

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Casa Coloma Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38834 Based on observation, interview, and records review, the facility failed to ensure staff answered call lights (devices used by residents to signal his or her need for assistance from staff) in a timely manner for two of 33 sampled residents (Resident 108 and Resident 3). In addition, the dedicated call system at nursing station 1, which was designed to facilitate communication between residents and staff, was muted. These failures had the potential to result in the resident's requests and care needs not being met jeopardizing the health and safety of residents. Findings: A review of the facility's 'Answering the Call Light' policy and procedure revised 9/2022, indicated, The purpose of this procedure is to ensure timely response to the residents' requests and needs. A review of the admission record indicated the facility admitted Resident 108 in 2023 with multiple diagnoses which included heart and kidney disease. A review of Resident 108's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/25/24 indicated Resident 108 was cognitively intact. A review of Resident 108's fall risk assessment dated [DATE] indicated that the resident had limited vision, was non-ambulatory, and dependent on staff for assistance. Resident 108 fall risk assessment indicated the resident scored 20 out of 42 and was at high risk for falls and injuries. A review of 'At risk for falls/injury' care plan dated 6/23/24 indicated the following interventions, Address identified risk factors from the fall risk assessment .Encourage/remind resident to ask for help if needed . keep environment free of hazards .keep personal items within reach .call light within reach .monitor for discomfort and pain .Provide assistance as identified in transfer and mobility. A review of 'Self care deficit' care plan dated 6/23/24 indicated Resident 108 had physical limitations and required extensive to total assist for transfers, bed mobility, toileting and other ADL's (activities of daily living, routine tasks/activities such as bathing and dressing a person performs daily to care for themselves). One of the nursing interventions indicated to provide assistance if needed. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission record indicated the facility admitted Resident 3 in 2024 with multiple diagnoses which included irritable bowel syndrome (a condition that affects stomach and intestines causing pain, gas, diarrhea or constipation), bladder infection, and muscle weakness. A review of Resident 3's MDS dated [DATE], indicated Resident 3 was cognitively intact. A review of Resident 3's bowel and bladder assessment dated [DATE] indicated the resident always .voids appropriately without incontinence .never incontinent of stool .always aware of need to toilet and required the assistance of one staff to be able to transfer to toilet or bedside commode. A review of Resident 3's fall risk care evaluation dated 11/12/24 indicated that the resident was assessed at high risk for falls and injuries. A review of 'At risk for falls/injury' care plan dated 11/12/24 indicated the following interventions, Address identified risk factors from the fall risk assessment .Encourage/remind resident to ask for help if needed . keep environment free of hazards .call light within reach. During an observation and interview on 1/28/25, at 8:15 a.m., Resident 108 was observed lying in her bed. Resident 108 stated that call light response was really bad, especially at night. Resident 108 stated, Takes forever .Nobody checks on us if we need help at night and its impossible to get help from 2 to 5 a.m.They keep telling me to call for assistance, but what do you do if you call and they don't come .[I] call if I am in pain or need help to use the bathroom. I need lots of help with transferring from bed and back to bed. When Resident 108 was asked what she did when nobody answered her call light, the resident stated, [I] have to wait, no other choice. During an observation and interview on 1/29/25, at 8:55 a.m., Resident 3 was observed awake and sitting in bed. Resident 3 stated, Call light response is bad. Resident 3 explained that it took morning and afternoon shift staff anywhere from 30 minutes to one hour to answer her call light. Resident 3 stated her room was at the end of the hall and nobody could hear her when she would shout for help. Resident 3 continued, They bring the food, leave and disappear .They never offer to wash my face and hands before meals . unless I specifically request it, and it might take a while until they come and bring me washcloth to refresh my hands before eating .You push the call button to ask for wipes or washcloth, wait and wait and eat without washing hands because by the time they come, the food is cold. Resident 3 stated about a month ago she fell and added, Could not get help in time; was on commode [portable equipment placed at bedside as a toilet] and kept pushing the call button and nobody came. It was painful to sit for so long and I have pain all over me all the time, so I attempted to get to bed by myself, stood up and fell . Resident 3 stated she was lucky she did not break any bones but her buttocks were sore for a while. During an observation on 1/30/25, at 7:40 a.m., the Department observed lights above rooms [ROOM NUMBERS] were on and continued on for another 10 minutes while CNAs were passing breakfast trays in the first part of the hall. The display on a phone at the nursing station Hall 1 had yellow lights showing the call lights have originated in room [ROOM NUMBER]-B, 27-C, and 29-A, but there were no audible sounds coming from the phone. During the observation, two staff were sitting at the nursing station by the computer, but were unaware of the lights on the phone display and continued documentation. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 1/30/25, at 7:48 a.m., the Administrator (ADM) confirmed that the lights above room [ROOM NUMBER] and 29 were on. The ADM stated that the the new call system transferred all call lights to a dedicated phone at the nursing station. The ADM checked the phone display and explained that the lights on the phone originated in room [ROOM NUMBER]-B, 27-C, and 29-A when the residents pushed their call buttons. The ADM acknowledged there were no audible sounds coming from the phone indicating three call lights were on. The ADM attempted to increase volume on the phone and acknowledged that he was not sure why there was no audible sound coming to alert staff of residents calls. During an interview with Certified Nursing Assistant (CNA 4) in the presence of ADM on 1/30/25, at 8 a.m., CNA 4 stated the call lights have to be answered as soon as staff noticed them on. CNA 4 explained when the resident pushes his or her call button, the light on the phone at the nursing station eliminates and should be making audible sounds. CNA 4 turned a 'Tone Mute' button on a right side of the phone and the phone started making audible sounds. The ADM acknowledged that audible sounds on the phone help staff to identify that the resident was calling for help and if the mute button was on, the staff that are not at the desk might not be able to hear the resident calling for assistance. The ADM stated the staff has to answer call lights in a timely manner, as soon as possible and agreed that if no audible sounds come from the phone, the call lights response might be delayed. A review of the facility's policy titled, Call System, Resident, dated 9/2022, indicated, Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting .Call system communication may be audible or visual .The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard .Calls for assistance are answered as soon as possible, but not later than 5 minutes.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43247 Based on observation, interview, and record review, the facility failed to ensure physician orders were appropriate and followed as ordered for two of 33 sampled residents (Resident 94 and Resident 37) and failed to ensure Resident 109 took all the medications, when: 1. Resident 94 had conflicting orders for a knee brace, and 2. Resident 94 had order for oxygen that was not followed, and 3. Resident 37 had orders for monitoring for a medication that was no longer ordered. 