and Resident 234 with mobility exercises who were both on enhanced standard precaution (ESP- also known as enhanced barrier precaution/EBP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use); and,

2. Resident 14's nasal cannula (a medical device with two prongs connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils) was left uncovered and hanging on the resident's bedside rail when not in use.

These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure of Resident 233, Resident 234, and Resident 14 to germs, and may cause infection among residents, staff, and visitors.

Findings:

1a. A review of Resident 233's clinical record indicated Resident 233 was admitted April of 2024 and had diagnoses that included cutaneous abscess (a localized collection of pus in the skin)

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F 880 Continued From page 44

F 880

of right lower limb, cutaneous abscess of head, and stage 3 pressure ulcer (PU/PI- injury to skin and underlying tissue resulting from prolonged pressure which extends through the skin into deeper tissue and fat but do not reach muscle or bone).

A review of Resident 233's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/22/24, indicated Resident 233 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 233 had an intact cognition.

A review of Resident 233's physician's order, dated 5/13/24, indicated, "Enhanced Based [sic] Precaution (EBP) d/t [due to] stage 3 pressure ulcer (PU- also known pressure injury/PI, injury to skin and underlying tissue resulting from prolonged pressure which extends through the skin into deeper tissue and fat but do not reach muscle or bone) and occipital [back of the head] abscess. every shift."

During an observation on 5/13/24 at 10:29 a.m., of Resident 233's room had a sign posted on the door which indicated, "Enhanced Standard Precaution...ANYONE PARTICIPATING IN ANY OF THESE SIX MOMENTS MUST ALSO: Don [put on] gown and gloves...Mobility assistance..."

During an observation on 5/13/24 at 10:36 a.m. in the therapy gym, Physical Therapy Assistant (PTA) was observed not wearing a gown or gloves while assisting Resident 233 with his mobility exercises in using the stairs. PTA went in contact with Resident 233's clothing multiple times and touched Resident 233's shoulder. PTA

F 880 Continued From page 45

F 880

was also observed assisting Resident 233 to sit on his walker and proceeded on checking Resident 233's oxygen level using a pulse oximeter (an electronic device that clips onto a resident's finger to measure the oxygen level in the blood) without using gown or gloves.

During an interview on 5/13/24 at 10:37 a.m. with PTA, PTA confirmed she did not wear a gown or gloves while assisting Resident 233 in his mobility exercises and when checking Resident 233's oxygen level using a pulse oximeter. PTA stated, "...We [therapy staff] don't wear those in therapy [gym] because his [Resident 233] wound is covered...Our practice is not to wear them [gown and gloves] in the therapy gym." PTA further stated the importance of following ESP is for infection control and prevention of bacterial transmission.

During a concurrent observation and interview on 5/13/24 at 10:56 a.m. with Licensed Nurse (LN) 4, in Resident 233's room, LN 4 confirmed that Resident 233 had no dry dressing covering his stage 3 PU on the coccyx (area on the lower back where the bottom/base of the spine is). LN 4 stated he would expect Resident 233's stage 3 PU on the coccyx to be covered with a dry dressing.

A review of Resident 233's care plan, undated, indicated, "[name of Resident 233] is on enhanced based [sic] precautions d/t stage 3 pressure injury to coccyx and occipital abscess." A review of Resident 233's care plan intervention, undated, indicated, "Don...PPE as indicated when doing one of the following: ...mobility assistance..."

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F 880 Continued From page 46

F 880

1b. A review of Resident 234's clinical record indicated Resident 234 was admitted May of 2024 and had diagnoses that included encounter for other orthopedic aftercare (a care provided after a surgery that involves bones, muscles, and joints), and need for assistance with personal care.

A review of Resident 234's "ADMISSION-NURSING ASSESSMENT", dated 5/10/24, indicated, "...Patient [Resident 234] is A&Ox4 [the patient is alert and oriented to person, place, time, and situation] and has the capacity to make medical decisions..."

