DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING _____ B. WING _____ Received 7/30/14 LL	06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	4635 COLLEGE OAK DRIVE SACRAMENTO, CA 95841

(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an annual RECERTIFICATION survey conducted 6/3/14 through 6/6/14. Representing the Department of Public Health: HFEN, 32525 HFEN, 26663 HFEN, 29583 HFEN, 29721 The facility census was 105 and the sample size was 21.	F 000	Preparation and/ or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/ or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 CFR 405.1907.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure each resident was cared for in a dignified manner when; 1. One Random Resident (Random Resident 22) waited 45 minutes to be fed by staff and; 2. Three staff members described residents requiring staff assistance with eating, as "feeders" for a census of 105. This failure had the potential to diminish these resident's self-esteem and self-worth. Findings:	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Irina Kaplan — TITLE: Administrator — (X6) DATE: 7/24/14

Irina Kaplan — Administrator — 6/30/14

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 241	Continued From page 1 1. Random Resident 22 was admitted to the facility on 4/4/05 with diagnoses that included Parkinson's disease (a progressive disorder of the nervous system that affects your movement) and dysphagia (difficulty in swallowing). Review of the Minimum Data Set (MDS-an assessment tool), dated 4/23/14, indicated Random Resident 22 did not have the capability to understand others and was unable to make himself understood. According to the MDS, the resident was dependent on staff for eating and required a mechanically altered diet (puree). A review of the medical record included the following: -A Care Plan Conference/Interdisciplinary Review, dated 4/29/14, indicated Random Resident 22 "...eats all meals in main dining room with assistance from staff." -A Self Care Deficit Care Plan, dated 3/25/11, indicated, "Does not communicate needs to staff." During a meal observation on 6/3/14 the lunch trays were served in the main dining room beginning at 12:20 p.m. to the residents. There were 27 residents and 9 aides observed in the dining room. Random Resident 22 was seated at a table with 3 other residents that required feeding assistance and 1 certified nurses aide. All 3 residents were fed their meals before Random Resident 22 was offered his food. Random Resident 22 was offered his first bite of food at 1:05 p.m., 45 minutes after the lunch trays were served. Random Resident 22 took one bite and then refused the next. The Department asked the	F 241	**F241(1)** **Corrected Action for Affected Residents:** Staff were directed during the time of the survey to ensure that all residents seated at the same table eat at the same time. **Identification of Other Potential Residents:** Department Managers are observing meal service to identify residents who are not being assisted timely and directing staff as necessary. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** All nursing staff were inserviced regarding timeliness of food service and dining assistance. All nursing staff were trained to ask the resident if their food was hot enough, and options available for when a resident's reply is "No". **Monitoring Plan:** DSD and ADONs to monitor daily. Reviews to be forwarded to QA Committee **F241(2)** **Corrected Action for Affected Residents:** Staff have been inserviced regarding dignified treatment, specifically with residents who require dining assistance. Staff have been trained in "Person First" language. **Identification of Other Potential Residents:** Department Managers are observing meal service to ensure staff	6/3/14 6/9/14 and ongoing 6/27/14 and ongoing 6/27/14 6/27/14 6/9/14 and ongoing

By Administrator

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F 241	Continued From page 2 Certified Nurses Aide (CNA 5) if the food was still warm, since the covered food had not been served on a hot dish. CNA 5 touched the plate and replied, "No, let me go heat this up." A review of the un-dated policy titled, "Dining Program," indicated, "Serve meals timely and at appropriate temperatures...Residents at one table will be served at the same time." In an interview with the Director of Staff Development on 6/6/14 at 8:50 a.m., she stated that a resident should not have to wait longer than 10-15 minutes before they were fed their food. 2. During Dining Observation on 6/3/14, at 12:20 p.m., Certified Nursing Assistant 4 (CNA 4) was observed in the assisted dining room to say to another CNA, "Is she a feeder?" There were 25 residents in the room at the time the question was asked. During an observation on 6/5/14, at 8:30 a.m., Licensed Nurse 6 (LN 6) was asked where one of the sampled residents was located. LN 6 stated, "...She is a feeder, she is in the feeders dining room." In an interview with the Restorative Nursing Assistance Supervisor on 6/6/14 at 10 a.m., she referenced a random resident as being "a feeder in the main dining room." In an interview with the Director of Staff Development (DSD) on 6/6/14, at 9 a.m., the DSD stated, " It's not OK," to call residents 'feeders.' The DSD stated staff had been taught not to use the term 'feeders'.	F 241	are using "Person First" language that is dignified. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** Staff have been inserivced regarding dignified treatment, specifically with residents who require dining assistance. Staff have been trained in "Person First" language. **Monitoring Plan:** DSD and ADONs to monitor daily. Reviews to be forwarded to QA Committee.	6/27/14 By Administrator 6/27/14