4. Loose pills in a medication cup were observed at the bedside of Resident 109. These failures had the potential for Resident 94, Resident 37 and Resident 109 to receive care and treatment that was contradictory to the physician's orders leading to adverse outcomes. Findings: A review of Resident 94's Admission Record indicated Resident 94 was admitted to the facility in October 2022 with multiple diagnoses including asthma (condition in which airways become narrow making it difficult to breathe), morbid obesity (severe obesity), and difficulty walking. A review of Resident 94's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 1/3/25, indicated Resident 94 had a Brief Interview for Mental Status (BIMS- an assessment tool) score of 15 out of 15, that indicated Resident 94 was cognitively intact. A review of Resident 94's MDS, Functional Abilities, dated 1/3/25, indicated Resident 94 required mostly supervision or set up assistance for eating, hygiene, bathing, dressing, bed mobility, transfers and was able to walk ten feet with supervision. A review of Resident 94's MDS, Special Treatments, Procedures, and Programs, dated 1/3/25, indicated Resident 94 required oxygen therapy. 1. A review of document Details for Order . indicated an order placed 1/3/25 for knee brace support, knee compression sleeve, for delivery to the facility. A review of Resident 94's Order Summary Report indicated order dated 12/20/24, Knee Brace Left Knee when OOB [out of bed] every shift for OA [osteoarthritis- arthritis due to cartilage wearing down at the end of the bones] of Right knee . A review of Resident 94's Order Summary Report indicated order dated 1/18/25, Right knee brace three times a day for OA of the knee . A review of Resident 94's Care Plan, initiated 5/1/24, indicated At risk for falls/injury due to: .Balance problem .Interventions/Tasks .Identify type of assistance resident needs .Provide assistance as identified in transfer and mobility . (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 8:49 a.m. with Resident 94, Resident 94 stated she requested for a knee brace for right knee a month ago. Resident 94 stated she is waiting for surgery on her right knee but in the meantime needed a brace for support. During an interview on 1/29/25 at 9:16 a.m. with the Director of Rehabilitation (DOR), the DOR stated a brace was ordered for Resident 94's left knee and was waiting for delivery. The DOR stated the brace was ordered for the left knee to help with instability. During an interview on 1/30/25 at 10:35 a.m. with Resident 94, Resident 94 stated the knee brace was for the right knee, not the left knee. During an interview on 1/30/25 at 10:39 a.m. with Licensed Nurse (LN) 1, LN 1 acknowledged that Resident 94 had two conflicting orders for a knee brace. LN 1 stated the order for the right knee brace was the correct order. LN 1 stated the front desk puts in the orders and should clarify the orders. LN 1 stated, If orders incorrect does not fix the problem. During a concurrent interview and record review on 1/30/25 at 2:39 p.m. with the Director of Nursing (DON), the DON acknowledged the conflicting orders for left knee brace and right knee brace for Resident 94. The DON stated the order for the right knee brace on 1/18/25 was the correct order and the order for the left knee brace should have been discontinued. The DON stated, The orders are confusing to nursing. The DON stated it is the nurse's responsibility to determine if an order is correct and to double check the orders. 2. A review of Resident 94's Order Summary Report indicated an order dated 4/30/24, Oxygen: At 2 Liters/Min [rate of oxygen flow per minute] via Nasal Cannula [a flexible tube that delivers the oxygen through the nose] every shift . A review of Resident 94's Care Plan, initiated 5/1/24, indicated Alteration in Respiratory Status . Interventions/Tasks .Administer oxygen as ordered . During a concurrent observation and interview on 1/28/24 at 8:49 a.m. with Resident 94, observed oxygen concentrator (a machine that uses air to make oxygen) at bedside set to 4 liters/minute being administered via nasal cannula. Resident 94 stated the liter flow should be 2 1/2 liters/minute. During a concurrent observation and interview on 1/30/25 at 10:35 a.m. with Resident 94, observed oxygen concentrator on other side of the curtain set to 3 liters/minute. Resident 94 stated it was set to 2 liters/ minute, but she needed more so it was turned up to 3 liters/minute. Resident 94 stated she wanted to wean it down to 2 liters/minute. During a concurrent observation and interview on 1/30/25 at 10:39 a.m. with LN 1, LN 1 confirmed Resident 94's oxygen concentrator was set to 3 liters/ minute and the order was for 2 liters/ minute. LN 1 stated the oxygen concentrator should be set to 2 liters/minute. LN 1 stated should have an order indicating oxygen concentrator to be set between 2 and 3 liters/ minute. LN 1 stated the desk nurse puts the orders in. LN 1 further stated, What she [Resident 94] had was not the order. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/30/25 at 2:39 p.m. with the DON, the DON acknowledged Resident 94's oxygen order was for 2 liters/minute and the oxygen concentrator should be set at 2 liters/ minute all the time. The DON stated the order for oxygen for 2 liters/ minute is incorrect and Resident 94 should have an order for range of liter flow with parameters to titrate (adjust according to need). 3. A review of Resident 37's Admission Record indicated Resident 37 was admitted to the facility in September 2017 with multiple diagnoses including diabetes (too much sugar in the blood), asthma, depressive disorder, single episode (mental health disorder characterized by low mood and loss of interest that interferes with daily functioning), bipolar disorder (mental health disorder with mood swings), and chronic kidney disease (kidneys do not filter the blood as well as they should). A review of Resident 37's MDS, Cognitive Patterns, dated 11/5/24, indicated Resident 37 had a BIMS score of 8 out of 15 that indicated Resident 37 was moderately cognitively impaired. A review of Resident 37's Order Audit Report, indicated order initiated 3/29/23 and discontinued 10/3/23, Mirtazapine [medication used to treat depression] 7.5 mg [milligrams] Give 1 tablet by mouth at bedtime for depression manifested by poor meal intake . A review of Resident 37's Order Summary Report indicated current orders including: [Behavior] Mirtazapine-monitor poor meal intake .due to depression, with meals start date 5/8/23. [Side Effects] Mirtazapine- monitor for A) drowsiness B) appetite stimulation C) dry mouth D) constipation E) weight gain F) dizziness every shift . start date 3/29/23 A review of Resident 37's Medication Administration Record (MAR), 1/1/25 to 1/31/25, indicated staff continued to enter information in the MAR for monitoring of the Mirtazapine's behavior and side effects as ordered. The medication was no longer being given. A review of Resident 37's Care Plan, initiated 3/29/23, indicated The resident uses antidepressant medication MIRTAZAPINE r/t [related to] poor meal intake .Interventions/Tasks .Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/ document side effects and effectiveness Q [every]-SHIFT . During a concurrent interview and record review on 1/31/25 at 1:29 p.m. with the DON, the DON acknowledged that Resident 37 was not receiving Mirtazapine currently. The DON acknowledged that the medication monitoring should have been discontinued when the medication was discontinued. The DON stated when a medication is discontinued all the batch orders, including behavior and side effect monitoring, related to the medication should be discontinued as well. The DON stated it was the nurse's responsibility to discontinue the monitoring at the time the medication was discontinued. The DON stated the nurse did not check and did not update the orders. A review of the facility's Policy and Procedure (P&P) titled Assistive Devices and Equipment, revised 1/20, indicated, . Our facility maintains and supervises the use of assistive devices and equipment for residents . Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan . (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled Medication and Treatment Orders, revised 7/16, indicated .Orders for medications and treatments will be consistent with principles of safe and effective order writing . A review of the Job Description Charge Nurse/Nurse Supervisor, revised 10/20, indicated . Audit nursing documentation in the clinical record for appropriate and relevant entries .Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures .Monitor medications administration process and provide appropriate feedback or changes to prevent medication errors .Administer medications in accordance with physician orders, regulations and facility policies .Order prescribed medications, supplies and equipment as necessary in accordance with established facility policies .Assess residents for conditions which may be aided by assistive or adaptive devices . 