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 _____	06/07/2012

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

(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 represents the findings of the California Department of Public Health during a Recertification survey conducted 6/4/2012 - 6/7/2012. Representing the Department: HFEN, 29750 HFEN, 29236 HFEN, 29823 HFEN, 18972 HFEN, 31640 The facility census was 123 and the sample size was 24.	F 000	**Temporary and Permanent Correction (F 241)** **It is the policy of this facility to provide 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.** **Resident 25 was informed that the facility was no longer permitting refrigerators in residents rooms due to inability to ensure that resident refrigerators and their contents are maintained in a manner that is in compliance with Health Regulations. Resident had her responsible remove refrigerator from facility.**	7/15/2012
F 241 SS=D	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 observations, interviews, and record reviews, the facility failed to care for a one random resident (25) in a manner that enhanced her dignity and respect when her personal refrigerator was removed from her room without her knowledge. Findings: Random Resident 25 was readmitted to the facility on 9/3/09 with multiple diagnoses. Review	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard M. Patula — TITLE: Administrator — (X6) DATE: 7/01/2012

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 of the Physician Orders stipulated Resident 25 had the mental capacity to understand the nature and consequences of the diagnosis, prognosis, and treatment options. During the initial tour of the facility on 6/4/12 at 9:30 a.m., while accompanied by the Infection Control Nurse (ICN), a personal refrigerator was noted on top of the bedside table of Resident 25. The ICN said Resident 25 has had her refrigerator ever since she came to the facility, and was the only resident left that had one. Uncovered, undated food was observed in the refrigerator. There was no thermometer. A crust of ice approximately 2 inches think was observed in the freezer. An interview was conducted with Resident 25 on 6/5/12 at 4 p.m. She asked why her refrigerator had been removed from her room. She stated she was sad and upset about it because she did not know why it happened. She stated, "They said you made them take it away because it wasn't cleaned." An interview was conducted with the Housekeeping Staff (HS) on 6/7/12 at 1:40 p.m. She said the Assistant Administrator (AA) told her to take the refrigerator from the room of Resident 25. The HS said she removed the refrigerator on 6/4/12 at around 3 p.m. When asked if Resident 25 was aware that her refrigerator was being taken, the HS said that she did not know. The HS said Resident 25 was out on pass with her daughter at the time. An interview was conducted with Resident 25 on 6/7/12 at 12:20 p.m. She said she felt sad and	F 241	**New admissions are informed upon admission of facility policy that no refrigerators are allowed in resident rooms.** **Facility policy will be reviewed by Activity Coordinator at the next Resident Council meeting to ensure that all residents understand facility policy.** **Inservice will be provided by the Staff Development Coordinator to all staff that reviews Facility policy regarding Resident Dignity.** **Administrator will monitor facility compliance through review of resident council meetings, Interdisciplinary Meetings and Open Door Policy.**	7/15/2012

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F 241	Continued From page 2 upset because her refrigerator to be taken away from her. When asked if she was made aware that her refrigerator was being removed, she stated, "I was out on a pass with my other daughter and when I came back my fridge was gone." She said she did not know it was going to be taken. An interview was conducted with the Administrator and AA on 6/7/12 at 1:50 p.m. They acknowledged Resident 25 was not notified before the refrigerator was removed.	F 241	**Temporary and Permanent Correction (F279)** **It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial well-being that are identified in the comprehensive assessment.** **Resident 18 had been admitted to the facility on 06/01/2012 fall precautions were in place for the resident which included: high-low bed, transfer pole, and call light in place. Physical Therapy was also initated as ordered on June 4, 2012**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		7/15/2012

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F 279	Continued From page 3 by: Based on interviews and record reviews, the facility failed to develop a comprehensive plan of care for falls for 1 of 24 sampled residents (18). Findings: Resident 18 was admitted to the facility on 6/1/12 with multiple diagnoses including chronic vertigo (dizziness), muscle weakness, osteoporosis and aftercare following a thoracic (upper spine) compression fracture. Review of the facility's Fall Risk Evaluation for Resident 18, dated 6/3/12, indicated a total score of 14. The Fall Risk Evaluation form indicated, "Total score of 10 or above represents a high risk." Review of the facility's Admission Check List Sheet for Resident 18 indicated the Fall Risk Assessment (care plan if indicated) was done 6/3/12. Review of the Physical Therapy Initial Assessment for Resident 18, dated 6/4/12, indicated she was a high fall risk. A concurrent interview and record review was conducted with Licensed Nurse 3 on 6/7/12 at 7:30 a.m. She verified the score of the Fall Risk Evaluation for Resident 18 indicated she was a fall risk. She acknowledged a Fall Care Plan should have been made. When asked if the facility had any sort of fall precautions in place for new admissions, she said, "No." A concurrent interview and record review was	F 279	**F 279 continued.** **The written Fall Care Plan was not completed in the resident record. The Fall Care Plan was written in the resident care plan on 06/03/2012.** **Inservices will be provided by the Director of Nursing or her designee that reviews facility policy concerning resident Care Plans and ensuring that care provided is documented as required in each residents plan of care.** **Resident Care Plans for new admissions will be monitored by the director of nursing for one month to ensure that care plans are completed timely and in compliance with facility policy. If good compliance is maintained, monitoring will be reduced to Medical records audits of new admissions and Medical Records consultant audit and review of records during monthly reviews that are reported to Director of Nursing to ensure ongoing compliance.**	7/15/2012