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F 248	Continued From page 3	F 248	**F248**	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by; Based on observation, interview and record review, the facility failed to provide an ongoing activity program to meet the needs of 1 of 21 sampled residents (Resident 14) when his care plan for activities required 3 weekly in-room visits, and they were not all provided. This failure had the potential to lead to social isolation and depression. Findings: Resident 14 was admitted to the facility on 4/8/12 with diagnoses which included a stroke with right sided weakness, and the inability to swallow. An MDS (Minimum Data Set- an assessment tool) dated 3/5/14 described the resident as being totally dependent upon staff to move in bed, and for all care. The MDS also described the resident as having a gastric feeding tube, as he was unable to eat. A feeding tube was inserted into the stomach through a surgical opening in the abdomen, in order to administer liquid food and medications. During an observation of Resident 14 on 6/5/14 at 9 a.m., the resident was awake, lying in bed with his head elevated.	F 248	**Corrected Action for Affected Residents:** There is no manner to go back in time to make the room visits occur. The Activity Staff have been directed to ensure that Resident 14 has at least three room visits per week. **Identification of Other Potential Residents:** The Activity Director reviewed the Room Visit logs for all other residents on the Room Visit roster. All other residents have received their room visits per their care plan. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** The Activity Director shall ensure that Activity Staff are maintaining the scheduled room visits. Activity Staff received Disciplinary Action for failing to maintain Room visits as scheduled for Resident 14. The Room Visit Log for Resident 14 shall be turned into the Administrator at the conclusion of each month for review and signature. **Monitoring Plan:** Activity Director and Administrator to monitor weekly. weekly reviews to be forwarded to the QA Committee.	6/9/14 6/25/14 6/27/14 and ongoing 6/30/14 6/30/14 and ongoing

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F 248	Continued From page 4 During an interview with Resident 14 on 6/5/14 at 9 a.m., the resident was unable to speak, but could use his left hand to signal thumbs-up, indicating 'yes' to questions. The resident was able to follow commands, such as opening his mouth, and he denied having pain. The resident began to cry when asked about his family. Review of the clinical record for Resident 14 included an "Activity Care Plan," dated 1/2/13, which included, "Act[ivity] staff to room visit [resident] for additional social contact." Under approaches the care plan specified, "Act[ivity] staff will visit res at least 3x [times per week] for socialization...to read aloud, play music, sing.." A 6/5/14 review of the Resident Room Visits calendar, dated May 2014, which documented individual room visits made by activity staff to provide socialization, documented 6 days, of the 31 days of the month of May, were marked to indicate an activity staff room visit. The facility provided an average of 1.5 visits per week, rather than 3 visits per week as directed in his care plan. A Thursday, 6/5/14 review of the Resident Room Visits calendar, dated June 2014, showed there were no documented visits during the first 4 days of June. In an interview with the Activity Coordinator (AC) on 6/5/14 at 1:05 p.m., the AC verified the care plan directed staff to visit Resident 14, three times weekly, which she confirmed had not been met in May 2014. The AC also confirmed the resident had not been visited yet during the first 4 days of June.	F 248		

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F 323	Continued From page 5	F 323	F323(1)	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish an effective system to monitor the presence and function of assistive devices used to prevent memory-impaired residents from leaving the facility undetected (eloping), for 10 random residents, and 2 of 21 sampled residents (Residents 4 and 13), for a census of 105. This failure placed memory-impaired residents at risk of unmonitored exit from the facility, which could result in serious injury. Findings: 1. During the Environmental Tour of the facility on 6/5/14 at 9 a.m., the exit monitoring system was tested with the Maintenance Supervisor (MS). The exit door located in the Main Dining Room was observed and it did not alarm when an exit monitoring device neared the door. The exit led to a patio which led to a parking lot, secured by a simple latch on a gate. The gate latch was unlocked, and it was located approximately 5 feet from the ground.	F 323	**Corrected Action for Affected Residents:** A door alarm is installed at the door to the Main Dining Room. All Staff have been trained in the presence and instructions for disarming the alarm when activated. **Identification of Other Potential Residents:** All of the exit doors have been assessed and new door alarms shall be installed for consistency. All exit doors shall alarm when opened. These alarms are in addition to the facility's Code Alert System. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** All of the exit doors have been assessed and new door alarms shall be installed for consistency. All exit doors shall alarm when opened. These alarms are in addition to the facility's Code Alert System. The door alarms shall be inspected on a weekly basis as part of the Preventative Maintenance Program. **Monitoring Plan:** Maintenance Supervisor to monitor weekly. QA to review quarterly F323(2) **Corrected Action for Affected Residents:** A door alarm is installed at the door to the Main Dining Room. All Staff have been trained in the presence and instructions for	6/30/14 6/30/14 and ongoing 6/30/14 6/30/14 6/30/14 and ongoing 6/30/14 6/30/14 and ongoing

