CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055776 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 01/25/2006 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COLONIAL HEALTHCARE | STREET ADDRESS, CITY, STATE, ZIP CODE 12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY | | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | The following reflects the findings of the Department of Public Health during a Complaint Investigation visit [redacted]<br><br>CLASS AA CITATION -- MEDICATION<br>03-1407-0003206-S<br>Complaint(s): CA00082166, CA00070667, CA00070451, CA00070355<br><br>72361, Pharmaceutical Service-Orders for Drugs.<br><br>(a) No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness.<br><br>72311, Nursing Services-General.<br><br>(a) Nursing service shall include, but not be limited to, the following:<br>(1) Planning of patient care, which shall include at least the following:<br>(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.<br><br>On 1/26/06 an unannounced visit and subsequent visits were made to the facility to investigate complaint number [redacted] regarding patient | | | |

Event ID:UWW211 10/28/2009 11:21:01AM

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055776 | A. BUILDING<br>B. WING | 01/25/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLONIAL HEALTHCARE | 12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | **Continued From page 1**<br>care and services.<br><br>The Department determined that the facility failed to:<br><br>1. Ensure that medications were administered to Patient A as prescribed. Patient A did not have a diagnosis of [redacted]<br><br>2. Assess and provide an adequate level of care for Patient A upon return from the general acute care hospital (GACH) emergency room (ER) for treatment [redacted] sugar) [redacted] Patient A was unresponsive, rigid, with a fixed stare and was not able to eat or drink yet nursing staff did not notify a physician or provide further assessment until 4:20 p.m. (3 hour, 50 minute period). At 4:20 p.m., Patient A was found choking in bed with cool/clammy skin, unresponsive [redacted] transferred to the ER.<br><br>These failures resulted in Patient A's admission to the GACH from 1/04/06 to 1/13/06 with diagnoses that included [redacted] Patient A expired on 1/13/06 with cause of death documented as [redacted] | | | |



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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055776 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 01/25/2006 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: COLONIAL HEALTHCARE | STREET ADDRESS, CITY, STATE, ZIP CODE: 12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY | | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | **Continued From page 2** | | | |
| | [redacted] | | | |
| | The 11/01/05 initial Minimum Data Set (MDS, an assessment tool used to describe the patient's physical and psychosocial functioning) documented that Patient A had moderately impaired cognitive functioning, was independent with eating, required limited to extensive assistance with other activities of daily living (ADL) and had experienced a decline in ADL functioning in the prior 90 days. | | | |
| | [redacted] | | | |



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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055776 | A. BUILDING ____ B. WING ____ | 01/25/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLONIAL HEALTHCARE | 12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | **Continued From page 3** Nursing staff documented in the [redacted] weekly nursing summary that Patient A was alert, confused, cooperative and spent most of the day in a wheelchair. [redacted] a Licensed Vocational Nurse (LVN 1) documented in a nurse's progress note that Patient A was "unresponsive, fixed stare, right facial droop, right arm limp" and the physician was notified and gave orders for transfer to the ER.<br><br>The ambulance report documented that paramedic staff arrived at the facility on [redacted] in response to Patient A's reported altered level of consciousness. Patient A had no visible signs of trauma, [redacted] at 8:19 a.m. and was transported to the ER.<br><br>[redacted]<br><br>Staff documented in the [redacted] nurse's notes that Patient A [redacted] 10:05 a.m. [redacted] Staff documented that Patient A "knows name, place, following commands, confused about | | | |



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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055776 | A. BUILDING<br>B. WING | 01/25/2006 |
| NAME OF PROVIDER OR SUPPLIER<br>COLONIAL HEALTHCARE | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | **Continued From page 4**<br>year...swallows oral fluids and custard applesauce easily." At 12:15 p.m. staff documented that Patient A was transported back to the facility via gurney van. The ER physician's discharge orders documented [redacted]<br><br>[redacted] LVN 1 documented that Patient A returned from the ER and described Patient A's condition as "remains unresponsive, rigid, fixed stare; [patient] not able to eat or drink at this time; [patient] nonresponsive to verbal stimuli and not responding to chest rub. [redacted]<br><br>Patient A's facility medical record did not contain documentation that described staff assessment of Patient A's condition or [redacted] when he returned from the ER for treatment of [redacted] choking in bed with cool/clammy skin was unresponsive and [redacted]<br><br>On [redacted] LVN 2 documented that Patient A was "choking in bed, skin cool and clammy to touch, nonresponsive, sat up in bed as far as possible, attempts made to suction airway, nothing coming out, call placed to M.D." [redacted] | | | |