A review of Resident 234's physician's order, dated 5/13/24, indicated, "Enhanced Based [sic] Precaution (EBP) d/t surgical site to L [left] knee. every shift."

During an observation on 5/13/24 at 11:25 a.m., in Resident 234's room there was a sign posted on the door which indicated, "Enhanced Standard Precaution...ANYONE PARTICIPATING IN ANY OF THESE SIX MOMENTS MUST ALSO: Don [put on] gown and gloves...Mobility assistance..."

During an observation on 5/13/24 at 11:27 a.m. in the therapy gym, PTA was observed not wearing a gown or gloves while assisting Resident 234 with his sit-to-stand mobility exercises. PTA went in contact with Resident 234's clothing multiple times while standing closely to Resident 234 during the mobility exercises.

A review of Resident 234's care plan, undated, indicated, "[name of Resident 234] is on enhanced based [sic] precautions d/t stage surgical site to L knee." A review of Resident

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F 880 Continued From page 47

233's care plan intervention, undated, indicated, "Don...PPE as indicated when doing one of the following: ...mobility assistance..."

During an interview on 5/13/24 at 1:11 p.m. with the Chief Clinical Officer (CCO), the CCO stated they are aware about the new QSO (policy, memos, and guidance from the Centers for Medicare & Medicaid Services [CMS]) regarding ESP and the facility follows it.

During an interview on 5/15/24 at 1:51 p.m. with the Director of Nursing (DON), the DON stated facility staff should be observing ESP if a resident is placed under ESP to avoid potential spread of diseases, if there's any.

A review of the facility's policy and procedure (P&P) titled, "Enhanced Standard Precautions", revised 8/2022, indicated, "1. Enhanced standard precautions (ESPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents."

A review of the "QSO-24-08-NH" memorandum from CMS with the subject, "Enhanced Barrier Precautions in Nursing Homes", dated 3/20/24, indicated, "...Outside the resident's room, EBP should be followed...when working with residents in the therapy gym..."

2. A review of Resident 14's clinical record indicated Resident 14 was admitted April of 2024 and had diagnoses that included respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), chronic obstructive pulmonary disease

F 880

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F 880 Continued From page 48

F 880

(COPD- a group of diseases that causes airflow blockage and breathing-related problems, heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body), and dependence on supplemental oxygen.

A review of Resident 14's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/15/24, indicated Resident 14 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 14 had a moderately impaired cognition. A review of Resident 14's MDS Health Conditions, dated 4/15/24, indicated Resident 14 had shortness of breath or trouble breathing with exertion such as when walking, bathing, or transferring and when lying flat, and was a current tobacco user. A review of Resident 14's MDS Special Treatments, Procedures, and Programs, dated 4/15/24, indicated Resident 14 had continuous oxygen therapy on admission and while he is a resident in the facility.

A review of Resident 14's physician's order, dated 4/8/24, indicated, "OXYGEN D/T SOB [shortness of breath]/COPD at _2_L PER MIN [liters per minute/lpm- unit of measurement for oxygen administration] VIA NASAL CANNULA CONTINOUS [sic]. every shift."

During a concurrent observation and interview on 5/13/24 at 10:14 a.m. with LN 4, in Resident 14's room, LN 4 confirmed that Resident 14's nasal cannula was left wrapped around and hanging on resident's bedside rail when not in use. LN 4 stated Resident 14 went to his dialysis (the process of removing excess water, particles, and

F 880	Continued From page 49 toxins from the blood in people whose kidneys can no longer perform these functions naturally) treatment and was picked up before 9 a.m. today. LN 4 further stated he would expect the nasal cannula to be placed inside a bag when not in used, for infection control. During an interview on 5/15/24 at 1:51 p.m. with the DON, the DON stated, "...It [nasal cannula] should be bagged when not in use... for infection control..." A review of the facility's P&P titled, "Departmental (Respiratory Therapy)- Prevention of Infection", revised 11/2011, indicated, "Steps in the Procedure. 8. Keep the oxygen cannula and tubing. in a plastic bag when not in use."	F 880		