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F 323	Continued From page 6 In an interview with the MS on 6/5/14 at 9 a.m., he stated the residents could not get out the gate and that no one has eloped. MS stated he monitored the door alarms monthly, but he did not have written evidence of the monitoring. MS stated residents did not use that exit door. In an interview with the Director of Nurses (DON) on 6/5/14 at 1:20 p.m. the DON stated the facility did not require a physician's order for the exit monitoring devices, and stated the, "Nurses know who has a [device]." The DON further stated, "Nobody goes out that door, ever." The DON was unwilling to describe further, how the presence and function of the elopement devices for 12 residents were monitored by staff. 2. Resident 4 was admitted to the facility on 7/23/13 with diagnoses of dementia. An MDS (Minimum data set, an assessment tool) dated 4/18/14 described the resident as having severe cognitive impairment and being able to walk independently around the facility. The MDS assessment described the resident as wandering. Review of the clinical record for Resident 4 included: An "At Risk for Fall Care Plan," initially dated 7/23/13, listed the following problems: "Cognitive [memory] impairment and doesn't consistently follow thru [with] instructions. Episodes of removing [exit monitoring device brand name]." Under Approaches was, "[exit monitoring device brand name] on L [left] wrist for safety." A "Care Plan Conference/Interdisciplinary Review" form, dated 10/29/13, included, "Ambulates throughout the facility [with]	F 323	disarming the alarm when activated. Resident 4 was assessed and determined to be an elopement risk and will continue to wear a Code Alert bracelet. The Nursing Care Plan for Resident 4 reflects that he has a history of removing the Code Alert bracelet. A Nursing measure has been added to his monthly Treatment Sheet for Nurses to check the placement of the Code Alert bracelet each shift. **Identification of Other Potential Residents:** The facility has developed a systemic process for assessing residents for elopement and utilizing a Code Alert bracelet when indicated. The systemic process includes checking for placement of the Code Alert bracelet on the resident each nursing shift, checking daily that the Code Alert bracelet is properly functioning, and also that the Code Alert Receivers on the facility doors are functioning on a daily basis. Residents who are identified as risk for elopement are assessed on a quarterly basis and as needed for continued utilization of the Code Alert bracelet. All of the exit doors have been assessed and new door alarms shall be installed for consistency. All exit doors shall alarm when opened. These alarms are in addition to the facility's Code Alert System.	6/9/14 6/30/14

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F 323	Continued From page 7 supervision." There were no notes about his elopement risk, or the use of an exit monitoring device. A "Care Plan Conference/Interdisciplinary Review" form, dated 4/17/14, did not contain notes about the resident's elopement risk, or the use of an exit monitoring device. The "Licensed Nurses Progress Notes," weekly summaries, dated: 5/22/14, 5/29/14; and 6/4/14, did not include any references to his elopement risk, or the use of an exit monitoring device. There was no elopement assessment documented in the record. The clinical record did not contain any evidence nurses were checking the function, and presence of the exit alarm device for Resident 4 to ensure his safety. During an observation of Resident 4 on 6/3/14 at 11:35 a.m., the resident was sitting on the edge of his bed, dressed in street clothes, visiting with 2 family members. The resident was cheerful and social. There was not an exit monitoring device attached to his wrists or ankles. During an observation of Resident 4 on 6/4/14 at 10:30 a.m., the resident walked out the front door of the facility accompanied by his family members for a pass. The facility's audible exit alarm system was not activated as the resident passed the sensors while leaving the building. In an interview and observation with Licensed Nurse 1 (LN 1) on 6/5/14 at 9:15 a.m., LN 1 stated Resident 4 wore an exit monitoring device.	F 323	**Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** The facility has developed a systemic process for assessing residents for elopement and utilizing a Code Alert bracelet when indicated. The systemic process includes checking for placement of the Code Alert bracelet on the resident each nursing shift, checking daily that the Code Alert bracelet is properly functioning, and also that the Code Alert Receivers on the facility doors are functioning on a daily basis. Residents who are identified as risk for elopement are assessed on a quarterly basis and as needed for continued utilization of the Code Alert bracelet. All of the exit doors have been assessed and new door alarms shall be installed for consistency. All exit doors shall alarm when opened. These alarms are in addition to the facility's Code Alert System. The door alarms shall be inspected on a weekly basis as part of the Preventative Maintenance Program. **Monitoring Plan:** Maintenance Supervisor to monitor weekly. Nursing Staff to monitor per facility policy. Monitoring forms to be forwarded to QA Committe.	6/9/14 6/30/14 6/30/14 and ongoing

