STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555798	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodside Healthcare Center	2240 Northrop Ave Sacramento, CA 95825

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure one out of 23 sampled residents (Resident 365) was assisted with nail care as part of her Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) when Resident 365 had long fingernails with blackish substance underneath the fingernails. This failure had the potential for Resident 365 to sustain injury and/or for Resident 365 to acquire an infection. Findings: A review of Resident 365's clinical record indicated Resident 365 was admitted November of 2024 and had diagnoses that included muscle weakness, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hearing loss. A review of Resident 365's Minimum Data Set (MDS - a federally mandated resident assessment tool) Cognitive Patterns, dated 11/11/24, indicated Resident 365 had a Brief Interview for Mental Status (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13 out of 15 which indicated Resident 365 had an intact cognition. A review of Resident 365's MDS Functional Abilities and Goals, dated 11/11/24, indicated Resident 365 required substantial/maximal assistance with toileting hygiene, shower/bathing, upper and lower body dressing, and setup or clean-up assistance with personal hygiene and eating. During a concurrent observation and interview on 11/19/24 at 10:28 a.m. with Resident 365, in Resident 365's room, Resident 365 had fingernails that were long and with blackish substance underneath the fingernails. Resident 365 stated she wanted her fingernails to be cleaned and trimmed and already told a staff about it. During a concurrent observation and interview on 11/19/24 at 10:31 a.m. with Certified Nurse Assistant (CNA) 5, in Resident 365's room, CNA 5 confirmed that Resident 365 had long fingernails and with blackish substance underneath the fingernails. CNA 5 stated she would expect that Resident 365's fingernails to be properly trimmed and cleaned because it would be a risk for infection and Resident 365 might scratch her skin. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/21/24 at 9:52 a.m. with the Infection Preventionist/Director of Staff Development (IP/DSD), Resident 365's clinical records were reviewed. The IP/DSD confirmed that Resident 365 had no documentation that she was refusing personal hygiene assistance and nail care. The IP/DSD stated residents should have a clean and well-trimmed fingernails because it is a component of personal hygiene and a part of infection control. During an interview on 11/22/24 at 9:44 a.m. with the Director of Nursing (DON), the DON stated if the patient has diabetes, the CNA should notify the Licensed Nurse to clean and trim the resident's fingernails. The DON further stated she would expect residents' fingernails to be clean and trimmed because long fingernails could cause infection and skin injury. A review of Resident 365's care plan, dated 11/6/24, indicated, Resident Is at risk for altered ADL's .Needs ext [sic] assistance with all ADL's. A review of Resident 365's care plan intervention, dated 11/6/24, indicated, Provide assistance with ADLs as indicated. 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 .).underneath the fingernails. CNA 5 stated she would expect that Resident 365's fingernails to be properly trimmed and cleaned because it would be risk for infection and Resident 365 might scratch her skin. During a concurrent interview and record review on 11/21/24 at 9:52 a.m. with the Infection Preventionist (IP), Resident 365's clinical records were reviewed. The IP confirmed that Resident 365 had no documentation that she was refusing personal hygiene assistance and nail care. The IP stated residents should have a clean and well-trimmed fingernails because it is a component of personal hygiene and a part of infection control. During an interview on 11/22/24 at 9:44 a.m. with the Director of Nursing (DON), the DON stated if the patient has diabetes, the CNA should notify the Licensed Nurse to clean and trim the resident's fingernails. The DON further stated she would expect residents' fingernails to be clean and trimmed because long fingernails could cause infection and skin injury. A review of Resident 365's care plan, dated 11/6/24, indicated, Resident Is at risk for altered ADL's .Needs ext [sic] assistance with all ADL's. A review of Resident 365's care plan intervention, dated 11/6/24, indicated, Provide assistance with ADLs as indicated. 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 .).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to provide an environment free from potential accident hazard for three of 23 sampled residents (Resident 259, Resident 261, and Resident 414), when electrical extension cords were observed laying on the floor inside the rooms of Resident 259 and Resident 261, and hanging unsecured in Resident 414's room. This failure had the potential to result in accidents and falls for Residents 259, 261, and 414. Findings: 1a. During a review of Resident 259's admission records, the records indicated Resident 259 was admitted in November 2024 with diagnoses which included anxiety, restless legs syndrome (a very strong urge to move the legs), and muscle weakness. Resident 259's Minimum Data Set (MDS - a federally mandated resident assessment tool) indicated Resident 259 had intact cognition. During a review of Resident 259's care plan, undated, the care plan indicated, Resident is at risk for falls r/t [related to] impaired balance. During a review of Resident 259's IDT [Interdisciplinary Team] Clinical Review, dated 11/17/24, the evaluation indicated resident 259 had an unwitnessed fall on 11/15/24. The evaluation indicated, 1. Fall prevention measure in place .2. Environment free of clutter . During a concurrent observation and interview on 11/19/24 10:29 a.m. with Resident 259 in her room, an electrical extension cord with wires connected was noted on the floor beside Resident 259's bed. Resident 259 stated, That can be dangerous. 1b. During a review of Resident 261's admission records, the records indicated Resident 261 was admitted in November 2024 with diagnoses which included fracture of fifth metatarsal bone (broken bone in the smallest toe) of right foot, muscle weakness, and history of falling. Resident 261's MDS indicated Resident 261 had moderate cognitive impairment. During an observation on 11/19/24 at 9:27 a.m. in Resident 261's room, an electrical extension cord with multiple wires connected was noted on the floor beside the bed. During a concurrent observation and interview on 11/20/24 at 11:40 a.m. with Certified Nursing Assistant 1 (CNA 1) in Resident 261's room, CNA 1 confirmed the extension cord was on the floor beside the bed and stated, It's not supposed to be there, they can trip and fall .it's supposed to be on the wall, for resident safety. During a concurrent observation and interview on 11/20/24 at 12:04 p.m. with Licensed Nurse 1 (LN 1) in Resident 261's room, LN 1 confirmed the extension cord was on the floor and stated that it's a trip hazard and safety issue. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 2:37 p.m. with the Maintenance Director (DM), the DM stated, Power strips [extension cords] should be up on the wall .I just wish there was a better design .The DM confirmed there were safety issues on the power strips on the floor and stated, I hope there's a better way. During a concurrent observation and interview on 11/21/24 3:42 p.m. with the Director of Nursing (DON), the DON confirmed the extension cord was still on the floor on the side of the bed and stated, Some [extension cords] are already put in, but it comes off .They put it on the wall for safety .They could possibly trip on these wires .That's a safety hazard. During a concurrent observation and interview on 11/19/24 10:29 a.m. with Resident 259 in her room, an electrical extension cord with wires connected was noted on the floor beside Resident 259's bed. Resident 259 stated, That can be dangerous. 1b. During a review of Resident 261's admission records, the records indicated Resident 261 was admitted in November 2024 with diagnoses which included fracture of fifth metatarsal bone (broken bone in the smallest toe) of right foot, muscle weakness, and history of falling. Resident 261's Minimum Data Set (MDS, an assessment tool) indicated Resident 261 had moderate cognitive impairment. During an observation on 11/19/24 at 9:27 a.m. in Resident 261's room, an electrical extension cord with multiple wires connected was noted on the floor beside the bed. During a concurrent observation and interview on 11/20/24 at 11:40 a.m. with Certified Nursing Assistant 1 (CNA 1) in Resident 261's room, CNA 1 confirmed the extension cord was on the floor beside the bed and stated, It's not supposed to be there, they can trip and fall .it's supposed to be on the wall, for resident safety. During a concurrent observation and interview on 11/20/24 at 12:04 p.m. with Licensed Nurse 1 (LN 1) in Resident 261's room, LN 1 confirmed the extension cord was on the floor and stated that it's a trip hazard and safety issue. During an interview on 11/20/24 at 2:37 p.m. with the Maintenance Director (DM), the DM stated, Powerstrips [extension cords] should be up on the wall .I just wish there was a better design .The DM confirmed there were safety issues on the powerstrips on the floor and stated, I hope there's a better way. During a concurrent observation and interview on 11/21/24 3:42 p.m. with the Director of Nursing (DON), the DON confirmed the extension cord was still on the floor on the side of the bed and stated, stated, Some [extension cords] are already put in, but it comes off .They put it on the wall for safety .They could possibly trip on these wires .That's a safety hazard. 1c. During an observation in the room of Resident 414 on 11/19/24 at 8:55 a.m., observed a metal power strip was not anchored and had another electrical cord plugged into it. During an observation and interview on 11/20/24 at 09:21 a.m. with CNA 7, CNA 7 confirmed the metal power strip was not attached properly and normally was attached to the wall. CNA 7 indicated the power strip was a safety hazard for the staff and residents as someone could fall if they tripped over it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an in interview on 11/20/24 at 1:26 p.m. with the DM, the DM stated that the metal power strip should be attached to the wall and not hanging. The DM stated that if the power strip was not attached properly, it could be a fall hazard for resident, staff, or visitors. During an interview on 11/22/24 at 8:44 a.m. with the DON, the DON stated that the power strip should be anchored to the wall and not freely hanging. She further stated that it was a risk for someone to fall if the power strip cord was not attached to the wall. A review of the facility's policy and procedure (P&P), Safety Precautions, Electrical, dated 2011, the P&P indicated, Report any and all unsafe electrical hazards to your supervisor immediately.