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F 279	Continued From page 4 conducted with the Director of Nurses (DON) on 6/7/12 at 8 a.m. Resident 18's record was discussed and reviewed. The DON verified the Fall Risk Evaluation score of 14, the Physical Therapy Initial Assessment, the admission diagnoses, and the Admission Checklist all indicated the need for a Fall Care Plan for Resident 18. She verified there was no Fall Care Plan in Resident 18's record. She acknowledged one should be there. Review of the facility's undated Policy and Procedure titled Fall Prevention Policy, indicated, "It is the policy of ... to provide care in a manner and in an environment as to prevent falls of our residents as possible. The facility will assess each resident on admission for their fall risk potential and will develop a plan of care to address risk and provide preventative measures as appropriate."	F 279	**Temporary and Permanent Correction (F 281)** **It is the Policy of this facility to ensure that services provided meet professional standards of quality.** **Resident 19 medication administration times were adjusted to ensure that there were two hours between the time that Ferrous Sulfate and Calcium Carbonate are administered.** **Inservice will be provided by the Director of Nursing or her designee that reviews Facility policy on drug administration including standard that ferrous sulfate and calcium carbonate should not be administered within two hours of each other.**	7/15/2012
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure nursing staff did not give ferrous sulfate (a dietary supplement) and calcium carbonate (Tums) within two hours of each other for 1 of 24 sampled residents (19). Findings: Resident 19's Physician Orders, dated	F 281		

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F 281	Continued From page 5 6/1/12-6/30/12, were reviewed. Resident 19 had an order, dated 7/15/11, for Tums Tablets Chewable, 500 milligrams (mg) 2 tablets by mouth every 4 hours as needed for GI upset. She had an order, dated 4/2/12, for ferrous sulfate 325 mg 1 tablet by mouth two times a day for anemia. A review of the facility's Medication Record, dated 6/1/12, indicated ferrous sulfate 325 mg 1 tablet by mouth twice a day for anemia was to be given at 8 a.m. and 5 p.m. It was initialed as given as ordered 6/1/12- 6/5/12. Tums Tablets 500 mg 2 tablets by mouth as needed every 4 hours for GI upset were given: 6/1 and 6/4 at 6 p.m. 6/2 at 5:30 p.m. 6/3 at 5:45 p.m. 6/5 at 6:30 p.m. A concurrent interview and record review was conducted with Licensed Nurse 2 on 6/7/12 at 9:40 a.m. She verified Tums were given within two hours of the administration of ferrous sulfate for Resident 19 on dates 6/1 - 6/5 and should have not have been. She stated, "The calcium interferes with the iron absorption." A telephone interview was conducted with the facility's Pharmacy Consultant on 6/7/12 at 10 a.m. She acknowledged ferrous sulfate and Tums needed to have the doses separated by 2 hours. She acknowledged she comes in monthly and reviews records, but missed this during her pharmacy review. Review of the facility's drug reference book 32nd Edition Nursing 2012 Drug Handbook stipulated	F 281	**F-281 continued.** **Pharmacy Consultant will monitor drug regimens monthly to ensure that continued compliance is maintained. Drug regimens are provided to the Director of Nursing and discrepancies are addressed promptly and written documentation is maintain of correction of discrepancies and follow through of recommendations.** **The Pharmacy Consultant reports quarterly to the Pharmacy Committee and the Patient Care Policy Committee to ensure continued compliance to professional standards and regulations.**	7/15/2012

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F 281	Continued From page 6 on page 240, "calcium carbonate dosage must be separated by two hours of dosage of iron salts."	F 281		
F 323 SS=D	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 and staff interview, the facility failed to maintain an environment free of accident hazards when: 1. The hand rails were rough and splintered throughout the facility. 2. The shower drain covers were not in place and secured. 3. 1 of 24 sampled residents' (17) bed was not in the low position when occupied by the resident, as indicated on a sign. Findings: 1. A tour of the facility was completed on 6/4/12. The hand rails throughout the facility had rough and splintered areas. These areas were accessible to residents. 2. The shower room on Station 2 had two shower areas. Both areas had drainage pipes approximately 4 inches in diameter in the middle of the shower stalls. The metal covers for the	F 323	**Temporary and Permanent Correction (F323)** **It is the policy of this facility to 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.** **Hand rails that were rough and splintered throughout the facility were repaired by the maintenance department.** **Shower drain covers were secured by the maintenance department.** **Resident 17s bed was immediately placed in low position.**	7/15/2012

