poc rec'd 9/1/23
approved 9/10/23
BIC - 9/4/23 per D.B.

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

PRINTED: 08/24/2023
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
	056495	A. BUILDING _____ B. WING _____	C 08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA COLOMA HEALTH CARE CENTER	10410 COLOMA RD RANCHO CORDOVA, CA 95670

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00849333. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 44780 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00849333. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 44780 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice:** No other resident's affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Upon admission, the resident will be evaluated to see if they are at risk for a pressure injury via the Braden Scale. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur:** Inservices on repositioning, support surface guidelines, prevention of pressure injuries, and pressure injury risk assessment will be done by 9/4/23. Medical records will ensure the Braden Scale assessment is done for every new admission. It will be announced in the morning stand-up meeting if the assessment is missing or incomplete.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/1/23

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 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide preventative care, consistent with their own policies and procedures; "Support Surface Guidelines", "Prevention of Pressure Injuries", "Repositioning", and "Pressure Injury Risk Assessment", for one (Resident 1) of the three sample residents when Resident 1 developed an unstageable (when the stage is not clear) pressure ulcer (injury that breaks down the skin and underlying tissue) on his sacrum (area of the lower back and tail bone) which was identified on admission to the Acute Care Hospital (ACH). This failure had the potential to have caused Resident 1 to develop an unstageable pressure ulcer. Findings: Review of ACH clinical record for Resident 1, indicated that, Resident 1 arrived at the hospital from the facility on 4/8/23 at 6:56 p.m. Review of ACH ' s clinical record showed a picture of a sacral wound, scanned on 4/9/23 at 2:21 a.m. Release of Information Department (RID) at ACH validated that the picture was uploaded shortly after it was taken. A review of ACH ' s clinical record, titled, "Flow sheet", indicated, the first skin assessment done by a nurse at 3:24 a.m. on 4/9/23, Resident 1 had a sacral wound. Another clinical record dated 4/9/23 at 4:53 a.m., Care Plan, referenced to the picture uploaded at 2:21 a.m., on 4/9/23.	F 686	**How the facility plans to monitor its performance to make sure that solutions are sustained:** Medical Records will track the timely completion of the Braden Scale assessment for three months and will announce the results in the daily stand up meeting and the cumulative results in the Q3 and Q4 QAPI meetings. **Date of Compliance: 9/3/23**	

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F 686	Continued From page 2 Review of Resident 1 ' s facility clinical record, titled, "Face sheet"(a record of admission), indicated Resident 1 was admitted in March, 2023 with diagnosis that included Hemiplegia and Hemiparesis (weakness or inability to move on one side of the body, making it hard to perform every-day activities) following cerebral infarction (stroke that occurs as a result of disrupted blood flow to the brain due to the blood vessels that supply it) affecting left non-dominant side, Acute Kidney Failure (condition in which kidneys can ' t filter waste from the blood), Chronic Kidney disease, Stage 4 (a medical condition in which the kidneys no longer function, and waste builds up in the body), Hyperosmolality and Hypernatremia (a condition in which the blood has a high concentration of salt (sodium), glucose, and other substances). Review of Resident 1 ' s facility clinical record, titled, "Minimum Data Sheet" (MDS - an assessment tool to help measure health status of patients in nursing homes), dated 4/1/23, indicated, Resident 1 needed extensive assistance for all activities of daily living such as dressing, eating, hydration(drinking water), oral hygiene, toilet hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear/ use, rolling left to right in bed, sit to laying, lying to sitting on side of the bed, sit to stand, chair to bed and bed to chair transfer. Review of Resident 1 ' s facility clinical record, titled, "Progress Notes", dated 3/26/23, indicated, Skin condition on admission right outer heel with non-blanchable deep tissue injury and left heel non blanchable deep tissue injury (persistent	F 686		

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F 686	Continued From page 3 non-blanchable deep red, purple or maroon areas of intact skin, non-intact skin or blood-filled blisters caused by damage to the underlying soft tissues). Review of Resident 1 ' s facility clinical record, titled, "Braden Scale for Predicting Pressure Sore Risk" [is a risk identifying assessment tool for skin to help healthcare professionals, assess a patient ' s risk of developing a pressure ulcer and then modify interventions to preventing worsening or forming of pressure ulcer], dated 3/26/23, indicated Resident 1 with was at moderate risk of developing a pressure ulcer with a score of 14 (score of 13-14 is moderate risk). Review of Resident 1 ' s Care Plan for presences of pressure ulcer: DTI [deep tendon injury]- left heel, DTI- right outer heel, dated 3/27/23, indicated, for interventions, "as re-position resident as indicated and use of a low air loss (LAL) mattress (are designed to distribute the patient's body weight over a broad surface area and helps prevent skin breakdown)". Review of Resident 1 ' s clinical record, titled, "Braden Scale for Predicting Pressure Sore Risk", dated 4/2/23, indicated Resident 1 with high risk of developing pressure ulcer with score of 11 (score of 10-12 is high risk). Review of Resident 1 ' s clinical record, titled, "Weekly Wound Evaluation -V4", dated 4/2/23, indicated, Skin right heel and left heel suspected deep tissue injury. There was no documented evidence of a sacral wound. Review of Resident 1 ' s clinical record, titled, "Weekly Wound Evaluation -V4", dated 4/7/23,	F 686		