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure safe and effective pharmaceutical services for a census of 55 residents when: 1. Resident 35's controlled drug (medications that the use and possession of are controlled by the federal government) use and removal from Controlled Drug Record (CDR- a paper log of controlled drug removal for administration to resident) was not accurately documented in Resident 35's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and Resident 12's controlled drug use documented in the MAR was not accurately signed out in Resident 12's CDR; and, 2. Resident 16 received expired eye medication for 27 days. These failed practices may contribute to unsafe medication use and risk of controlled drug diversion. Findings: 1a. A review of Resident 35's clinical record indicated Resident 35 was admitted October of 2024 and had diagnoses that included encounter for other orthopedic aftercare (a care provided after a surgery that involves bones, muscles, and joints) following surgical amputation (a procedure to remove a limb or other body part), low back pain, chronic (long-lasting) pain, and spinal stenosis (narrowing of the spaces inside the backbone, putting pressure on the spinal cord and nerve roots leading to pain, numbness, or weakness in the arms or legs). A review of Resident 35's Minimum Data Set (MDS – a federally mandated resident assessment tool) Cognitive Patterns, dated 11/3/24, indicated Resident 35 had a Brief Interview for Mental Status (BIMS -an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 out of 15 which indicated Resident 35 had an intact cognition. A review of Resident 35's MDS Health Conditions, dated 11/3/24, indicated Resident 35 had received scheduled and as needed pain medication regimen. A review of Resident 35's physician's order, dated 10/28/24, indicated, oxyCODONE HCl [a controlled pain medication] Oral Tablet 5 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 6 hours as needed for moderate-severe pain. A random audit of Resident 35's MAR and the CDR for oxycodone, for the month of November 2024, indicated nursing staff did not document oxycodone administration on the MAR when signed out from CDR on 11/1/24 at 9:38 p.m. 1b. A review of Resident 12's clinical record indicated Resident 12 was admitted August of 2014 and had diagnoses that included osteoarthritis (a deteriorating disease that causes pain, stiffness, and swelling where two or more bones meet), severe obesity (a disorder that involves having too much body fat), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 12's MDS Cognitive Patterns, dated 10/15/24, indicated Resident 12 had a BIMS score of 15 out of 15 which indicated Resident 12 had an intact cognition. A review of Resident 12's MDS Health Conditions, dated 10/15/24, indicated Resident 12 had received scheduled and as needed pain medication regimen. A review of Resident 12's physician's order, dated 4/15/22, indicated, Norco [a medication for pain which contains a combination of Hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever that increases the effects of hydrocodone] Tablet 5-325 MG .Give 1 tablet by mouth two times a day for PAIN MANAGEMENT. A random audit of Resident 12's MAR and the CDR for oxycodone, for the month of November 2024, indicated the Norco administration documented in the MAR of Resident 12 on 11/12/24 at 9 a.m. was not documeted on Resident 12's CDR. During a concurrent interview and record review on 11/21/24 at 10:18 a.m. with the Infection Preventionist/Director of Staff Development (IP/DSD), Resident 35's and Resident 12's CDR and MAR for November 2024 were reviewed. The IP/DSD confirmed the finding of Resident 35's oxycodone being signed out of the CDR but was not accurately documented on the MAR on 11/1/24 at 9:38 p.m. The IP/DSD also confirmed the finding of Resident 12's Norco administration being documented in the MAR but was not accurately signed out in the CDR on 11/12/24 at 9 a.m. The IP/DSD stated the process should be when the nurse pulls out controlled drug in the bubble pack (a form of packaging where an individual pushes individually sealed tablets through the foil to remove the medication), the nurse should sign out the CDR, then administer the medication, and then sign the administration in the MAR. The IP/DSD further stated nurses should follow the process as part of controlled drug accountability. During an interview on 11/21/24 at 3:56 p.m. with the Consultant Pharmacist (CP), the CP stated, The process [of controlled drug administration], you [facility staff] must be signing both [CDR and MAR] .The risk [if CDR and MAR are not both signed] .off-count [uneven count] of the [controlled] medication and possible [controlled drug] diversion . During an interview on 11/22/24 at 9:44 a.m. with the Director of Nursing (DON), the DON stated when staff takes out controlled drug medication from the bubble pack, the staff should sign it out in the CDR, the staff would then administer the medication to the resident, and then after administration, the staff should sign the MAR. The DON further stated the risk if staff are not signing both CDR and MAR for controlled drug administration are possible controlled drug diversion. A review of the facility's policies and procedures (P&P) titled, Controlled Substances, revised 12/2012, indicated, Nursing staff must count controlled medications at the end of each shift. The nurses coming on duty and the going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. A review of the facility's P&P titled, Administering Medications, revised 04/2019, indicated, .22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 16's clinical record indicated Resident 16 was admitted January of 2022 and had diagnoses that included glaucoma (an eye condition that can cause vision loss), dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities), and communication deficit (difficulty with communication). A review of Resident 16's physician's order, dated 3/3/24, indicated, Latanoprost [a prescription medication used to treat glaucoma] Ophthalmic [eye] Solution 0.005 % [percent- measurement of one part in every hundred] (Latanoprost) Instill 1 drop in both eyes at bedtime for Glaucoma. During a concurrent observation and interview on 11/19/24 at 4:15 p.m. with Licensed Nurse (LN) 4 of medication cart 2- south station, an opened bottle of Latanoprost for Resident 16 was found stored in medication cart 2- south station labeled, EXP DT [expiration date] -10/22/24 . [Dispense date] 9/10/24 . No other bottle of Latanoprost for Resident 16 was found in medication cart 2- south station. LN 4 confirmed the observation. LN 4 stated the expired medication would not work anymore if it was administered to Resident 16. A review of Resident 16's MAR for October 2024 and November 2024 indicated Resident 16 received one drop in both eyes of Latanoprost Ophthalmic Solution 0.005 % from 10/23/24 to 11/18/24 which was a total of 27 days. Requested a copy of the pharmacy receipt of another Latanoprost Ophthalmic Solution 0.005 % between 9/11/24 to 11/18/24 to Medical Records (MR) on 11/21/24 at 3:50 p.m. but none was provided. During an interview on 11/22/24 at 9:40 a.m. with the Nurse Consultant (NC), the NC confirmed that they could not provide receipt of Latanoprost Ophthalmic Solution 0.005 % before the expiration of the found Latanoprost bottle. The NC agreed that this would mean that Resident 16 received expired Latanoprost Ophthalmic Solution 0.005 % from 10/23/24 to 11/18/24 which was a total of 27 days. During an interview on 11/22/24 at 9:44 a.m. with the DON, the DON agreed that Resident 16 most likely received expired Latanoprost Ophthalmic Solution 0.005 % from 10/23/24 to 11/18/24 which was a total of 27 days. The DON stated expired medications should not be administered to residents because the efficacy of the treatment is affected. A review of the facility's P&P titled, Administering Medications, revised 04/2019, indicated, .12. The expiration/beyond use date on the medication label is checked prior to administering.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on observation, interview, and record review, the facility failed to ensure one of 23 sampled residents (Resident 259) was free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behaviors) when Resident 259's antidepressant was given without appropriate documented diagnosis. This failure decreased the facility's potential to monitor Resident 259's for target behaviors and had the potential to result in Resident 259's increased risk and exposure to side effects associated with psychotropic medications. Findings: During a review of Resident 259's admission records, the records indicated Resident 259 was admitted in November 2024 with diagnoses which included anxiety, restless legs syndrome (a very strong urge to move the legs), and abnormal involuntary movements. There was no diagnosis of depression on Resident 259's records. Resident 259's Minimum Data Set (MDS – a federally mandated resident assessment tool) indicated Resident 259 had intact cognition. During a review of Resident 259's physician order, dated 11/13/24, the order indicated, Sertraline KCl [Zoloft, medication to treat depression] Oral [by mouth] Tablet 50MG [milligrams, a unit of measurement] .Give 1 tablet by mouth in the morning for Depression m/b [manifested by] verbalized sadness. During a review of Resident 259's document titled Psychotropic Informed Consent and Verification, dated 11/13/24, the document indicated, 1. List Medication, Dose, Frequency, Diagnosis and Behavior manifestation: Sertraline HCl Oral Tablet 50 MG .1 tablet by mouth in the morning for Depression m/b verbalized sadness. During a review of Resident 259's Admission-Nursing Assessment, dated 11/13/24, the assessment indicated, Is the Resident currently taking psychotropic medication? .5ca. Antidepressant .The resident uses antidepressant medication Zoloft r/t Depression .Monitor for behaviors of depression .and notify MD [medical doctor] .if behavior worsens. During a review of Resident 259's IDT [Interdisciplinary Team]: admission Notes, dated 11/18/24, the notes indicated, Psychotrophic Drug Use: [Resident] is on Sertraline HCl 50MG in the morning for depression m/b verbalized sadness & current dose is well tolerated with no side effects reported. During an interview on 11/21/24 at 12:46 p.m. with Resident 259, Resident 259 stated, I was taking medication for depression, and I still take them here. I've been taking it for a while. I'm actually feeling good now. During an interview on 11/21/24 at 12:48 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated, She eats a lot, not really sad, prefers to be in the bed and wait for family .No behaviors that would indicate sadness or depression, not at all. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 12:53 p.m. with Licensed Nurse 6 (LN 6), LN 6 stated, When I go to the room, she's alright especially when family comes .I don't think she shows any signs of sadness or depression .When the family leaves, she feels sad but that's natural. During a concurrent interview and record review on 11/21/24 1:39 p.m. with LN 5, LN 5 stated, If it's antidepressant, we can get consent from resident to administer that, we get the consent and we let the MD sign it .We also monitor the target behavior and side effects .If we can't found a diagnosis related to the medication, that's going to the doctor to get clarified .if they are not in the list of diagnosis, it can be a problem. LN 5 verified Resident 259 was receiving Sertraline for depression m/b verbalized sadness and had no depression diagnosis based on the hospital discharge documents and stated, She doesn't have diagnosis of depression .The indication was wrong, it should have been for anxiety. During an interview on 11/21/24 at 2:12 p.m. with the Director of Social Services (DSS), the DSS stated, She's usually pretty calm, haven't had any complaints that something's off .She was a little down upon admission .No concerns with roommate .Her facial expressions are not always smiley, but she doesn't verbalize sadness or depression . During an interview on 11/21/24 at 3:46 p.m. with the Director of Nursing (DON), the DON stated, I found that sertraline was given for anxiety in the hospital so I changed it and called [doctor] .They put that one as depression, and there was no diagnosis for depression .The hospital wrote it for anxiety .It's important when we are getting the consent and also the [resident] doesn't have depression .We put the wrong target behavior. During a telephone interview on 11/21/24 at 4:15 p.m. with the Consultant Pharmacist (CP), the CP stated, It is important to have the diagnosis .to make sure to get the right dose and make sure there's a benefit .I expect that there's a diagnosis for the medication .when I check if the psychotropic is necessary, I look for the diagnosis, and from discharge documents from the hospital. During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use, dated 7/2022, the P&P indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to ensure safe medication administration practices when the facility's medication error rate was more than 5% (percentage- number or ratio that expressed as a fraction of 100) for a resident census of 55. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of four errors out of 33 opportunities which resulted in a facility wide medication error rate of 12.12 % in three out of 11 residents (Resident 261, Resident 359, and Resident 360) observed for medication administration. These failures had the potential for unsafe and ineffective medication use of Resident 261, Resident 359, and Resident 360 and potential to affect the residents' medical conditions. Findings: 1. During a medication administration observation which started on 11/19/24 at 3:24 p.m. with Licensed Nurse (LN) 2 at North Station, LN 2 administered one tablet of Famotidine (a medication that works by decreasing the amount of acid the stomach produces) 20 mg (milligrams- unit of measurement) to Resident 261. A review of Resident 261's active physician's order, dated 11/5/24, indicated, Famotidine Oral Tablet 20 MG(Famotidine) Give 1 tablet by mouth two times a day for GERD [Gastroesophageal reflux disease- a condition in which stomach acid and/or other contents leak back and irritates the food pipe lining] Take with food. 2. During a medication administration observation which started on 11/19/24 at 3:35 p.m. with LN 2 at North Station, LN 2 administered one tablet of Pantoprazole (a medication that reduces the amount of acid the stomach makes) 40 mg to Resident 359. A review of Resident 359's active physician's order, dated 11/11/24, indicated, Pantoprazole .Oral Tablet .40 MG .Give 1 tablet by mouth two times a day for GI [Gastrointestinal- refers to the digestive system, which includes the organs and passageways that food and liquids travel through as they are digested, absorbed, and leave the body] protection Take 30 minutes before a meal. The administration time on the Medication Administration Record (MAR-a document that listed administered drugs) indicated the medication was scheduled to be administered at 4:30 p.m. 3. During a medication administration observation which started on 11/19/24 at 3:35 p.m. with LN 2 at North Station, LN 2 administered a total of two tablet medications which included one tablet of Pantoprazole 40 mg to Resident 360. A review of Resident 360's active physician's order, dated 11/11/24, indicated, Pantoprazole .Oral Tablet .40 MG .Give 1 tablet by mouth two times a day for GI protection Take 30 minutes before a meal. The administration time on the MAR indicated the medication was scheduled to be administered at 4:30 p.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and medication order review on 11/19/24 at 3:45 p.m. with LN 2 at North Station, LN 2 acknowledged the observed medication administration of Famotidine to Resident 261, and Pantoprazole to Resident 359 and Resident 360. LN 2 stated the dinner mealtime for residents would start at 5 p.m. which was about an hour and 30 minutes after the medications were administered. LN 2 further stated the physician's order should be followed when administering Famotidine and Pantoprazole because the residents could get heart burn (a burning pain in the chest or throat that occurs when stomach acid flows back into the food pipe lining) and the medications would not be effective anymore when residents eat. A review of the facility's document titled, Woodside Healthcare Center Meal Times, undated, indicated, . Dinner: 5:00-6:00 PM. 4. During a medication administration observation which started on 11/20/24 at 8:32 a.m. with LN 3 at North Station, LN 3 administered a total of 12 medications to resident 360 which included one inhaler capsule of Spiriva (a medication that relaxes muscles in the airways and increases air flow to the lungs) 18 mcg (micrograms- unit of measurement). LN 3 placed 1 capsule of Spiriva 18 mcg in the handihaler device (a breath-activated device that delivers dry powder medication directly to the lung), pressed the green button on the handihaler to release the medication, held the handihaler up to Resident 360's mouth, and instructed Resident 360 to inhale (breath-in) through the mouth slowly one time. After administering the other medications, LN 3 went to clean the handihaler and stored it in the medication cart. A review of Resident 360's active physician's order, dated 11/14/24, indicated, Spiriva HandiHaler Inhalation Capsule 18 MCG .1 capsule inhale orally one time a day for COPD [Chronic obstructive pulmonary disease- a group of diseases that causes airflow blockage and breathing-related problems] Rinse mouth with water after each use *repeat inhalation process a 2nd time to ensure entire contents of capsule inspired*. During a concurrent interview and medication order review on 11/20/24 at 2:06 p.m. with LN 3 at North Station, LN 3 acknowledged the observed medication administration of Spiriva to Resident 360. LN 3 stated she should have given two inhalations of the medication to Resident 360 so the resident could get the whole dose of the medication. LN 3 further stated that not repeating inhalation process for the second time may cause Resident 360 to not get the whole dose of the medication and the treatment will be less effective. During a concurrent interview and medication order review on 11/21/24 at 3:56 p.m. with the Consultant Pharmacist (CP), the CP stated the physician's order should be followed when administering medications. During a concurrent interview and medication order review on 11/22/24 at 9:44 a.m. with the Director of Nursing (DON), the DON stated that nurses should follow physician's order when administering medications, if not, the residents would not get the full benefits of the medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Administering