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F 323	Continued From page 8 In a concurrent observation in the resident's room LN 1 was unable to locate the monitoring device. She stated there was not a doctors order for the device, as the facility considered the devices to be nursing measures, not requiring an order. LN 1 stated the nurses were not required to document the presence of the monitoring device on either the medication or treatment records. Review of a handwritten list provided by the facility on 6/5/14, titled "Code Alarms," included 12 residents, and listed the location of their exit monitoring device (i.e. left wrist, right ankle, etc.). The location for Resident 4's device was documented as, "Where ever." In a follow up interview with LN 1 on 6/5/14 at 9:30 a.m., LN 1 stated the exit monitor had been located in his drawer. The monitor was observed to be tied with gauze, with multiple knots. LN 1 stated the resident was known to remove the device. LN 1 reviewed the clinical record for Resident 4 and was unable to locate an elopement risk assessment. In an interview with the MDS Coordinator (MDSC) on 6/5/14 at 10 a.m., MDSC stated the nurses monitor the presence of the exit monitoring device, she stated, "I'm sure they check it frequently...weekly." Review of an undated facility policy titled "Wandering/Elopement," directed, "Purpose: To protect residents from injury who wander and/or attempt to elope from the facility...All residents shall be assessed by the interdisciplinary team (IDT) regarding the risk of wandering on the MDS...If it is determined that an alert device is needed, the licensed nurse shall contact the	F 323	**F323(3)** **Corrected Action for Affected Residents:** Resident 13 was assessed and determined to NOT be an elopement risk and the Code Alert bracelet was removed. **Identification of Other Potential Residents:** All residents currently wearing Code Alert bracelets have been reassessed utilizing the new facility systemic process for elopement. The facility has developed a systemic process for assessing residents for elopement and utilizing a Code Alert bracelet when indicated. The systemic process includes checking for placement of the Code Alert bracelet on the resident each nursing shift, checking daily that the Code Alert bracelet is properly functioning, and also that the Code Alert Receivers on the facility doors are functioning on a daily basis. Residents who are identified as risk for elopement are assessed on a quarterly basis and as needed for continued utilization of the Code Alert bracelet. All of the exit doors have been assessed and new door alarms shall be installed for consistency. All exit doors shall alarm when opened. These alarms are in addition to the facility's Code Alert System.	6/9/14 6/20/14 6/9/14 6/30/14