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F 323	Continued From page 7 drains were sitting in the corner of the shower stalls, leaving the drainage pipe open. An interview was conducted with the Maintenance Supervisor on 6/4/12 at 2:30 p.m. He acknowledged the rails were rough and splintered in areas and the shower drain covers were not secured over the drainage pipes in the shower room. 3. During the initial tour of the facility, while accompanied by the Infection Control Nurse (ICN), on 6/4/12 at 8:30 a.m., Resident 17 was observed in her bed. The bed was in the high position and no staff were present. On the footboard was a sign which indicated, "Keep bed at lowest position when in bed." The ICN acknowledged the bed was not in the lowest position and it should have been. An interview was conducted with the Director of Nursing (DON) on 6/6/12 at 3 p.m. The sign at the bottom of Resident 17's bed was discussed. The DON said the sign was there because the resident was a fall risk. She further stated if the resident was in the bed and unattended, the bed should be in the lowest position.	F 323	**F-323 continued.** **Inservice will be provided by the Staff Development Coordinator to all nursing staff that covers facility policy that all beds should be kept in their lowest position when staff is not present to help prevent injury.** **Inservice will be provided by the Staff Development Coordinator to all staff that covers facility policy that all maintenance repairs should be placed on maintenance log and dated, so that a record of repair needed and date completed can be maintained and repairs will be completed promptly.** 7/15/2012	
F 371 SS=F	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	**Maintenance Supervisor will conduct monthly audits of physical plant which include hand rails and shower rooms to ensure that facility is kept in good repair. Monthly logs will be reviewed quarterly by the Administrator to ensure continued compliance.**	

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review, the facility failed to store and prepare food under sanitary conditions when: 1. Chicken thighs were not stored properly in the walk-in freezer. 2. Cutting boards were worn, scratched, and discolored. 3. Floor tile was worn through and concrete flooring beneath the tile was pitted. 4. A portion of the ceiling between the stove and steam table was cracked and open. 5. A multi-holed floor drain in the dishwashing area of the kitchen was not draining. Findings: 1. During the initial tour of the kitchen with the Food Service Supervisor (FSS) on 6/4/12 at 7:50 a.m., the food in the walk-in freezer was observed. A box containing an opened plastic bag of frozen chicken thighs was observed. The FSS acknowledged the bag containing the chicken thighs was supposed to be secured in an air-tight manner. Review of the facility's Policy and Procedure, dated 9/08, from Healthcare Management Composite, Inc., titled Food Service Management Storage of Food and Non-Food Supplies Policy No. 510", indicated under Procedure 2, "Storage Practices", d. "Opened containers of food will be stored in tightly closed non-corrosive containers or in sealed plastic bags. No exposed food will	F 371	**Temporary and Permanent Correction (F371)** **It is the policy of this facility to: (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.** **Chicken thighs were removed.** **Cutting boards were replaced with new cutting boards.** **Floor tile was repaired.** **Floor drain was repaired.** **Dietary Manager will conduct Infection Control Surveillance Reports monthly, that monitor dietary equipment and environment to ensure that equipment and supplies are**	7/15/2012

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F 371	Continued From page 9 be stored in the storeroom, refrigerators, or freezer." 2. During the initial tour of the kitchen with the FSS on 6/4/12 at 7:55 a.m., six chopping boards were observed in the storage rack in the clean side of the kitchen. They were dull-looking, with brownish gray smudges, and had blackened scratches around the edges. A concurrent interview was conducted with the FSS and Dietary Services Supervisor (DSS) on 6/4/12 at 7:55 a.m. They acknowledged the six chopping boards were old, worn out, and not as clean as they could be. They said they needed to be replaced. 3. During the initial tour of the kitchen with the FSS on 6/4/12 at 7:55 a.m., 4 linoleum floor tiles were observed between the clean area of the kitchen and the dry goods storage area. The tiles were worn through down to the concrete floor, which was scratched and pitted. A concurrent interview was conducted with the FSS and DSS on 6/4/12 at 8 a.m. They acknowledge the worn tiles were an infection control issue and a safety issue, and needed to be replaced. An interview was conducted with the Infection Control Nurse (ICN) on 6/6/12 at 2:30 p.m. She stated, "Worn tile and concrete that is damaged is a safety hazard and infection issue because bacteria can collect." 4. During observation of the kitchen on 6/5/12 at 12:30 p.m., a portion of the ceiling between the	F 371	**F-371 continued.** **kept in good repair.** **Inservice will be provided to dietary staff by the Dietary Manager that reviews facility policy regarding safe storage and handling of food, supplies and equipment.** **Dietary Manager will observe staff daily during at least one meal preparation and service each day five days a week for one month. If good compliance is maintained, monitoring will be reduced to Monthly Infection Control Surveillance by Dietary Manager.** **Dietician will monitor safe handling storage, of food items and infection control during her monthly visits to the facility. Written reports will be provided to the Dietary Manager and the Administrator for review and follow-up.**	7/15/2012

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F 371	Continued From page 10 stove and steam table, was observed to be cracked and stained. The crack was approximately 18 inches long, and up to approximately 8 inches wide. Sheet rock with a blackened area was exposed. A concurrent interview was conducted with the FSS on 6/5/12 at 12:30 p.m. The FSS said the damaged area had been there since February 2012. She said it was not in good repair and not sanitary. An interview was conducted with the Assistant Maintenance Man (AMM) on 6/6/12 at 6:55 a.m. He acknowledged the damaged ceiling area it had been there awhile and needed to be fixed. He acknowledged it was a problem and could be an infection control issue. An interview was conducted with the ICN on 6/6/12 at 2:30 p.m. Her expectation was for the ceiling in the kitchen to be repaired because intact surfaces decrease risk of infection. 5. The kitchen was observed on 6/5/12 at 9:30 a.m. A multi-holed floor drain, approximately 4 inches wide, had slow draining water approximately 1 inch deep in an area approximately 3 foot in diameter. Two dietary aides were doing dishes. One dietary aide wore rubberized shoe coverings and the second dietary aide's shoes were covered in clear plastic and taped. An interview was conducted with the Infection Control Nurse on 6/6/12 at 2:30 p.m. The slow draining water in the kitchen was discussed. She said this was an infection control issue and the	F 371	**F-371 continued** **Written reports will be reviewed by the Infection Control Committee at their quarterly meeting to ensure continued compliance.**	7/15/2012

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F 371	Continued From page 11 drain should empty the water.	F 371	**Temporary and Permanent Correction (F517)**	
F 517 SS=F	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to follow their plan for emergencies and disasters when: 1. Emergency food supply for 198 people, including residents, staff and visitors, was missing items as indicated in the plan. 2. Food was being borrowed from the emergency food supply. 3. Food in the emergency food closet was stored within 18 inches of the sprinkler head interfering with the distribution of water from the sprinkler head in the event of a fire. 1. A concurrent interview and record review was conducted with the Food Services Supervisor (FSS) and Dietary Services Supervisor (DSS) 2 on 6/6/12 at 12:55 p.m. They agreed the 3 Day Emergency Menu Inventory Supply List, dated 3/12/12, contained an accurate listing of the emergency food supply that was expected to be in the emergency closet. The document indicated under the Emergency Stock heading that emergency supplies should not be removed. An observation of the facility's emergency food inventory was conducted with the FSS and DSS 2	F 517	**It is the policy of this facility To have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.** **All emergency supplies as outlined in disaster plan were placed in emergency supply.** **Items of coffee that were stored within 18 inches of the sprinkler head were removed.** **Inservice was provided to the Dietary Manager and the Food Service Supervisor by The Administrator that outlined facility policy that no items are to be borrowed from the emergency food supply. Dietary Manager will review policy with dietary staff.**	7/15/2012

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 _____	06/07/2012

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

(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 517	Continued From page 12 on 6/6/12 at 12:55 p.m. The following items were missing from the emergency stock: 1 case of apple juice. 300 garbage bags. 1 box of 5 ounce dessert bowls. 2. An interview was conducted with the DSS 2 on 6/5/12 at 12:15 p.m. She stated, "Sometimes we borrow food from the emergency supply if we do not have what we need." An interview was conducted with the FSS on 6/5/12 at 12:25 p.m. She said staff borrows from the emergency supplies. An interview was conducted with the Administrator on 6/6/12 at 2:45 p.m. She said no food was to be borrowed from the emergency food supply. 3. A observation of the emergency food supply closet was conducted with DSS 2 on 6/5/12 at 1:20 p.m. Three cases of coffee were found within 18 inches from the sprinkler head. When asked, DSS 2 acknowledged the cases of coffee needed to be more than 18 inches away from the sprinkler head.	F 517	**Dietary Manager will monitor emergency food supply daily five days each week for one month to ensure that compliance is maintained.** **If good compliance, monitoring will be reduced to monthly review by Dietary Manager. Logs of monitoring will be maintained in the dietary department.**	7/15/2012