Medications, revised 04/2019, indicated, 4. Medications are administered in accordance with prescriber's orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication .7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .10. The individual administering the medication checks the label THREE (3) times to verify the .right dosage .of administration before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored in accordance with the facility's policies and procedures (P&P), and accepted professional principles for a census of 55 residents when: 1. A total of 3 loose pills were found in medication cart 1- north station and medication cart 2- south station; and, 2. An expired bottle of an opened Latanoprost (a prescription eye drop medication used to treat increased pressure in the eye) for Resident 16 was found stored in medication cart 2- south station. These failures resulted in Resident 16 receiving expired medication with unsafe and/or reduced potency and had the potential for diversion (illegal distribution) of the loose medications. Findings: During a concurrent observation and interview on 11/19/24 at 1:40 p.m. with Licensed Nurse (LN) 1, of medication cart 1- north station, two loose pills were found inside the second-right drawer of the medication cart. LN 1 confirmed the observation. LN 1 stated there should not be loose pills inside a medication cart because staff would not know what medication those were anymore. During a concurrent observation and interview on 11/19/24 at 4:15 p.m. with LN 4, of medication cart 2- south station, one loose pill was found inside the third-right drawer of the medication cart and an expired bottle of an opened Latanoprost for Resident 16 was found stored in the first-left drawer of the medication cart. LN 4 confirmed the observations. LN 4 stated the risk of having loose pill in the medication cart was that staff would not know what medication it is and who the medication if for. LN 4 further stated expired medication should not be stored inside the medication cart. During an interview on 11/21/24 at 3:56 p.m. with the Consultant Pharmacist (CP), the CP stated there should not be any loose pills inside the cart because those pills are lost dose, and the medication cart should be kept clean. The CP further stated expired medications should not be stored in medication carts because of the health consequences it could give if administered to a resident. During an interview on 11/22/24 at 9:44 a.m. with the Director of Nursing (DON), the DON stated the risk of having loose pills is that it could fall on the floor and a resident can pick it up and take it. The DON also stated that staff would not know what medication the loose pills were anymore. The DON further stated that there should be no expired medication stored in medication carts to prevent administering expired medications to residents. A review of the facility's P&P titled, Storage of Medications, revised 04/2007, indicated, 1. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing system in which they are received .2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner .4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food and maintain equipment in accordance with the professional standards for food service safety for a 54 residents out of 54 residents eating facility prepared meals, when: 1. The fruit and vegetable wash sink did not have an air gap (a gap in the draining pipe of a sink to prevent backflow); and 2. Food was expired in the residents' refrigerator. These failures had the potential to result in residents acquiring food-borne illnesses. Findings: 1. During an observation and interview on 11/19/24 at 8:25 a.m. with the Dietary Supervisor (DS), the DS confirmed that the sink that was used to wash fresh produce did not have an air gap. During an observation and interview on 11/20/24 1:55 p.m. with the Director of Maintenance (DM), the DM confirmed that there was no air gap for the sink in the kitchen where fresh produce was washed. The DM stated the purpose of the airgap was to prevent the possibility of backflow of contaminated water to the sink. During an interview on 11/21/24 1:47 p.m. with Registered Dietician (RD), the RD stated she remembers there was some problem with the air gap but did not remember the issue. The RD stated that if the sink did not have an air gap there was the potential that contaminated water could back up to clean produce and may result in a resident catching a food-borne illness. During a review of the 2022 FDA [Food and Drug Administration] Food Code, Section 5-202.13 Backflow Prevention, Air Gap, the Food Code indicated, During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system .Providing an air gap between the water supply outlet and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow. 2. During an observation and interview on 11/19/24 at 3:30 p.m. with Licensed Nurse (LN) 6, LN 6 found a seafood salad and crackers in a plastic container and a bag of lettuce labeled for Resident 43 in the residents' refrigerator. The lettuce appeared brownish, with a small amount of discolored water in the bag. LN 6 confirmed that the food was dated 11/8/24 and was expired and stated that the food items should have been thrown out. During an observation and interview on 11/19/24 at 3:45 p.m. with the DS, the DS stated that it was the responsibility of the nursing staff to throw away expired foods. The DS stated the lettuce should be thrown out based on the looks of the lettuce, and the seafood salad with crackers would only be good for 3-4 days. The DS further stated that the potential harm would be food-borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 8:58 am with the DON, the DON stated the process for food from home was the family will bring food from home and it was labeled with the resident's name and dated. The DON stated the LN was responsible for throwing out expired food. The DON further stated that food would be thrown out 72 hours after it had been brought in. The DON indicated if expired food was left in the refrigerator, residents were at risk for upset stomach and risk for food-borne illness. During a review of the facility's policy and procedure (P&P) titled, Bringing in Food for a Resident, dated 2023, the P&P indicated, Any suspicious or obviously contaminated food or beverages will be thrown away immediately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 2. During a review of Resident 41's admission records, the records indicated Resident 41 was admitted in October 2024 with diagnoses that included obstructive sleep apnea (breathing pauses during sleep), chronic obstructive pulmonary disease (COPD, chronic lung disease causing difficulty in breathing), asthma (airways narrow and swell), and dependence on supplemental oxygen. Resident 41's Minimum Data Set (MDS, an assessment tool) indicated Resident 41 had intact cognition. During a review of Resident 41's physician order dated 10/13/24, the order indicated, Supplemental oxygen 2-4L [Liter, a unit of measurement] via NC [nasal cannula] or oxymask [oxygen mask] to keep SpO2 [oxygen saturation, a measurement of how much oxygen the blood is carrying as a percentage] > or = 92% [percent, a unit of measurement] .as needed for SOB/Dyspnea [shortness of breath]. During an observation on 11/19/24 at 10:39 a.m. in Resident 41's room, Resident 1 was not in the room and nasal cannula was observed connected to oxygen concentrator and hanging on bed side rail, uncovered. During an observation on 11/19/24 at 11:59 a.m. in Resident 41's room, Resident 1 was still not in the room and the nasal cannula was still hanging, uncovered, on the side rails of the bed. During a concurrent observation and interview on 11/19/24 at 12 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 confirmed the nasal cannula was hanging on the bed side rail uncovered. CNA 2 stated, It's not supposed to be hanging and should be in a bag. During an interview on 11/20/24 at 12:08 a.m. with Licensed Nurse 1 (LN 1), LN 1 stated, There should be a black bag where we put it every time it's not in use .We don't want germs in it, people could walk on it. During an observation on 11/21/24 at 8:48 a.m. in Resident 41's room, Resident 41 was observed going out of the room via wheelchair assisted by CNA 2. Nasal cannula was observed connected to oxygen concentrator and placed on top of the bed, uncovered, while not in use. During a concurrent observation and interview on 11/21/24 at 8:57 a.m. with the Infection Preventionist/irector of Staff Development (IP/DSD) in Resident 41's room, the IP/DSD confirmed the nasal cannula was place on top of the bed, uncovered, when not in use and stated, Looks like he left and I don't know why he is not using oxygen tubing .it's not supposed to be lying on the bed, it should be in a bag .by touching the linen, it will be contaminated and will not be clean, if resident use it again, might introduce bacteria . During an interview on 11/21/24 at 3:34pm with the Director of Nursing (DON), the DON stated, [For nasal cannula storage] We have the black bags, if not being used they [staff] have to store it in the bag. When asked about the possible outcome if the nasal cannula was not stored properly, the DON stated, It's already contaminated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised 11/2011, the P&P indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff .Infection Control Considerations Related to Oxygen Administration .5. Keep the oxygen cannula and tubing used PRN [as needed] in an antimicrobial bag when not in use. 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 55 when: 1. A shared glucometer (a device which measures blood sugar using blood from the fingertip) was not cleaned and sanitized properly after use of three residents (Resident 261, Resident 24, and Resident 359); and, 2. Resident 41's nasal cannula (a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils) was not properly stored 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), and potential exposure of Resident 261, Resident 24, Resident 359, and Resident 41 to germs. Findings: 1. During a medication administration observation on 11/19/24 at 3:24 p.m., Licensed Nurse (LN) 2 took a shared glucometer ([Brand Name] G3 blood glucose monitoring system) and supplies in Resident 261's room to measure the blood sugar of Resident 261. LN 2 used a lancet (a sharp piercing device) to pierce the Resident 261's finger to get blood and then applied the blood to the test strip that was attached to the glucometer. After reading the result, LN 2 went out of Resident 261's room, discarded the used lancet and test strip, and wiped the shared glucometer using one wipe of [Brand Name] micro-kill one Germicidal Alcohol wipes (wipe with chemicals the facility is using to disinfect surfaces) quickly (less than 5 seconds), which dried-up immediately, to clean the glucometer's outer surface, then placed it on top of the medication cart. During a subsequent medication administration observation on 11/19/24 at 3:30 p.m., LN 2 again took the same shared glucometer and supplies in Resident 24's room to measure the blood sugar of Resident 24. LN 2 pierced Resident 24's finger using a new lancet to get blood and then applied the blood to the new test strip that was attached to the glucometer. After reading the result, LN 2 went out of Resident 24's room, discarded the used lancet and test strip, and again wiped the shared glucometer using one wipe of [Brand Name] micro-kill one Germicidal Alcohol wipes quickly (less than 5 seconds), which dried-up immediately, to clean the glucometer's outer surface, then placed it on top of the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another subsequent medication administration observation on 11/19/24 at 3:35 p.m., LN 2 again took the same shared glucometer and supplies in Resident 359's room to measure the blood sugar of Resident 359. LN 2 pierced Resident 359's finger using a new lancet to get blood and then applied the blood to the new