50351 4. A review of Resident 109's admission record, indicated resident 109 was admitted on [DATE] with multiple diagnoses including prostate [male gland] cancer and respiratory failure with Hypoxia [low oxygen in the body tissues]. A review of Resident 109's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 1/22/25, indicated Resident 109 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 13 out of 15 which indicated resident was cognitively intact. During a concurrent interview and record review on 1/30/25 at 12:05 p.m. with Licensed Nurse 4 (LN 4), LN 4 stated for Resident 109, . we get medication ready whatever the dosage according to doctor's orders, [Resident 109] requires extra assistance, I make sure I set up the bed for him. He doesn't have enough coordination to pour medications himself so personally when administering medication to [Resident 109] , I will administer to him to make sure the medication is tolerated because he may drop the medications . LN 4 further confirmed medication cup left at bedside via photo and stated the medication should have been given to [Resident 109] and best practice was to stay and watch the resident swallow the medications. During a concurrent review and interview on 1/30/25 at 4:05 p.m. with Director of Nursing (DON), the DON confirmed pictures of medications left at the bedside of Resident 109. The DON Stated, this is not supposed to happen, this should not be left at bedside. That patient is noncompliant . needs additional staff sometimes to take his medications . During a review of the facility's policy and procedure, titled Documentation of Medication Administration, dated April 2007, the Policy indicated, . 2. Administration of medication must be documented immediately after (never before) it is given . During a review of the facility's policy and procedure, titled Administering Medications dated April 2019, the Policy indicated, .10. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .21. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones .		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 51078 Based on observation, interview, and record review the facility failed to ensure services were provided to one of 33 sampled residents (Resident 87) when Resident 87 was not assisted in the repair or daily use of their hearing aids. This failure had the potential to cause Resident 87 psychosocial harm by making him frustrated and angry due to his inability to hear clearly and communicate properly with staff, other residents, and visitors. Findings: A review of Resident 87's facesheet indicated Resident 87 was admitted to the facility in February of 2024 with a diagnoses including presence of left artificial shoulder joint with severe weakness, sensorineural hearing loss (a type of hearing loss that occurs when there is damage to the inner ear (cochlea) or the auditory nerve that carries sound signals to the brain), and need for assistance with personal care. A review of Resident 87's Order Summary Report dated 2/5/24 indicated Resident 87 is capable of understanding rights, responsibilities, and Informed Consent. A concurrent observation and interview on 1/29/25 at 08:58 a.m. with Resident 87 inside his room. Resident 87 stated he would like his hearing aids in during the day so he can communicate with staff and other residents and that he has asked his nurse and Social Services several times to assist him in getting an appointment because he thinks they aren't working properly. Resident 87 stated nobody had offered to put in his hearing aids this morning and that it made him frustrated and angry when he couldn't hear and communicate. Observed hearing aids on night stand, in the case, fully charged. An interview on 1/30/25 at 11:43 a.m. with Resident 87 in his room. Resident 87 stated nobody had offered to help him with his hearing aids. Observed hearing aids were not on the nightstand and not in residents' room or placed in resident's ears. A review of Resident 87's Order Summary Report dated 6/17/24 indicated to put the hearing aids in by 7:30 a.m. to 8:00 a.m. daily and to make sure they are charged and functioning. An interview conducted on 1/30/25 at 12:05 p.m. with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated the expectation is to put Resident 87's hearing aids in every morning per orders. CNA 6 confirmed that the hearing aids were no longer in the room and not in Resident 87's ears. CNA 6 stated that Resident 87 had complained about the hearing aids not working several days in a row. CNA 6 further stated it was very important for Resident 87 to be able to hear properly in case he needed help and to communicate with staff and others, and that it's not good mentally for the resident to feel left out of the conversation and feel isolated. (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 1/30/25 at 12:15 p.m. with the Social Services Assistant (SSA), the SSA stated that the expectation is that staff will inform her that hearing aides are not working as soon as possible. The SSA stated Resident 87 gets angry because he gets frustrated when he can't hear and communicate with staff or others. The SSA stated that she was informed for the first time of Resident 87's hearing aids not working on 1/29/25. An observation on 1/31/25 at 09:29 a.m. Resident 87 was not wearing hearing aids, and they were not found in his room. A concurrent interview and record review on 1/31/25 at 10:13 a.m. with Licensed Nurse 7 (LN 7), LN 7 confirmed Resident 87 did not have hearing aids in. LN 7 confirmed Resident 87's Medical Administration Record (MAR - a daily documentation record used by licensed nurses to document medications and treatments given to a resident) initialed by LN 7 was incorrect for 1/28/25, 1/30/25, and 1/31/25 indicating hearing aids were working and placed in Resident 87's ears. LN 7 stated Resident 87 had been complaining about his hearing aids not working for over a week and she had not contacted anyone regarding the broken hearing aids. LN 7 stated that the expectation was to tell Social Services as soon as possible if an item is not working. LN 7 could not answer as to why she did not tell anyone when the issue was first identified or why she charted that the hearing aids were working and placed in Resident 87's ears when they were not for three days. LN 7 stated it wasn't easy for Resident 87 to communicate without his hearing aids, it affected him socially in a negative way, and it made him angry and frustrated when he couldn't hear. An interview was conducted on 1/31/25 at 12:47 p.m. with the Director of Nursing (DON). The DON stated the expectation is for staff to follow physician orders regarding assistive devices and if they are not working properly to immediately notify Social Services to arrange for appointments or repair. The DON stated if this was not reported and taken care of quickly it could cause undue stress to Resident 87 and affect him psychosocially. The DON further stated that communication between staff and patients is very important to give residents the best care possible. A review of the facility's policy titled Assistive Devices and Equipment revised January 2020, the policy indicated Our facility maintains and supervises the use of assistive devices .for residents .assistive devices include hearing aids .Staff are trained and demonstrate competency on the use of devices .prior to assisting or supervising residents .Devices .are maintained on schedule .Defective devices are .repaired .Staff are required to demonstrate competency on the use of devices and are available to assist and supervise residents as needed.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38834 Based on observation, interview, and record review, the facility failed to ensure the safety of one of 33 sampled residents (Resident 78), who had tube feeding (TF, a medical device surgically implanted into the stomach, so the person who can not eat normally due to swallowing problems can receive liquid nutrition), when the facility did not follow the physician's order to keep Resident 78's head of bed (HOB) elevated at 30 degrees during administration of nutrition through the TF on multiple occasions. This failure had the potential for Resident 78 to experience aspiration (inhalation of TF formula) and develop aspiration pneumonia (a lung infection that develops after the person inhales food or liquids into their lungs where the bacteria will grow and cause an infection) which could lead to death. Findings: A review of the admission record indicated the facility admitted Resident 78 in the fall of 2024 with multiple diagnoses which included pneumonitis (lung infection that causes inflammation and swelling of the air sacs in the lungs) due to inhalation of food, lung disease, and dysphagia (difficulty swallowing solids and liquids). Resident 78's clinical records indicated she was admitted after she had a tube feeding placed in the hospital. A review of physician 'Progress Notes' dated 12/24/24 indicated, Patient does not have capacity she is mostly bedbound due to her advanced dementia [loss of cognitive functioning]. The physician documented that Resident 78's legs were contracted (permanent tightening of muscles and ligaments making them shortened and that the resident had an increased tone [of] all 4 extremities [the muscles in the arms and legs had abnormally high tension, making them stiff and hard to move. A review of the physician order dated 11/28/24 directed nursing staff to elevate Resident 78's head of bed (HOB) 30-45 degrees at all times during feedings and 1 hour post-administration of medications. A review of the care plan titled, Resident [is] on tube feeding dated 12/2/24 indicated Resident 78 was at risk for aspiration, abdominal discomfort, nausea and vomiting and one of the nursing interventions to prevent these conditions was to elevate resident's head of the bed at all times during the feeding. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 78's clinical records contained a document titled, SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 12/15/24 and timed at 3 a.m., which indicated that the resident had a change in condition. The nurse documented, Patient showing signs of restlessness. Started 12/14 NOC [night shift] .Patient [is] unable to sleep .Crackles [abnormal breath sounds that sound like bubbling/rattling, usually caused by excess fluid in the airways]. Gurgling breath sounds. Oxygen desat [desaturated, decreased] to 88% [normal oxygen level is 97-100%] on RA [room air] when flat. Resident 78's records indicated that the resident continued having excessive secretions from her lungs, had an X-Ray of the chest done, and the physician prescribed treatment for pneumonia (lung infection). A review of physician 'Progress Notes' dated 12/17/24 indicated that Resident 78 experienced episode of . excessive secretions [cough producing large amount of bodily secretions, which could be saliva, mucus or food], had low oxygen level and was prescribed antibiotic. A review of Resident 78's clinical records contained a speech therapy (ST, a medical professional trained to evaluate and treat people who experience difficulties with swallowing) note dated 1/24/25. The note indicated, Pt [patient] in bed .asleep and when HOB elevated by ST to further rouse pt, pt with emesis [vomit] noted; appeared to be TF contents. The ST documented, Notified nursing and also educated nurse in importance of HOB being elevated to at least 30 degrees at all times and pt should not be laid flat at any time. The ST documented that the sign was placed at HOB for adherence to 30-45 degrees positioning requirements for safety. A review of Resident 78's medication administration records (MARs) from 1/1 through 1/29/25 indicated the resident's nurses documented (initialed) every shift that the resident's HOB was elevated at 30-45 degrees during the feedings contrary to the observations made on 1/28/25 at 7:35 a.m., 1/28/25 at 8:50 a.m. ; 2:41 p. m., 1/29/25 at 9:30 a.m. During an observation on 1/28/25, at 7:35 a.m. in Resident 78's room, Resident 78 was observed and was receiving a tube feeding at 70 milliliters per hour (ml/h, a unit of measurement) while laying on her back. The resident's HOB was elevated approximately 15 degrees and looked almost flat. A sign printed with large letters on the wall above the resident's bed indicated Keep Head of Bed Elevated to 30 [degrees] at All Times. During a follow up observation and a concurrent interview with Licensed Nurse (LN 1) on 1/28/25, at 8:50 a. m., Resident 78 was in the same position laying on her back with TF running at 70 ml/h and the resident's HOB was not elevated as ordered by the physician. LN 1 validated that the resident's HOB was low and not at 30-45 degrees as ordered by the physician and the posted sign. LN 1 stated Resident 78 was at risk for aspiration and should have her HOB elevated at least 30 degrees while the feeding was on. During a concurrent observation and interview on 1/28/25, at 2:41 p.m., with LN 2 in Resident 78's room, Resident 78 was observed in bed, almost flat while the tube feeding was running at 70 ml/h. LN 2 stated, Head of bed elevated about 15 degrees. Not good .[Resident] is at risk for aspiration .[HOB] should be at least 30-45 degrees. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Certified Nursing Assistant (CNA 2) on 1/29/25 at 9:30 a.m., Resident 78 was observed laying in bed on her back with HOB slightly elevated while receiving tube feeding at 70 ml/h. CNA 2 confirmed that Resident 78's HOB was low and added, Yes, almost flat. She should have it elevated to 30-45 degrees because the feeding can go into her lungs. LN 1 entered Resident 78's room and validated that the resident's HOB was not elevated as it was required. During a concurrent observation and interview with CNA 3 on 1/31/25, at 8:05 a.m., Resident 78 was observed laying completely flat in the bed with the tube feeding running at 70 ml/h. Resident 78 had small amount of tube feeding formula on her lips. The CNA 3 validated that the resident was laying flat in her bed. During a follow up observation and interview with LN 3 on 1/31/25, at 8:10 a.m., LN 3 confirmed that the resident was flat while receiving tube feeding and added, She can't lay flat .her HOB has to be elevated to 30-45 degrees .I don't know what happened and why the HOB is flat. During a concurrent interview and record review on 1/30/25, at 11:20 a.m., with the the ST, the ST stated on a few occasions when she conducted a swallow therapy with Resident 78, she noticed that the resident's HOB was not at 30 degrees. The ST stated when she saw Resident 78 on 1/24/25, the resident wasn't [laying] flat, but [was not] at 30 degrees and she had a copious amount of tube feeding [formula] secretions in her mouth. The ST added, I had to suction her and instructed caregivers about proper positioning and high risk for aspiration. I posted a sign on the wall about 30 degrees at all times. A review of the facility's most current policy titled, Enteral Feedings - Safety Precautions, revised 11/2018, indicated the purpose of the policy was to ensure the safe administration of enteral (tube feeding) nutrition. The policy indicated, All personnel responsible for .administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities .Preventing aspiration .Elevate the head of bed (HOB) at least 30 [degrees] during tube feeding and at least 1 hour after feeding. During an interview with the facility's Director of Nursing (DON) on 1/30/25, at 1:50 p.m., the DON stated that residents receiving tube feeding were at high risk for aspiration and they should be positioned properly while receiving tube feedings to prevent complications, including aspiration of the formula. During the interview, Resident 78's improper HOB positioning on multiple observations was discussed. The DON stated her expectation was that the staff follow the physician's order and ST instructions to keep her [Resident 78's] HOB elevated at least 30 degrees, ideal 45 degrees .I always remind them to check on HOB before leaving the room.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 38834 Based on observation, interview, and record review, the facility failed to ensure two of 33 sampled residents (Resident 78 and Resident 93) received oxygen therapy as prescribed by the residents' physicians, when Resident 78 and Resident 93 received oxygen at a higher rate than ordered. These failures had the potential to contribute to residents' discomfort and decreased ability to breathe. Findings: A review of the admission record indicated the facility admitted Resident 78 in the fall of 2024 with multiple diagnoses which included chronic obstructive pulmonary disease (COPD, a chronic lung condition causing restricted airflow and breathing problems) and pneumonitis (lung infection that causes inflammation and swelling of the air sacs in the lungs) due to inhalation of food. A review of Resident 78's physician order dated 12/23/24 indicated, Oxygen inhalation at 2 liters [L, unit of measurement] per minute via NC [nasal cannula, a tubing used to deliver supplemental oxygen] continuously every shift. A review of the care plan titled, A risk for ineffective breathing pattern, dated 12/2/24 directed nursing to administer oxygen as ordered by the physician. A review of Resident 78's medication administration records (MAR) from 1/1/25 through 1/27/25 indicated that licensed nurses had initialed every shift that Resident 78 received oxygen at 2 Liters via NC. During an observation on 1/28/25 at 7:33 a.m., Resident 78 was lying in her bed with the oxygen tubing on and the tubing was connected to oxygen concentrator (electrical device that extracted oxygen from surrounding and filtered it for the patient to breathe). Resident 78's oxygen concentrator's gauge was set to deliver 3.5 liters of oxygen per minute. During a concurrent observation and interview in Resident 78's room on 1/28/25 at 8:50 a.m., Licensed Nurse (LN 1) stated, Looks like [Resident 78 is] getting 3.5 liters of oxygen. Upon checking the physician's order for Resident 78, LN 1 stated the physician order indicated to administer 2 liters of oxygen. LN 1 acknowledged that the resident received the oxygen at a higher rate than prescribed by the physician. A review of the admission record indicated the facility admitted Resident 93 in 2022 with multiple diagnoses which included COPD and heart failure. A review of Resident 93's physician order dated 8/16/24 indicated to administer oxygen at 2 liters per minute via NC continuously every shift. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 93's care plan titled, Alteration in respiratory status due to .chronic respiratory failure, dated 9/7/22 directed nursing to Administer oxygen as ordered. Oxygen 2 LPM [liters per minute] every shift. A review of Resident 93's medication administration records (MAR) from 1/1/25 through 1/27/25 indicated that licensed nurses had initialed every shift that Resident 93 received oxygen at 2 liters via NC. During an observation on 1/28/25, at 7:53 a.m., Resident 93 was observed sitting in bed with the oxygen tubing on and the tubing was connected to oxygen concentrator. Resident 93's oxygen concentrator's gauge was set to deliver 3 liters of oxygen per minute. During a concurrent observation and interview in Resident 93's room on 1/28/25, at 8:53 a.m., LN 1 acknowledged that the resident was receiving 3 liters of oxygen per minute. Upon reviewing the physician's order, LN 1 stated that per physician's order, Resident 93 should have her oxygen delivered at 2 liters per minute. LN 1 acknowledged that the rate of oxygen delivered to Resident 93 was higher than ordered by the physician. During an interview with the Director of Nursing (DON) on 1/30/25, at 1:50 p.m., the DON stated that she was made aware by LN 1 that Resident 78 and Resident 93 were receiving the oxygen therapy at the wrong rates which were higher than prescribed by the resident's physician. The DON stated the expectation was that nurses always followed the physician orders. A review of the facility's policy titled Oxygen Administration, revised 10/2010 indicated that the purpose of the policy was to provide guidelines for safe oxygen administration. The policy indicated, Verify that there is a physician's order . Review the physician's orders or facility protocol for oxygen administration .Review the resident's care plan. A review of an article published in the National Library of Medicine, dated 2014, titled ABC of Chronic Obstructive Pulmonary Disease: Oxygen and inhalers, indicated Administering oxygen for chronic obstructive pulmonary disease (COPD) is not without risk and it should be properly prescribed in terms of flow rate and mode of delivery like any other drug. Giving high concentrations of oxygen to hypoxemic (low oxygen in the blood) patients .can result in individuals losing their .drive to breathe.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43258 50282 Based on observation, interview, and record review, the facility failed to ensure accurate accountability of controlled medications (those with high potential for abuse or addiction) when: 1. Licensed Nurse 7 (LN 7) disposed tramadol (a controlled substance medication to treat pain without another LN to cosign the destruction; 2. Two out of five medication cart-controlled drug sign-in/sign-out sheets (sheets used to reconcile inventory of controlled medications in the medication cart by the outgoing and the incoming LN during a shift change) did not have signatures of the outgoing and the incoming nursing shift; and 3. The DON and pharmacist did not document destruction of controlled medications in accordance with facility policy and procedure (P&P). These failures resulted in the facility not having accurate accountability of controlled medications with the potential for abuse or misuse of these medications. Findings: 1. During a medication pass observation on 1/28/25 at 9:36 a.m. with LN 7, LN 7 was observed administering medications to Resident 138, including tramadol 50 milligrams (mg, a unit of measurement). Resident 138 refused the tramadol so LN 7 returned to the medication cart and disposed of it in a drug buster (a bottle containing a substance that deactivates and destroys medication) container without having another LN to witness the destruction. LN 7 signed the narcotic sheet indicating the resident refused the dose and that she had disposed of it. During a concurrent observation and interview on 1/28/25 at 10:10 a.m. with LN 7, LN 7 stated that she forgot to get another LN to witness the destruction of tramadol. LN 7 requested the assistance of LN 2 to cosign the destruction of the tramadol on the narcotic count sheet without having witnessed it. During an interview on 1/28/25 at 10:13 a.m. with both LN 7 and LN 2, LN 2 stated nursing staff were expected to observe the destruction of narcotics before cosigning. LN 7 confirmed she should have gotten another LN to observe the destruction. LN 7 and LN 2 confirmed that their narcotic destruction process was not properly done, and stated that it was important to follow the facility's policy to potentially avoid misuse of narcotic medications. During an interview on 1/29/25 at 1:30 p.m. with Director of Nursing (DON), DON stated that two nurses must sign and observe the destruction. DON stated the reason the staff did not follow the facility's P&P was because they had worked together for many years and trusted one another in order to cosign without witnessing narcotic destruction. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Controlled Substances, revised 4/2019, the P&P indicated, 11. Upon Disposition . b. Medications that are opened and subsequently not given . are destroyed. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet. 2. During a concurrent interview and record review on 1/28/25 at 12:33 p.m., the controlled drug sign-in/sign-out sheets for Medication Cart (Med Cart) Station 3 (60's) and Med Cart Station 3 (70's), dated 1/1/25 to 1/28/25, were reviewed. The sign-in/sign-out sheets indicated seven missing LN signatures for Med Cart Station 3 (60's) and 18 missing LN signatures for Med Cart Station 3 (70's). LN 5 confirmed the finding and stated nursing staff were expected to count narcotics in the Med Carts between shift changes then sign the sign-in/sign-out sheet to reconcile the count. LN 5 stated, signing meant that all narcotics were counted and correct. During an interview on 1/29/25 at 2:01 p.m. with DON, DON stated that it was policy and part of nursing staff routine to count narcotics between shift change and to sign right away to endorse the count. During a review of the facility's P&P titled, Controlled Substances, revised 4/2019, the P&P indicated 12. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together 3. During a concurrent interview and record review on 1/29/25 at 1:30 p.m. with DON, the narcotic destruction process performed by the Consultant Pharmacist (CP) and DON was reviewed. The DON stated the narcotics were destroyed by her and the CP. She stated a log was kept documenting each medication that was destroyed along with signatures of the witnesses. A review of the narcotic destruction logs dated January 2025 were reviewed with the DON. A review of the January 2025 narcotic destruction log indicated only the CP's signature as witness of the destruction. DON confirmed the finding and stated she had planned to sign but got busy. DON acknowledged that she should have signed simultaneously with the pharmacist at the time of narcotic destruction. During a review of the facility's P&P titled, Discarding and Destroying Medications, revised 4/2019, the P&P indicated, 7. For unused, non-hazardous controlled substances that are not disposed of by an authorized collector . c. Dispose .in the presence of two witnesses. d. Document the disposal on the medication disposition record. e. Include the signature(s) of at least two witnesses . 11. The medication disposition record will contain the following information . h. Signature of witnesses.