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F 323	Continued From page 9 physician and the family/surrogate decision maker...Maintenance will check the efficacy of the alarm system during regular preventative maintenance program." In an interview with the DON on 6/5/14 at 1:20 p.m. the DON could not describe a systemic monitoring of the presence and function of the exit monitoring devices to ensure 12 resident's safety. The DON stated, "What can I say, you caught us." 3. According to the, "Record of Admission", the facility admitted Resident 13 on 9/13/13 with multiple diagnoses that included history of stroke (a sudden interruption in the blood supply to the brain that may result in sudden weakness, loss of sensation, or difficulty speaking, seeing or walking). The Minimum Data Set (MDS, an assessment tool) dated 3/13/14 indicated Resident 13 scored 9 out of 15 on a Brief Interview for Mental Status (BIMS) indicating Resident 13 had mild memory loss. Further review of the MDS dated 9/18/13, 12/6/13 and 3/13/14 under section on wandering presence and frequency, it was marked, "0", indicating the behavior was not exhibited. During an observation on 6/3/14, at 11:30 a.m., Resident 13 was observed resting in bed and was able to carry out a meaningful conversation. Resident 13 indicated she was able to walk. On 6/3/14, at 12:15 p.m., Resident 13 was observed walking independently from her room to the nurse's station and self reporting her pain to a Licensed Nurse.	F 323	**Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** The facility has developed a systemic process for assessing residents for elopement and utilizing a Code Alert bracelet when indicated. The systemic process includes checking for placement of the Code Alert bracelet on the resident each nursing shift, checking daily that the Code Alert bracelet is properly functioning, and also that the Code Alert Receivers on the facility doors are functioning on a daily basis. Residents who are identified as risk for elopement are assessed on a quarterly basis and as needed for continued utilization of the Code Alert bracelet. All of the exit doors have been assessed and new door alarms shall be installed for consistency. All exit doors shall alarm when opened. These alarms are in addition to the facility's Code Alert System. The door alarms shall be inspected on a weekly basis as part of the Preventative Maintenance Program. **Monitoring Plan:** Maintenance Supervisor to monitor weekly. Nursing Staff to monitor per facility policy. Monitoring forms to be forwarded to QA.	6/9/14 6/30/14 6/30/14 and ongoing

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F 323	Continued From page 10 During an interview with Licensed Nurse 5 (LN 5), on 6/5/14, at 1:25 p.m., she indicated Resident 13 wore an exit monitoring device on her left ankle for poor safety awareness. LN 5 indicated there was no system in place to ensure the exit monitoring device was functional. She stated, "We can know it is not working when resident goes out on LOA [leave of absence]...if the alarm door doesn't sound." LN 5 verified that placement and functionality of the alarmed device was not included in the nurse's progress notes or nurse's weekly summary documentation for Resident 13. During an interview with Certified Nursing Assistant 1 (CNA 1), on 6/5/14, at 1:45 p.m., CNA 1 was questioned regarding monitoring the function of the exit monitoring device for Resident 13. CNA 1 stated, "That's hard to say, one of the residents went out alarm did not sound...she came in and it sounded." CNA 1 indicated there was no CNA documentation in place to monitor the exit monitoring device placement or functionality of the device for Resident 13. A review of Resident 13's care plan titled, "At Risk For Fall", dated 9/12/13, with an evaluation date 8/13/14 indicated under approaches, "[Exit monitoring device] applied to Rt [right] ankle for poor safety awareness." A review of Resident 13's, "Care Plan Conference/Interdisciplinary Review" notes dated 12/19/13 indicated, "... Has [exit monitoring device] placed for poor safety awareness." During a review of the clinical record for Resident 13, which included the Licensed Nurses Progress Notes dated 12/1/13 through 6/5/14, there was no documented evidence of monitoring	F 323		

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F 323	Continued From page 11 placement or functionality of the exit monitoring device. Review of an undated facility policy titled ,"Wandering/Elopement," directed, "Purpose: To protect residents from injury who wander and/or attempt to elope from the facility...All residents shall be assessed by the interdisciplinary team (IDT) regarding the risk of wandering on the MDS...If it is determined that an alert device is needed, the licensed nurse shall contact the physician and the family/surrogate decision maker...Maintenance will check the efficacy of the alarm system during regular preventative maintenance program."	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents received food at the proper temperature, when 2 of 21 sampled residents (Residents 5 and 6) and 3 random residents (Random Residents 23, 24 and 25) received food that was not hot; and 1 random resident (Random Resident 22) was observed to wait to be fed for 45 minutes while his food sat on the table in front of him then it was served to him at an unpalatable temperature, for a census of 105. This failure had the potential to	F 364		

