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	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Coloma Health Care Center	10410 Coloma Rd Rancho Cordova, CA 95670

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide a safe environment, supervision, and equipment maintenance to ensure safety and prevent accidents for 3 of 32 sampled residents (Resident 164, Resident 7, and Resident 108) when: 1. Specimen collection tubes were left unsecured at Resident 164's bedside;2. The physician's order to apply and monitor padded side rails for Resident 7, who had a history of seizures (a condition in which abnormal electrical activity in the brain occurs causing changes in level of consciousness and jerking movements) was not implemented, and3. Resident 108's bed remote control cord had exposed frayed wires accessible to the resident. These failures resulted in Resident 164 ingesting chemical from specimen collection tube, placed Resident 7 at risk for injuries during seizure activity, and created a safety hazard for Resident 164, Resident 7, and Resident 108. 1. A review of the admission record indicated the facility admitted Resident 164 in March of 2026 with multiple diagnoses which included aftercare following the fracture of sacrum (triangular bone at the base of spine), anxiety disorder, hearing deficit, and macular degeneration in both eyes (incurable eye disease causing blurred and distorted vision). A review of Resident 164's Minimum Data Set (MDS, a federally mandated resident assessment) dated 3/11/26, indicated the resident scored 9 out of 15 in a Brief Interview for Mental Status (cognitive assessment), which indicated moderate cognitive impairment. A review of the care plan dated 3/18/26 indicated that Resident 164 had the incident of ingesting of preservative additives [chemicals designed to preserve urine specimens] from a BD Vacutainer [type of the tube] urine collection tube. The additives were identified as Boric Acid, Sodium Borate, and Sodium Formate (toxic substances if ingested). A review of Resident 164's clinical record contained a document titled, SBAR Communication Form (Situation, Background, Appearance, and Review) dated 3/18/26 at 7 a.m. The SBAR indicated that Resident 164 had a change in condition (COC) related to Consumption of unknown amount of hazardous toxins. The SBAR indicated that during morning rounds at approximately 5 a.m., Certified Nursing Assistant (CNA) reported to nurse that Resident 164 was observed opening biohazard specimen kit, removed the tube's lid and ate unknown amount of white contaminants inside.White material seen on lips/tongue. Increased confusion noted. A review of Resident 164's record indicated that the resident was monitored prior to be picked up by ambulance on 4/18/26 at 8:42 a.m. A review of the Resident 164's clinical record contained an Interdisciplinary Team (IDT, a team of different disciplines) note dated 3/25/26 for investigation of the incident dated 3/18/26. The IDT note indicated that IDT conducted a thorough investigation to determine how the specimen collection materials became accessible to the resident. The IDT note indicated that the nurse inadvertently left (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	the urine specimen collection pack near the resident's bedside cabinet rather than securing it in the designated storage area per facility protocol. During a joint interview on 4/23/26 at 10:45 a.m., the incident with Resident 164 ingestion of preservative additives was discussed with Administrator (ADM) and Director of Nursing (DON). The DON stated that evening nurse was unable to collect urine and left the specimen collection tubes at Resident 164's bedside. The DON stated that night shift nurse was not able to collect urine and the specimen collection tubes continued to be at Resident 164's bedside unsecured. The DON explained that per specimen tube's manufacturer's Safety Data Sheets (SDS, documents that provide detailed information about chemical substance and inform users about potential hazards), the Emergency Department physician determined that Boric Acid, Sodium Borate, and Sodium Formate were classified as low toxicity because it was ingested in small amount. The DON acknowledged that specimen collection tubes should not be left at bedside unsecured because it affected the resident's safety. A review of the facility's policy titled, Cultures and Specimens, dated 7/2014, indicated, When cultures [lab specimens] are ordered, they should be obtained and completed as soon as practicable. Cultures and specimens are to be kept in a secluded location. A review of the facility's policy titled, Safety and Supervision of Residents, 7/2017, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide- priorities. Resident supervision is a core component of the system's approach to safety. 