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43258 50282 Based on observation, interview, and record review, the facility failed to ensure Resident 47 was free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behaviors) when Resident 47 received psychotropic medication without implementation of non-pharmacological (non-drug) interventions and inadequate indication for use. This failure resulted in unnecessary medication for the resident, which had the potential for exposure to unwanted side effects associated with psychotropic medications such as sedation, falls, abnormal involuntary movements, and memory loss and increased risk of death. Findings: A review of Resident 47's medical record (MR) indicated Resident 47 was admitted to the facility on [DATE] with diagnosis including dementia (a brain disorder that leads to decline in memory) with unspecified psychosis not due to a substance or known physiological condition (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), and recurrent urinary tract infections (UTI). A review of Resident 47's medical record indicated the following physician's orders: 1. Quetiapine (an antipsychotic used to treat serious mental health conditions that affect how people think, feel and behave) 25 milligrams (mg, a unit of measurement): 25 mg twice daily and 50 mg at bedtime, ordered 7/8/24 to 9/23/24; 2. Quetiapine 25 mg: Give 1 tablet by mouth one time a day for Psychosis, manifested by (m/b) combative and swinging or grabbing and twisting staff's arms when redirected and give 2 tablets by mouth at bedtime for psychosis, m/b combative and swinging or grabbing and twisting staff's arms when redirected ordered 9/23/24 to 1/21/25; 3. Quetiapine 25 mg: Give 1 tablet by mouth one time a day for unspecified psychosis m/b paranoia with disorganized thoughts and behavior and give 2 tablet by mouth at bedtime for unspecified psychosis m/b paranoia with disorganized thoughts and behavior, ordered 1/21/25. During a concurrent observation and interview on 1/30/25 at 11:02 a.m. with Resident 47, Resident 47 was seated in a wheelchair self-propelling in the hallway towards his room. Resident 47 stated he had just left activities room and had watched the news. Resident 47 discussed current events, and was alert, oriented pleasant, well-groomed and spoke with clear speech. Resident 47 denied feeling depressed and stated he got along well with staff. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/30/25 at 11:08. a.m. with Licensed Nurse 7 (LN 7), LN 7 stated Resident 47 used to be angry upon admission and did not like his roommate. LN 7 stated Resident 47 had a room change and described him as alert, able to do self-care, liked to be in his room, and enjoyed coffee in the morning, LN 7 stated Resident 47 was pleasant, always smiled, and said that he was fine. During a concurrent interview and record review on 1/30/25 at 11:58 a.m. with Director of Nursing (DON), Resident 47's MR and progress notes and hospital discharge date d 5/21/24 were reviewed. DON stated when Resident 47 was admitted to the facility he was difficult to manage because he was wandering, was agitated and wanted to leave. DON stated Resident 47 received quetiapine while in the hospital for treatment of recurrent UTI but did not have an order to continue the medication upon his discharge to the facility. She stated Resident 47 was put back on quetiapine after admission to the facility because it was effective in controlling his behavior when he was in the hospital. DON stated she was aware that agitation was not an adequate indication for the use of quetiapine so Resident 47's order was updated to read, Psychosis m/b paranoia with disorganized thoughts and behavior. During a concurrent interview and record review on 1/30/25 at 3:18 p.m. with DON, the manufacturer's labeling for Seroquel (brand name for quetiapine) was reviewed. The labeling for quetiapine contains a Black Box Warning (BBW) (the highest safety-related warnings that medications can have assigned by the Food and Drug Administration) that indicates, Increased Mortality (risk of death) in Elderly Patients with Dementia. The labeling further indicated, Seroquel is not indicated in elderly patients with dementia . Seroquel not indicated for the treatment of elderly patients with dementia-related psychosis. DON confirmed the BBW and that it was not approved to be used in elderly patients with dementia-related psychosis. During the same interview and record review on 1/30/25 with DON, Resident 47's medical record was reviewed. DON stated it was expected to have documentation in the resident's record to support the use of an antipsychotic. She confirmed Resident 47's record did not contain documentation to indicate that the resident's behavior was persistent and not due to any underlying conditions were ruled out before initiating quetiapine. DON stated nursing staff were expected to implement non-pharmacological interventions anytime a resident was on an antipsychotic. She reviewed the record but was unable to provide documentation to support such interventions were implemented either prior to initiating quetiapine or along with the medication in order to use the lowest effective dose for the shortest period of time. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, revised 12/2016, the P&P indicated, Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed . 1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. 3. The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. 4. The Attending Physician and facility staff will identify acute psychiatric episodes, and will differentiate them from enduring psychiatric conditions. 5. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use .7. Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): 1. Schizophrenia; .8. Diagnoses alone do not warrant the use of antipsychotic medication. 11. Antipsychotic medications will not be used if the only symptoms are one or more of the following: Wandering; .16. The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications .		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 43258 50282 Based on observation, interview, and record review, the facility had an 8.82% error rate when three medication errors out of 34 opportunities were observed during a medication pass for two of four Residents (Residents 101 and 138). This failure resulted in medications not given in accordance with the prescriber's orders and potential to affect the residents' clinical conditions. Findings: During a medication pass observation on 1/28/25 at 9:30 a.m. with Licensed Nurse 6 (LN 6), LN 6 was observed preparing ten medications, including acarbose (a medication to lower blood sugar) 50 milligrams (mg, a unit of measurement) and ferrous sulfate (a medication to prevent low blood cells in the body) 325 mg for Resident 138. LN 6 administered the medications. A review of Resident 138's medical record indicated the following physician's orders: - Acarbose 50 mg: Give one tab by mouth three times a day, take with first bite of meal, ordered 12/28/24; - Ferrous gluconate 324 (37.5 Fe) mg: Give one tablet by mouth two times a day for supplement, ordered 12/28/24. During a concurrent interview and record review on 1/28/25 at 12:10 p.m. with LN 6, LN 6 confirmed the acarbose order stated to give with first bite of the meal and that Resident 138 had already eaten breakfast by 9:30 a.m., when the medication was administered. LN 6 stated he thought the medication could be administered after breakfast. LN 6 confirmed ferrous sulfate was administered instead of ferrous gluconate and stated, I made a mistake. A review of the manufacturer's labeling for Precose (brand name for acarbose), dated 3/2011 indicated, Dosage and Administration . Precose should be taken three times daily at the start (with the first bite) of each main meal. During a medication pass observation on 1/28/25 at 9:30 a.m. with LN 1, LN 1 was observed preparing five medications, including Humalog KwikPen (a medication to decrease blood sugar) 20 units for Resident 101. LN 1 dialed the pen to 20 units and did not prime (a process to remove air bubbles from the needle and ensure the pen is working properly). LN 1 injected the Humalog into Resident 101's back right upper arm. LN 1 depressed the button on the KwikPen to inject the medication for approximately 2 seconds. During an interview on 1/28/25 at 1:05 p.m. with LN 1, LN 1 stated not being aware of any special handling or preparations related to the Humalog KwikPen. LN 1 stated she pressed the KwikPen button for approximately 1-2 seconds. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the manufacturer's labeling for Humalog KwikPen, revised 3/2013, indicated, Prime before each injection. Priming ensures the Pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin . Giving your Humalog injection . Step 11: Put your thumb on the Dose Knob and push the Dose Knob in until it stops. Hold the Dose Knob in and slowly count to 5. Step 12: Pull the needle out of your skin. You should see '0' in the Dose Window. If you do not see '0' in the Dose Window, you did not receive your full dose. During an interview on 1/29/25 at 1:30 p.m. with Director of Nursing (DON), DON stated nursing staff were expected to review the medication administration record and the physician's orders to ensure medications were administered correctly. DON stated diabetic medications were to be administered with meals, including acarbose. She stated she expected nursing staff to follow the timing of medications as specified by the doctor. The DON stated nursing staff did not receive training specific to priming and administration of medications in delivery devices like the Humalog KwikPen. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed . 4. Medications are administered in accordance with prescriber orders, including any required time frame. During a review of the facility's P&P titled, Insulin Administration, revised 9/2014, the P&P indicated, 5. The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43258 50282 Based on observation, interview, and record review, the facility failed to ensure multi-dose medications were dated with an open and discard date to ensure they were not used beyond the discard date. The deficient practices had the potential for residents to receive medications with unsafe and reduced potency from being used past their discard date. Findings: During a concurrent observation and interview on [DATE] at 12:30 p.m. with Licensed Nurse 6 (LN 6), an inspection of Medication Cart 5 (Med Cart 5) identified one Stiolto Respimat (a medication used to treat chronic obstructive pulmonary disease (a lung disease that makes it hard to breathe) 2.5 microgram/2.5 microgram (mcg, a unit of measurement) inhaler and one fluticasone/salmeterol (a medication to treat asthma (a lung disease that makes it hard to breathe) 500 mcg/50 mcg inhalers, both opened and unlabeled with open dates. LN 6 confirmed the manufacturer's labeling on Stiolto indicated, Discard 3 months after insertion of cartridge into inhaler. LN 6 confirmed the manufacturer's labeling on the fluticasone/salmeterol inhaler indicated, Discard the inhaler 1 month after removal from the overwrap. LN 6 confirmed both inhalers should have been labeled with an open date because the manufacturer's indicated a shorter expiration date after they were first used. During a concurrent observation and interview on [DATE] at 2:42 p.m. with LN 1, an inspection of Med Cart 1 identified three budesonide (a medication to treat asthma) 0.5 milligrams/0.2 milliliters (mg/ml, a unit of measurement) ampules not in a foil pouch. LN 1 confirmed the manufacturer's labeling on the exterior box indicated, Once the foil envelope is opened, use the ampules within 2 weeks. DO NOT DISCARD THE FOIL ENVELOPE UNTIL THE LAST AMPUULE IS USED. LN 1 confirmed nursing staff should have written an opened date on the package and stored the ampules in it in order to know when they expired. During an interview on [DATE] at 1:45 p.m. with Director of Nursing (DON), DON stated she was told to just keep the box that an inhaler came with and to follow the expiration date on the pharmacy label. During a review of the facility's P&P titled, Administering Medications, revised ,d+[DATE], the P&P indicated, 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. During a review of the facility's P&P titled, Storage of Medications, revised ,d+[DATE], the P&P indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51078 Based on observation, interview, and record review, the facility failed to ensure food safety when: 1. One container of prepared apple juice and one container of iced tea concentrate were found expired in the walk-in refrigerator. 2. A box soaked with cooking oil was found in the dry food storage area of the kitchen. 3. Cracked light cover found overhead in between the steam table and food prep area. Missing light covers found in the dry storage area. 4. No air gaps were found on the food production sink, the three compartment sink, and the large sink next to the dishwasher. These failures had the potential to result in food contamination which could cause illness in medically vulnerable residents who received and consumed food from the facility kitchen for a census 130. Findings: 1. A concurrent observation and interview on [DATE] at 11:25 a.m. with Dietary Aide 3 (DA 3) in the walk-in refrigerator., DA 3 confirmed that the container of prepared apple juice and the container of iced tea concentrate were expired and should have been thrown out yesterday on [DATE]. An interview on [DATE] at 10:41 a.m. with the Assistant Manager of Dietary Services (AMDS) stated the expectation is for staff to label all food items correctly and discard them on time. The result could be residents getting sick from expired food or beverages. A review of the facility's policy titled Food Receiving and Storage revised [DATE] indicated Foods shall be received and stored in a manner that complies with safe food handling practices .all foods stored in the refrigerator will be labeled and dated .beverages must be dated when opened and discarded after 72 hours. 2. A concurrent observation and interview on [DATE] at 10:41 a.m. with the AMDS., confirmed there were three overhead lights in the dry storage area with no covers and the large overhead light cover between the steam table and the food prep table was cracked and broken. The AMDS stated these items should be replaced and that is a safety issue of physical debris and dangerous particles going into food served to the residents. A review of the facility's policy titled Food Receiving and Storage revised [DATE] indicated Foods shall be received and stored in a manner that complies with safe food handling practices. A review of the facility's policy titled Maintenance Service revised December of 2009 indicated Maintenance service shall be provided to all areas of the building .responsible for maintaining the buildings .in a safe manner at all times. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A concurrent observation and interview with the Director of Dietary Services (DDS) on [DATE] at 11:36 a. m. in the dry food storage area., the DDS confirmed there was an undated container of oil sitting in a large box dated [DATE] that was soaked through with oil on all sides. The DDS stated the expectation was for staff to take the plastic container out of the box, label and date it, pour oil from the container, and then wipe clean to maintain a sanitary environment. A review of the facility's policy titled Food Receiving and Storage revised [DATE] indicated Foods shall be received and stored in a manner that complies with safe food handling practices .staff will maintain clean food storage at all times. 4. A concurrent observation and interview with the DDS on [DATE] at 10:50 a.m. in kitchen., the DDS confirmed there were no air gaps found under the food production sink, the three compartment sink, and the large sink next to the dishwasher. The DDS stated the danger of not having air gaps is the risk of backflow of contaminated water into the clean water system and that this could cause sickness to the residents. The facilitiy could not produce any policy, procedure, or guideline regarding air gaps in the kitchen. A review of the 2022 Federal FDA Food Code, Section ,d+[DATE].13 indicated, .an air gap between water supply inlet and the flood level rim of the plumbing fixture .shall be at least twice the diameter of the water supply inlet and may not be less than 25 millimeters (1 inch).		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 51078 Based on observation, interview, and record review, the facility failed to ensure restorative services were provided for one of 33 sampled residents (Resident 15) when Restorative Nursing Services (RNS - nursing interventions that help people maintain or improve a resident's physical, mental, and emotional well-being.) were not initiated. This failure resulted in Resident 15 failing to maintain the highest practicable level of physical, functional, and emotional well-being. Findings: A review of Resident 15's facesheet indicated she was admitted to the facility in September of 2024 with diagnoses' which included Primary Osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both knees, Heart Failure, Chronic Obstructive Pulmonary Disease(COPD-a chronic lung disease causing difficulty in breathing), Type 2 Diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified difficulty in walking. A review of Resident 15's BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated December 2024 indicated she was cognitively intact. An observation and interview on 01/28/25 at 08:26 a.m. with Resident 15 in her room., Resident 15 stated she had not received Physical Therapy (PT -treatment that helps you improve how your body performs physical movement) or Occupational Therapy (OT- uses everyday life activities to promote health, well-being, and ability to participate in important activities of life) in a very long time and she would like to. Resident 15 stated she had some PT/OT when she was first admitted but hasn't had any type of therapy in months. Resident 15 stated she feels like she is losing her ability to sit up, sit on the edge of the bed for meals, and sit in a wheelchair and would like to get back some of her independence and be able to do simple things on her own. Resident 15 further stated she has asked several