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F 364	Continued From page 12 result in poor food intake and weight loss from being served foods which were not palatable. Findings: 1. a. Random Resident 25 was admitted to the facility on 9/21/13, for diagnoses which included heart failure. An MDS (Minimum Data Set, an assessment tool), dated 3/21/14, described the resident as having moderately impaired memory. In an interview, during the Initial Tour of the facility on 6/3/14, at 7:55 a.m., Random Resident 24 stated her food was often not hot when she received it. b. Resident 5 was admitted to the facility on 10/30/11, with diagnoses which included breast cancer. An MDS, dated 3/20/14 described the resident as having no memory problems. In an interview, during the Initial Tour of the facility on 6/3/14 at approximately 8 a.m., Resident 5 stated, "Sometimes the food is not hot, about 3 times a week." c. Random Resident 24 was admitted to the facility on 11/25/13 with diagnoses which included diabetes. An MDS, dated 5/26/14, described Random Resident 24 as having no memory problems. In an interview with Random Resident 24, during the Initial Tour of the facility, on 6/3/14 at approximately 8:25 a.m., Random Resident 24 stated the food was not really hot when she received it. d. Random Resident 23 was admitted to the	F 364	**F364(1)** **Corrected Action for Affected Residents:** **(a)** A QA Form has been implemented to interview Resident 25 on a daily basis for at least one meal per day to ensure and documents satisfaction for food temperatures. **(b)** A QA Form has been implemented to interview Resident 5 on a daily basis for at least one meal per day to ensure and documents satisfaction for food temperatures. Resident 5 is morbidly obese and has a chronic history of complaining noted in her Social Services Care Plan. **(c)** A QA Form has been implemented to interview Resident 24 on a daily basis for at least one meal per day to ensure and documents satisfaction for food temperatures. Resident 24 is obese and has a chronic history of complaining noted in her Social Services Care Plan. **(d)** Resident 23 discharged from the facility on 6/11/2014. (e) Resident 6 was a patient receiving hospice care. Resident 6 expired on 6/22/2014. **Identification of Other Potential Residents:** All of the residents identified are located on the same nursing unit identified as North Station. Department Managers are observing	6/23/14 6/23/14 6/28/14 6/11/14 6/22/14 6/9/14

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F 364	Continued From page 13 facility on 5/22/14, with diagnoses which included spinal narrowing. A physician's order, dated 5/22/14 indicated the resident had the capacity to understand and make health care decisions. In an interview with Random Resident 23, during the Initial Tour of the facility, on 6/3/14 at approximately 8:25 a.m., Random Resident 23 stated the food was often not hot. e. Resident 6 was admitted to the facility on 2/21/14 with diagnoses which included multiple myeloma. A physician's order, dated 2/21/14 indicated, "Resident has the capacity to understand choices and make health care decisions: Yes." In an interview with Resident 6 on 6/3/14 at 8:40 a.m., Resident 6 stated, "The food is not hot." During Tray Line observation, on 6/4/14, starting at 11:28 a.m., Kitchen Staff 1 (KS 1) was observed removing stacks of plates from the electric plate warmer, and placing them into a warm oven. KS 1 stated the plate warmer was, "Not hot enough, on and off for a couple of weeks." During a Test Tray observation, on 6/4/14 at 11:41 a.m., the Test Tray was plated, and placed on a large capacity tray cart for the North Station. Resident 5, and Random Residents 25, 24, and 23 all resided in rooms on the North Station hallway. Under continuous observation, the last resident on the North Station was fed by staff starting at 12:24 p.m., and the temperature of the Test Tray food was measured, under concurrent observation of the Registered Dietician (RD). The meat temperature was 99° Fahrenheit (F),	F 364	and assessing the delivery of meal trays on North Station. A component identified is that North Station received 18 new residents on that unit as part of the evacuation from another skilled nursing facility. The presence of so many additional residents, who had not yet been assigned to eat in the Dining Rooms, slowed the delivery of meal trays on that hall. The majority of the new residents received from the evacuation are now assigned to Dining Rooms. Timeliness of meal service on North Hall will continue to be assessed and improved until patients are consistently satisfied. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** Residents identified will be interviewed utilizing a QA Form to determine meal satisfaction. Residents are encouraged to dine in the Dining Rooms. Staff have been inserviced regarding timeliness of tray delivery. **Monitoring Plan:** DSD and Administrator to monitor daily. Monitoring forms to be forwarded to QA committee. **F364(2)** **Corrected Action for Affected Residents:** Staff were directed during the time of the survey to ensure that all residents seated at the same table eat at the same time.	6/30/14 and ongoing 6/23/14 and ongoing 6/30/14 and ongoing 6/8/14

