STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555555	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eskaton Village Care Center	3939 Walnut Ave. Carmichael, CA 95608

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 41054 Based on interview and record review, the facility failed to ensure the rights of one of three sampled residents (Resident 1) when a medication was discontinued without informing the resident. This failure resulted in Resident 1 not being able to have input into decisions regarding her plan of care. Findings: According to Resident 1's admission record, she was admitted in 4/24 with diagnoses including aftercare following joint replacement surgery and Stage 3 chronic kidney disease (mild to moderate loss of kidney function). It also indicated Resident 1 was her own responsible party (RP, medical decision maker). A review of Resident 1's Minimum Data Set (MDS, an assessment tool) indicated Resident 1 had no memory impairment. A review of Resident 1's clinical record included the following documents: A General Acute Care Hospital (GACH) Physician's (MD) Order for Admission, dated 4/16/24, indicated the following orders: 1. Hydrochlorothiazide-spironolactone (medication used to treat high blood pressure and fluid retention), 25mg.-25mg. (milligrams, a unit of measurement), 2 tablets, once daily. 2. Spironolactone (a medication to treat high blood pressure), 50 mg., 1.5 tablets once daily. An MD's Order Report, dated 4/16/24- 5/31/24, indicated the following orders: 1. Spironolactone-hydrochlorothiazide 25mg.-25 mg. tablet, 2 tablets, once daily. The order had a start date of 4/16/24. 2. Spironolactone, 50 mg. tablet, one tablet every other day at 5 p.m., hold for SBP (systolic blood pressure, the pressure in the arteries when the heart contracts) less than 100. The order's start date was 5/1/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Spironolactone, 50 mg. tablet, one tablet daily at 8 a.m., hold for SBP less than 100. The order's start date was 5/1/24. An MD note, dated 4/16/24 and written by MD 1, indicated he had met with Resident 1 and the plan was to include routine medications. An MD Order Sheet, dated 4/16/24 and written by MD 1, indicated the order for spironolactone 50 mg, 1.5 tabs daily was to be discontinued. A MD note, dated 5/2/24 and written by MD 2, indicated he had met with Resident 1 on 5/1/24 and she had requested to be put back on her previous dose of spironolactone 50 mg. in the morning and 50 mg. in the evening every other night. The note further indicated the plan for Resident 1 included placing her back on the spironolactone 50 mg. for worsening leg edema (swelling). In an interview, on 7/3/24 at 7:31 a.m., Resident 1 stated she had been taking spironolactone, 50 mg. tablets, 1.5 tablets daily and hydrochlorothiazide-spironolactone 25mg.-25 mg. tablets, 2 tablets daily for at least two years for her high blood pressure and fluid retention. Resident 1 stated after about two weeks at the facility, her left foot had become very swollen and it was at this time she had found out she was not getting both of the medications. Resident 1 stated she believed she had no longer been receiving the spironolactone 50 mg. tablets, 1.5 tablets daily. Resident 1 stated she wanted to know who decided to change her medications without telling her and stated she felt it had violated her rights. In an interview, on 7/9/24 at 1:34 p.m., the Director of Nursing (DON) stated it was her expectation that the MD explained to the resident or RP any changes in medications, such as new medications or the discontinuation of routine medications. The DON confirmed Resident 1 was her own RP and the spironolactone 50 mg. tablet, 1.5 tablets daily had been a routine medication for Resident 1 prior to her admission to the facility. The DON confirmed there was no documentation the MD had discussed this change in medication with Resident 1. A review of the facility's policy titled, Resident Rights, revised 12/13/16, stipulated, This community acts in accordance with all of the rights guaranteed to residents under federal and state law.