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F 686	Continued From page 4 indicated, right heel and left heel suspected deep tissue injury. There was no documented evidence of a sacral wound. Review of all facility documents for Resident 1, indicate, facility failed to implement interventions to prevent the development of pressure ulcer as facility did not intervene when Resident 1 ' s Braden scale score went from 14 to 11. There is no evidence available in Resident 1 ' s chart that would indicate an Interdisciplinary team (IDT) meeting to discuss a change in Care Plan, no documentation of a follow up with the Medical Director and family and subsequent change in interventions after it was identified that Resident 1 was at a higher risk to developing pressure ulcer. In an interview with ADON (Assistant Director of Nursing) on 8/17/23 at 12:15 p.m., validated that Braden scale score for Resident 1 was 14 on 3/26/23 and then fell to 11 on 4/2/23. ADON looked at Resident 1 ' s chart and validated that there is no evidence of a follow up from the nurse who did the Braden scale the second time to the supervisor or MD. There is no documentation of an IDT meeting, care plan is not revised, no new interventions were in place. ADON stated, " ...the nurse should have notified the doctor, supervisor, so that interventions could be put in place after it was identified that the patient was a high risk to developing pressure ulcer". In an interview with Director of Nursing (DON) on 8/17/23 at 2:00 p.m., when asked about Resident 1 ' s Braden ' s scale score change from moderate risk to high risk in a matter of week and that there was no documentation of a report to the attending doctor and family, no IDT meeting, no change in care plan and change in	F 686		

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F 686	Continued From page 5 intervention, were documented in the resident ' s chart. The DON stated that, " ...ideally there should be a change in Care Plan, but a Care Plan was already there, it was already addressed, the Braden scale just fell 3 points, it went from moderate to high risk ...". The DON further stated that, Residents who are already on a LAL mattress, are not required to be on a turn and position program because it defeats the purpose of having the LAL mattress. Resident 1 was on a LAL mattress, there was no need to turn or re-position them. A review of facility ' s policy and procedure, titled, "Support Surface Guidelines", revised 2013, indicated, " ...Support surfaces alone are not effective in preventing pressure ulcers, but studies indicate that the use of appropriate support surfaces with interventions such as turning, repositioning and moisture management can assist in reducing pressure ulcer development ...". A review of facility policy, titled, "Repositioning", revised 2020, indicated, "Review the resident ' s care plan to evaluate for any special needs of the resident ...Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Evaluation of a resident ' s skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning ...Residents who are in bed should be on every two hour repositioning schedule ...". A review of facility policy titled, "Pressure Injury	F 686		

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F 686	Continued From page 6 Risk Assessment", revised 2020, indicated, "The purpose of a pressure injury risk assessment is to identify all risk factors and then to determine which can be modified ...risk factors that increase a resident ' s susceptibility to develop or to not heal pressure injuries include ...under nutrition, malnutrition, and hydration deficits; impaired/decreased mobility and decreased functional ability; conditions such as end stage renal disease ...once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risks for pressure injuries. Repeat the risk assessment weekly for first four weeks, if there is any significant change in condition, repeat as often as needed. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin ... the effects of the interventions must be evaluated. The care plan must be modified as the resident ' s condition changes, or if current interventions are deemed inadequate ...Documentation in medical record addressing MD notification if new skin alteration noted with change of plan of care ...documentation in medical record addressing family notification if new skin alteration noted ...Notify attending MD if new skin alteration noted. Notify family ...if new skin alteration noted ..." A review of facility policy, titled, "Prevention of Pressure Injuries", revised 2020, " ...Review the resident ' s care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in	F 686		

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F 686	Continued From page 7 condition. Use a standardized pressure injury screening tool to determine and document risk factors ...Reposition all residents with or at risk of pressure injuries on an individualized schedule ...select appropriate support surfaces and pressure redistribution surfaces based on resident ' s risk factors ...Evaluate, report and document potential changes in the skin. Review the interventions and strategies for effectiveness on an ongoing basis".	F 686		