By Administrator

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F 364	Continued From page 14 the sweet potatoes were 99° F, and the zucchini was 99° F. The milk was measured to be 60° F. Upon tasting the meat, potatoes and zucchini, the food was lukewarm. Review of an undated facility policy titled, Dining Program, the purpose was, "To serve meals timely and at appropriate temperatures." In an interview with the RD on 6/4/14 at 12:30 p.m., the RD stated, "It [temperature] should be palatable to the residents." 2. Random Resident 22 was admitted to the facility on 4/4/05 with diagnoses that included Parkinson's disease (a progressive disorder of the nervous system that affects your movement) and dysphagia (difficulty in swallowing). Review of the Minimum Data Set (MDS, an assessment tool), dated 4/23/14 indicated Random Resident 22 did not have the capability to understand others and was unable to make himself understood. According to the MDS, the resident was dependent on staff for eating and required a mechanically altered diet (puree) A review of the medical record included the following: -A Care Plan Conference/Interdisciplinary Review, dated 4/29/14, indicated Random Resident 22 "...eats all meals in main dining room with assistance from staff." -A Self Care Deficit Care Plan, dated 3/25/11, indicated, "Does not communicate needs to staff." During a meal observation on 6/3/14 the lunch trays were served in the main dining room	F 364	**Identification of Other Potential Residents:** Department Managers are observing meal service to identify residents who are not being assisted timely and directing staff as necessary. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** All nursing staff were inserviced regarding timeliness of food service and dining assistance. All nursing staff were trained to ask the resident if their food was hot enough, and options available for when a resident's reply is "No". **Monitoring Plan:** DSD and ADONs to monitor daily. Monitoring forms forwarded to QA Committee By Administrator	6/9/14 and ongoing 6/30/14 6/30/14 and ongoing

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F 364	Continued From page 15 beginning at 12:20 p.m. to the residents. There were 27 residents and 9 aides observed in the dining room. Random Resident 22 was seated at a table with 3 other residents that required feeding assistance and 1 certified nurses aide. All 3 residents were fed their meals before Random Resident 22 was offered his food. Random Resident 22 was offered his first bite of food at 1:05 p.m., 45 minutes after the lunch trays were served. Random Resident 22 took one bite and then refused the next. The Department asked the Certified Nurses Aide, (CNA 5) if the food was still warm, since the covered food had not been served on a hot dish, CNA 5 touched the plate and replied, "No, let me go heat this up." A review of the un-dated policy titled, "Dining Program," indicated, "Serve meals timely and at appropriate temperatures...Residents at one table will be served at the same time." In an interview with the Director of Staff Development on 6/6/14 at 8:50 a.m., she stated that a resident should not have to wait longer than 10-15 minutes before they were fed their food.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store and serve foods under sanitary conditions when: 1. Two staff were observed touching the food for 1 of 21 sampled residents (Resident 1), and 1 random resident (Random Resident 26) with their bare hands; and 2. the can opener was dirty, with an irregular blade surface, for a census of 105. These failures had the potential to cause food-borne illness. Findings: The following observations were made during Dining Observation on 6/4/14 in the assisted/main dining room: At 7:58 a.m., Certified Nursing Assistant 3 (CNA 3) was observed touching Resident 1's tortillas and wrapping them using her bare hands, she then handed the burrito to Resident 1 who ate the burrito. At 8:01 a.m., CNA 3 was observed holding a waffle in her bare hands, folding it in half, and handing it to Random Resident 26, who ate the waffle. At 8:10 a.m. CNA 2 was observed taking a tortilla from Resident 1's plate and wrapping food inside it using her bare hands. CNA 2 then handed the burrito to Resident 1, who ate it. In an interview with CNA 3 on 6/4/14 at 8:25 a.m.,	F 371	**F371(1)** **Corrected Action for Affected Residents:** Staff have been inserviced regarding handling food for residents, especially those residents that consume hand held foods. Dietary Department provides food service gloves on the trays of residents that consume hand held foods. **Identification of Other Potential Residents:** Staff have been inserviced regarding handling food for residents, especially those residents that consume hand held foods. Dietary Department provides food service gloves on the trays of residents that consume hand held foods. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** Staff have been inserviced regarding handling food for residents, especially those residents that consume hand held foods. Dietary Department provides food service gloves on the trays of residents that consume hand held foods. **Monitoring Plan:** Dietary Supervisor, DSD and ADONs to monitor daily. Monitoring to be forwarded to QA Committee. By Administrator By Administrator By Administrator	6/30/14 6/5/14 6/30/14 and ongoing 6/5/14 and ongoing 6/30/14 and ongoing 6/5/14 and ongoing