Event ID:UWW211 10/28/2009 11:21:01AM

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055776 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 01/25/2006 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: COLONIAL HEALTHCARE | STREET ADDRESS, CITY, STATE, ZIP CODE: 12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY | | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | **Continued From page 5** [redacted] if he desires, send to [GACH] emergency room." [redacted] 2 documented that "paramedics arrived, [redacted] paramedics took a [redacted] and Patient A continued to be "comatose." The paramedics transported Patient A to the emergency room.<br><br>Paramedic staff documented in the ER medical record ambulance report arrival at the facility on [redacted] in response to Patient A's reported 3 hour altered level of consciousness. Paramedic staff documented that Patient A had a [redacted]<br><br>The ER physician documented in a [redacted] dictated report that Patient A was in the ER department earlier in the day, was found to have a [redacted] and was found again to have a [redacted] The ER physician documented that "At this time the patient presents with [redacted] | | | |

Event ID:UWW211 10/28/2009 11:21:01AM

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055776 | A. BUILDING<br>B. WING | 01/25/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLONIAL HEALTHCARE | 12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | **Continued From page 6**<br>[redacted]<br>Patient A's GACH medical record documented that after the second ER evaluation, Patient A was admitted to the hospital [redacted] Physician 2 documented in a [redacted] progress note that Patient A vomited and aspirated during a [redacted]<br><br>LVN 1 stated during a [redacted] interview that at the time of Patient A's return from the ER on [redacted], Patient A was unresponsive even to sternal rub (rubbing the breast-bone area to elicit a patient response) and his condition was unchanged from when he went to the ER earlier in the day. LVN 1 said that Patient A did not have any [redacted] | | | |



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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055776 | A. BUILDING<br>B. WING | 01/25/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLONIAL HEALTHCARE | 12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | **Continued From page 7**<br>[redacted]<br>The facility Director of Nurses (DON) stated during a 1/27/06, 12:45 p.m. interview that the facility does not have a policy that requires a higher level of assessment (by a RN) when a resident returns from an ER evaluation. The DON said that if LVN 1 felt that it was necessary (when Patient A returned from the ER on [redacted] in an unresponsive condition), an RN was available to assess Patient A.<br>[redacted] | | | |



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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055776 | A. BUILDING<br>B. WING | 01/25/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLONIAL HEALTHCARE | 12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | **Continued From page 8** | | | |
| | [redacted] | | | |
| | [redacted] | | | |
| | [redacted] | | | |
| | 1. Ensure that medications were administered to Patient A as prescribed. [redacted] | | | |

Event ID:UWW211 10/28/2009 11:21:01AM

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055776 | A. BUILDING<br>B. WING | 01/25/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLONIAL HEALTHCARE | 12225 SHALE RIDGE LANE, AUBURN, CA 95602 PLACER COUNTY |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE |
|---|---|---|---|---|
| | **Continued From page 9**<br>[redacted]<br>2. Assess and provide an adequate level of care for Patient A upon return from the general acute care hospital (GACH) emergency room (ER) for [redacted] (abnormally low blood sugar) on 1/04/06 at 12:30 p.m. Patient A was unresponsive, rigid, with a fixed stare and was not able to eat or drink yet nursing staff did not notify a physician or provide further assessment [redacted]<br>Patient A was found choking in bed with cool/clammy skin, unresponsive with a blood sugar of 35 (low) and was subsequently transferred to the ER.<br><br>The Department determined that the above violations presented an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was a direct proximate cause of death of the patient. | | | |

Event ID:UWW211 10/28/2009 11:21:01AM

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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.