test strip that was attached to the glucometer. After reading the result, LN 2 went out of Resident 359's room, discarded the used lancet and test strip, and again wiped the shared glucometer using one wipe of [Brand Name] micro-kill one Germicidal Alcohol wipes quickly (less than 5 seconds), which dried-up immediately, to clean the glucometer's outer surface, then placed it on top of the medication cart. During an interview on 11/19/24 at 3:45 p.m. with LN 2, LN 2 confirmed the three observations of her cleaning the shared glucometer quickly (less than 5 seconds) in between use of three residents. LN 2 stated the shared glucometer needed to be cleaned for one (1) minute to kill the germs and to sanitize it properly. During an interview on 11/21/24 at 10:33 a.m. with the Infection Preventionist/Director of Staff Development (IP/DSD), the IP/DSD stated that the facility's shared glucometer should be disinfected properly after each resident's use using the [Brand Name] Micro-Kill Germicidal Wipes. The IP/DSD further stated, .The glucometer should be cleaned for one minute .[it] should remain wet for one minute .You have to see it visibly wet .Disinfection should be done properly. During an interview on 11/22/24 at 9:44 a.m. with the Director of Nursing (DON), the DON stated staff should wipe the shared glucometer thoroughly. The DON also stated she would expect staff to follow the manufacturer's instruction in cleaning the shared glucometer. The DON further stated that there would be a risk of spreading infection to the residents if the shared glucometer was not sanitized properly. A review of the facility's policy and procedures (P&P) titled, Cleaning and Disinfecting .Resident-Care Items, dated 06/2011, indicated, .d. Reusable Items are cleaned and disinfected or sterilized between residents .5. Manufacturers' instructions will be followed for proper use of disinfecting products . A review of the manufacturer's instructions for [Brand Name] G3 blood glucose monitoring system titled, CLEANING AND DISINFECTING, undated, indicated, .The [Brand Name] G3 Meter should be cleaned and disinfected between each patient .The following products have been approved for cleaning and disinfecting the [Brand Name] G3 Meter: .[Brand Name] Micro-Kill .Germicidal .Wipes . A review of the label of [Brand Name] micro-kill one Germicidal Alcohol wipes, undated, indicated, .1 MINUTE KILL TIME .DIRECTIONS FOR USE .DISINFECTING: To disinfect hard, non-porous surfaces, use one or more wipes, as necessary, to thoroughly wet the surface to be treated. Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed on this label .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure call light system was accessible for one out of 23 sampled residents (Resident 24), when Resident 24's call light was observed under the bed and not within reach. This failure had the potential to negatively affect Resident 24's safety by preventing the resident from communicating a request for assistance when needed. Findings: During a review of Resident 24's admission records, the records indicated Resident 24 was admitted in August 2024 with diagnoses which included fracture of shaft of left tibia and fibula (broken bones in the lower leg), muscle weakness, and history of falling. Resident 24's Minimum Data Set (MDS – a federally mandated resident assessment tool) indicated Resident 24 was cognitively intact. During a review of Resident 24's MDS Section GG - Functional Abilities and Goals, dated 9/3/24, the MDS indicated Resident 24 required substantial/maximal assistance with toileting, shower, lower body dressing, putting in/taking off footwear, and personal hygiene. During a review of Resident 24's care plan, revised on 9/10/24, the care plan indicated, Resident is at risk for falls r/t [related to] impaired mobility, history of falling, muscle weakness .Ensure call light is within reach when in room . During an observation on 11/19/24 at 9:57 a.m. in Resident 24's room, Resident 24 was observed lying in bed, eyes closed, respirations unlabored. Resident 24's call light was observed under the bed and not within reach. During a follow-up observation on 11/19/24 at 12:02 p.m. in Resident 24's room, Resident 24's call light was still observed under the bed and not within reach. During a concurrent observation and interview on 11/19/24 at 12:05 p.m. with Licensed Nurse 3 (LN 3) in Resident 24's room, LN 3 confirmed the observation and took the call light from the floor under the bed. LN 3 stated, He uses call light if needs assistance. During an interview on 11/20/24 at 11:40 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated, For call lights, I place it within residents reach, if I put [a resident] in a chair, I put it where he can reach it .If he needs help, it's always with him, for safety .I broke safety if it's not within reach. During an interview on 11/20/24 at 11:48 a.m. with LN 1, LN 1 stated, It should be on the side where resident can reach it .CNAs are supposed to make sure .it's accessible and reorient the resident .They are supposed to be checking regular rounds, do random checks and do visual checks .That would be a problem if they can't reach the call light .There's a possibility their needs will not be met .Make sure call light is accessible . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555798	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodside Healthcare Center	2240 Northrop Ave Sacramento, CA 95825

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 3:35 p.m. with the Director of Nursing (DON), the DON stated, If the resident is alert, they will let the staff know about their preference .Either we put it on their hand or within their reach .The staff are informed that if the resident is in bed, they have to give the call light and should be reachable at all times . During a review of the facility's policy and procedure (P&P) titled, Call System, Resident, dated 9/2022, the P&P indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station .