2. A review of the admission record indicated the facility admitted Resident 7 earlier this year with multiple diagnoses which included epilepsy with seizures. A review of Order Listing Report for Resident 7 contained a physician order dated 2/22/26. The order directed nursing to monitor placement of side rails pads related to epilepsy every shift. A review of Resident 7's At risk for injury care plan initiated on 2/13/26 indicated that the resident was at risk for injuries related to seizure disorder. One of the care plan interventions directed nursing To monitor placement of side rails every shift. A review of Resident 7's Minimum Data Set (MDS, a federally mandated assessment), dated 2/27/26 indicated Resident 7 had intact cognition and intact ability to think, rationalize, and recall. During an observation on 4/22/26 at 8 a.m., Resident 7 was in bed. Resident 7 was pleasant and answered appropriately to all questions. Resident 7's bed had one side rail on each side of the bed and the side rails were not padded. During an observation on 4/23/26 at 9:23 a.m., Resident 7 was in bed with head of bed elevated. Resident 7's side rails were not padded. During a joint interview with Certified Nursing Assistant (CNA 4) and CNA 5 on 4/23/26 at 9:25 a.m., in Resident 7's room, CNA 4 and CNA 5 stated they were familiar with Resident 7 and her care needs. CNA 4 stated she had not seen the facility utilized foam side rails padding for Resident 7. CNA 4 stated, We have foam pads in other rooms, but not used for [Resident 7's name]. I was not aware she needed them. Resident 7 stated she had history of epilepsy and seizures and explained, I know I (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	should have side rails padded to prevent injuries in case I have seizure, but nobody placed it. During a concurrent interview and record review on 4/23/26 at 9:50 a.m., with Director of Nursing (DON), the DON stated that facility utilized foam side rails pads for residents who were on seizure precautions. The DON further stated that the side rails must be padded for resident's safety, to protect residents from injuries if the resident had a seizure. The DON reviewed Resident 7's order and validated that nursing was to monitor placement of side rails pads every shift. The DON reviewed Resident 7's Medication Administration Record (MAR) for April 2026 and stated that nurses placed 'Y' every shift validating that the side rails were padded, except 4/2, 4/10, 4/20, and 4/22 on the evening shift and 4/20 on the night shift. The DON reviewed MAR for March 2026 and validated that the MAR's had inconsistent documentation. The DON was unable to find non-compliance care plan indicating that the resident refused side rails padding. The DON stated her expectation was to follow physician's order and protect Resident 7 from potential injuries caused by seizure disorder. The DON added, Resident's safety must be protected. A review of the facility policy titled, Emergency Procedure- Seizure Management, dated 8/2018, indicated, Personnel will assist in safety measures for a resident who is having a seizure. A review of the facility policy titled, Charting and Documentation, dated 7/2017, indicated, All services provided to the resident. shall be documented in the resident medical record. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 3. A review of Resident 108's admission Record indicated Resident 108 was admitted to the facility in August 2023 with multiple diagnoses including encephalopathy (damage or disease that affects brain functioning), dementia (loss of memory, problem solving and thinking abilities that interfere with daily life), epilepsy (seizure disorder), and diabetes (blood sugar is too high due to insufficient insulin or body does not use insulin effectively). A review of Resident 108's MDS, Cognitive Patterns, dated 3/19/26, indicated Resident 108 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 7 out of 15 that indicated Resident 108 had severe cognitive impairment. During a concurrent observation and interview on 4/21/26 at 8:35 a.m. with Resident 108, observed bed remote control next to Resident 108 in bed. Observed frayed exposed wires at junction of remote and cord and where cord was wrapped around bed rail. Resident 108 stated he is able to use the bed remote and was observed picking it up. During a concurrent observation and interview on 4/21/26 at 9:42 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 confirmed that Resident 108's bed control remote cord had frayed and exposed wires. CNA 7 stated, This should not be. When asked what could happen to the resident, CNA 7 stated, Could shock the resident if he touches the frayed wire. During a concurrent observation and interview on 4/21/26 at 9:47 a.m. with the Director of Maintenance (DM), the DM confirmed that Resident 108's bed remote control cord has frayed and exposed wires. The DM stated the remote still works but needed to be changed. The DM stated this was the first time he was notified of the frayed cord. A review of the facility's Policy and Procedure (P&P) titled Safety and Supervision of Residents, revised 7/17, indicated .Our facility strives to make the environment as free from accident hazards as (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes .The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and adequate devices . A review of the facility's P&P titled Maintenance Service, revised 12/2009, indicated .Maintenance service shall be provided to all areas of the building, grounds and equipment . The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .