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 12/01/2021

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

Rec'd 3/8/2022 - Accepted by R. Schmitt, HFES 3/8/2022.

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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 facility reported incident #CA00751323. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 32525 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.	F 000	F 604 1. How corrective action will be accomplished for those residents found to be affected: Staff will be in-serviced again about proper care and that this facility is a restraint free building. Any employee found to be involved in such incidents will be terminated. 2. How will the facility identify other residents having the potential to be affected by the same practice: No other residents were affected.	- BIC 3/8/2022 (CM)
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604	3. What measures will be put into place to ensure the practice does not reoccur: Daily Room Rounds and frequent training to be provided to the care staff. Staff involved in this incident were terminated immediately. 4. How corrective action will be monitored: Room Rounds will be discussed daily morning Stand Up meetings and the facility will discuss and monitor findings for eight weeks. Corrective action will be complete as of March 8, 2022.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Lawrence	Administrator	March 8, 2022

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 604	Continued From page 1 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of 3 sampled residents (Resident 1) was free from physical restraints imposed for discipline or staff convenience when a Certified Nursing Assistant (CNA 1) transferred her to a gerichair (a medical recliner which is considered a restraint) and tied the draw strings of her pants to the metal part of the chair, therefore restraining her. This failure inhibited Resident 1's freedom of movement or activity. Findings: According to Resident 1's 'Admission Record' the facility admitted her early this year with multiple diagnoses which included right tibia (the larger of the two bones of the lower leg) fracture and dementia. The quarterly Minimum Data Set (MDS, an assessment tool) indicated she had both short-term and log-term memory problems and she used a regular wheelchair for mobility. Review of the 'Intake Information' report received by the Department on 9/3/21, indicated Resident 1's "sitter and her CNA were made aware the resident potentially being restrained to her bed by the accused CNA. The supposed restraint used	F 604		

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F 604	Continued From page 2	F 604		

was the strings on a residents clothing causing her to not freely be able to move."

A review of Resident 1's 'Progress Notes' dated 9/3/21, and timed at 10:30 a.m., indicated, "Around 7 p.m., the CNA endorsed the resident to the sitter before taking the meal break. Upon checking, the sitter noticed that the resident was tied to the gerichair using the drawstring attached to hold and tighten the pants. Immediately, the sitter went to the desk supervisor notifying the situation of the resident."

During an observation and interview with Resident 1 on 9/17/21, at 3:15 p.m., she was observed sitting up in a regular wheelchair in the hallway near her room. Resident 1 was observed crossing her legs back and forth. Resident 1 was unable to carry out a meaningful conversation.

An interview conducted with CNA 2 on 9/17/21, at 3:30 p.m., CNA 2 stated she was assigned to Resident 1 on 9/2/21, during the evening shift. CNA 2 stated she endorsed Resident 1 to a sitter and had taken a lunch break at around 7:05 p.m. CNA 2 reported CNA 1 was covering for her assigned residents while she went on break. CNA 2 further stated after her lunch break, she was told by Resident 1's sitter that a CNA (CNA 1) had restrained Resident 1 to the gerichair by tying the drawstrings of her pants to the metal part of the chair. CNA 2 further stated CNA 1 offered to transfer Resident 1 from bed to a gerichair by himself. CNA 2 stated Resident 1 used a regular wheelchair not a gerichair.

During an interview with the Director of Nursing (DON) on 9/17/21, at 4 p.m., the DON stated a Sitter to Resident 1 on 9/2/21 had noticed the

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F 604	Continued From page 3 resident restrained to a gerichair using the drawstrings of her pants by CNA 1 and the Sitter reported the incident to the Unit Manager (UM). The DON stated that she and the Administrator interviewed CNA 1 on 9/2/21 and he admitted restraining Resident 1 to a gerichair. The DON stated Resident 1 used a regular wheelchair and a gerichair was considered a restraint. The DON stated CNA 1 was terminated. During two attempts to reach CNA 1 via telephone on 10/29/21, the phone was not answered and he did not call back. CNA 1 replied to a text message that had requested his availability for an interview on 10/29/21 at 1:02 p.m., "I don't need help." An interview conducted with the UM on 10/29/21, at 1:46 p.m., the UM stated Resident 1 used a regular wheelchair for mobility, she was able to stand up and walk a few steps but was unsteady and at risk for falls. The UM stated a Sitter reported to him that she had observed the resident restrained to gerichair using the drawstrings of her pants on 9/2/21 during the evening shift. The UM stated when he interviewed CNA 1 after the incident, the CNA stated, "Everybody is standing up, everybody is crazy [residents]." The UM stated CNA 1 had told him that he could not take care of other residents because Resident 1 was attempting to stand up by herself and he did not want her to fall. The UM stated CNA 1 had already untied the drawstrings used to restrain Resident 1 to the chair by the time the he went to assess the resident. The UM stated CNA 1 denied restraining Resident 1. The facility's Administrator, the DON and the UM were requested to provide the phone number for	F 604		

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F 604	Continued From page 4 the sitter who witnessed the 9/2/21 incident on 10/29/21 and 11/4/21 and did not provide it. A review of a document dated 9/3/21 from the Sitter with the subject, 'Potential Restraint ... [Resident 1's name] indicated, "When I got into work at 6:30 P.M. on Thursday, September 02, 2021, I went directly to sat [sic] with room #40-C. Since there was a CNA watching the resident I went to room#43-A and offered to sit/watch the resident. Around 7 PM, the CNA endorsed the resident to me before taking her meal break. Upon checking, I noticed that the resident was tied to the gerichair using the drawstring attached to hold and tighten the pants. I went to the desk supervisor immediately and notified the LN [Licensed Nurse]. When the desk nurse went to check the resident, the restraint was already removed." The document was signed by the Sitter. During an interview with the facility's Administrator on 9/17/21 at 4:52 p.m., he stated the facility was restraint free and CNA 1 should not have restrained Resident 1 to a gerichair under any circumstance. A review of the facility's 'Abuse Prevention Program' dated 12/2016 indicated, "Our residents have the right to be free from abuse, neglect ... This includes but not limited to freedom from ... physical or chemical restraint not required to treat the resident's symptoms."	F 604		