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F 371	Continued From page 17 she acknowledged she had touched 2 resident's foods with her bare hands. In an interview with CNA 2 on 6/4/14 at 8:35 a.m., she verified she had wrapped a resident's tortilla using her bare hands. Review of U.S. Food Code 2013, Chapter 3, section 3-8 included: "Food employees may not contact ready-to-eat food." In an interview with the Registered Dietician (RD) on 6/4/14 at 9 a.m., the RD verified staff were not to touch resident's ready to eat foods with bare hands. 2. During the Initial Tour of the Kitchen on 6/3/14 at 7:35 a.m., the table mounted can opener was observed to have gold or light-brown colored dried drips. The blade surface was rough and irregular. In a concurrent interview with Kitchen Staff 2 (KS 2) on 6/3/14 at 7:35 a.m., KS 2 verified the can opener had dried drips, and the blade surface was irregular. Review of U.S. Food Code 2013, Chapter 4, section 4-202.11 included: "Multiuse food-contact surfaces shall be: Smooth; Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections." Review of facility policy titled, "Can Opener and Base," dated 3/13, included: "Proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shaving and shredding can result from a dull cutting blade... The can opener must be	F 371	**F371(2)** **Immediate Correction:** A new can opener was purchased and installed. **Identification of Other Similar Situations:** There is only one can opener in the Dietary Department. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** The RD shall recommend replacement as indicated. **Monitoring Process:** Dietary Supervisor shall monitor monthly. QA to review.	6/30/14 6/30/14 and ongoing

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F 371	Continued From page 18 thoroughly cleaned each work shift and, when necessary, more frequently...Replace blade on can opener as needed." During an interview with the RD on 6/3/14 at 3:45 p.m., the RD stated, The can opener was dirty and may need to be replaced."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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	F 431	**F431** **Immediate Correction:** LN 5 received Disciplinary Action for allowing unlicensed personnel unattended in the Med Room. 6/24/14 **Identification of Other Possible Situations:** Managers were directed to monitor Nursing Station Med Rooms when present conducting other work at each Nurse's Station. No other situations of Nurses allowing unlicensed personnel unattended in the Med Rooms occurred. 6/9/14 and ongoing **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** All Nursing Staff were inserviced regarding the Med Room policy, specifically with attending unlicensed personnel in the Med Rooms. 6/30/14 and ongoing **Monitoring Process:** DSD and DON to monitor. Monitoring to be forwarded to QA-Committee By Director of Nursing	

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F 431	Continued From page 19 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure only authorized personnel had access into the medication room when an outside vendor/medical supplier, was left unattended in the South medication room. This increased the potential for controlled drugs to be compromised. Findings: On 6/4/14 at 11:17 a.m., the Department observed a Licensed Nurse (LN 5) opening the South station medication room for an outside vendor/medical supply representative. After the medication room door was un-locked for the vendor, LN 5 then propped the door open with a foot stool and left the vendor un-supervised in the medication room while she continued her med pass. A review of the facility policy titled, "Storage of Medication," dated 09/10, stipulated, "Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by persons with authorized access." In an interview with LN 5 on 6/4/14 at 11:24 a.m., the Department asked who the vendor was, she replied, "She checks the tube feeding supplies. I don't know who she works for. Let me go ask her."	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING _____ B. WING _____	06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	4635 COLLEGE OAK DRIVE SACRAMENTO, CA 95841

(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 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for the residents and staff when it failed to remove a potentially hazardous pine tree which was leaning at a 70 degree angle on the north side of the facility, over the administrative offices and resident rooms 2 and 4, for a census of 105. This failure could potentially result in the tree falling on the building, putting residents and staff in harms way. Findings: During the Environmental Tour on 6/4/14 at 9:02 a.m., the Department observed a pine tree leaning over the north side of the facility at a 70 degree angle. The pine tree, and its large branches, were observed leaning over the administrative office, and resident rooms 2 and 4. It's roots were observed to be shallow and protruding up through the ground. In a concurrent interview with the Maintenance Supervisor on 6/4/14 at 9:02 a.m., he agreed it needed to be cut down. He stated, "I called somebody out about 4 or 5 years ago and got a quote. It should have been gone years ago. The whole foundation [ground around the tree] moves during a storm, especially when its windy."	F 465	**F465** **Immediate Correction:** The pine tree identified was removed by a tree removal company. The tree removal company stated that the pine tree had been healthy and was not in jeopardy of falling. The Administrator directed the tree removal despite the tree removal company's assessment. Identification of Other Potential Situations: All trees on the facility's campus were assessed. There was a pine tree noted on the front lawn area between the parking lot and the curb that was diseased. That pine tree was also removed. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** Trees on the facility's campus will be evaluated every five years for health and safety. **Monitoring Process:** Maintenance Supervisor to monitor every five years and as needed.	6/16/14 6/30/14 and ongoing

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