of the staff about this and nothing ever happened. A concurrent interview and record review on 1/30/25 at 11:00 a.m. with Director of Rehabilitation (DOR), the DOR stated he remembered Resident 15 and talked to her regarding PT/OT. The DOR stated he went to see Resident 15 and he believed she refused treatment. The DOR stated that once a resident refuses treatment or are no longer authorized by insurance for PT/OT they are referred to the RNS program. The DOR further stated that Resident 15 probably refused RNS too. The DOR could not show proof in Resident 15's clinical record of refusals for PT/OT or RNS services. An interview on 1/30/25 at 11:29 a.m. with Resident 15, Resident 15 stated she did not know what RNS was and had not been offered services or been seen by a Restorative Nursing Assistant (RNA - Certified Nursing Assistant that carries out restorative nursing services). (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of a form titled Restorative Program Referral Form for Resident 15 dated 9/30/24 indicated Resident 15 was discharged from PT/OT and referred to the RNS program due to PT/OT not being authorized by Resident 15's insurance any longer. An interview on 1/31/25 at 09:36 a.m. with RNA 2, RNA 2 confirmed a referral for Resident 15 was found in the RNA referral binder. RNA 2 stated it is then the Director of Staff Development (DSD)'s responsibility was to put this information into the RNA tasks section of the EHR (electronic health record), the RNAs then complete the evaluation and services are performed. RNA 2 confirmed there were no orders entered in the task entry section of the EHR regarding an RNA referral or request for services for Resident 15. An interview on 1/31/25 at 09:46 a.m. with the DSD, the DSD stated anytime the RNA program is adding new orders a hard copy is provided to the DSD and the RNA program from the DOR. DSD stated she never received a restorative program referral form for Resident 15. The DSD stated the expectation is for the RNA referral form to be filled out by the DOR and given to the DSD who then adds a new order to the EHR and creates an RNA task. The DSD stated that clearly the process was not followed by staff for Resident 15 and she fell through the cracks. The DSD further stated all staff should be following the process and the system should be utilized to prevent this from happening so the residents don't suffer, and treatment is not delayed which could have greatly affected Resident 15's day to day life. The DSD stated the goal is to keep the residents at the highest level of functioning possible for as long as possible. A record review of Resident 15's OT Discharge Summary dated 9/30/24 indicated that Resident 15 was referred to the RNS program with the goal to maintain her current level of functioning, with a predicted outcome of good with consistent staff follow through. A record review of Resident 15's PT Discharge Summary dated 9/30/24 indicated that Resident 15 was recommended discharge to the RNP (restorative nursing program) with a goal to maintain current level of functioning with a predicted outcome of Excellent with consistent staff support. Excellent with participation in RNP. An interview on 1/31/25 at 12:55 p.m. with the Director of Nursing (DON), the DON stated that the expectation was to put in orders timely so there is no delay in treatment to the resident. The DON stated that if there is no order showing in the tasks for the RNA's it cannot be carried out. DON stated this process should have been completed so Resident 15 could get the care she needed to prevent a decline in Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), muscle strength, independence, and could cause depression. A review of the facility's policy titled Restorative Nursing Services revised July 2017, indicated Residents will receive restorative nursing care as needed to help promote optimal safety and independence .Residents may be started on a restorative nursing program .when discharged from rehabilitative care .Restorative goals may include .maintaining his/her dignity, independence, and self-esteem.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43247 Based on observation, interview, and record review, the facility failed to maintain an effective infection control program when: 1. The facility did not implement proper infection control for two of 33 sampled residents (Resident 85 and Resident 301) when staff entered rooms of residents on droplet precautions without donning proper PPE (personal protective equipment- equipment worn to minimize exposure to infection); 2. The facility did not offer six out of 33 sampled residents (Resident 108, Resident 35, Resident 3, Resident 48, Resident 16, and Resident 110) to wash or sanitize their hands before meals; 3. Enteral feeding (providing nutrition) through a gastrostomy (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) equipments were not labeled and changed as scheduled. 4. A glucometer (a medical device used to test blood sugar levels) was not cleaned and disinfected by a wipe that was approved to be safe and effective by the manufacturer. These failures increased the risk of spreading infections and or transmission of diseases to the 130 vulnerable residents residing in the facility. Findings: 1. A review of Resident 85's Admission Record indicated Resident 85 was admitted to the facility in August 2023 with multiple diagnoses including Alzheimer's disease (a disease that destroys memory and other important mental functions), epilepsy (seizure disorder), and severe protein calorie malnutrition (the body is severely deficient in protein and calories). A review of Resident 85's Minimum Data Set (MD'S- a federally mandated assessment tool), Cognitive Patterns, dated 12/23/24, indicated Resident 85 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 3 out of 15 that indicated Resident 85 was severely cognitively impaired. A review of Resident 85's roommate's clinical record indicated roommate was positive for Influenza A on 1/23/25. A review of Resident 301's Admission Record indicated Resident 301 was admitted to the facility in January 2025 with multiple diagnoses including bilateral osteoarthritis of the hip (degenerative joint disease affecting both joints that occurs when cartilage cushioning the hip joints breaks down), malignant neoplasm of the prostate (cancer of the prostate), and malignant neoplasm of the bone (cancer of the bone). A review of Resident 301's MDS, Cognitive Patterns, dated 1/14/25, indicated Resident 301 had BIMS score of 13 out of 15 that indicated Resident 301 was cognitively intact. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 301's SBAR [Situation, Background, Assessment, Recommendation] Communication Form, dated 1/25/25, indicated .Positive for influenza .Resident's .test results came back positive for influenza .Droplet precautions [a set of infection control measures used to prevent the spread of respiratory infections, these precautions include wearing mask, using PPE including gown, gloves and faceshields] initiated . A review of Resident 301's Order Summary Report indicated order dated 1/28/25, Droplet isolation: Influenza A every shift for influenza A for 10 days . During the initial tour of the facility conducted on 1/28/25 beginning at 6:01 a.m., observed signs posted at door of rooms of Resident 85 and Resident 301. The signs indicated Droplet and Contact Precautions, Staff Required to Wear Gown & Gloves. Observed PPE cart outside of rooms. During a concurrent observation and interview on 1/28/25 at 7:28 a.m. observed Certified Nursing Assistant (CNA) 8 enter Resident 301's room wearing mask, carrying coffee cup. CNA 8 did not put on gown or gloves before entering room. Observed CNA 8 put on gloves inside room. When CNA 8 exited room, CNA 8 acknowledged the droplet precautions sign at door. CNA 8 stated Resident 301 was on precautions for influenza, but had just started her shift and had not received report on isolation. CNA 8 stated, Should have worn gown and gloves. During an observation on 1/ 28/25 at 8:49 a.m., observed CNA 2 enter Resident 85's room. CNA 2 was wearing a mask, but did not put on gown or gloves before entering room. During an interview on 1/28/25 at 9:17 a.m. with CNA 2, when asked why she did not wear gown or gloves when entering Resident 85's room, CNA 2 stated she was providing care to Resident 85 and the the droplet precautions only apply to Resident 85's roommate who is positive for Influenza A and not to Resident 85. During an interview on 1/28/25 at 9:20 a.m. with Licensed Nurse (LN) 1, reviewed observation of CNA 2 who entered Resident 85's room without putting on gown or gloves. LN 1 stated staff need to wear gown and gloves when entering rooms with droplet precautions and it does not matter which resident is being seen. During an observation on 1/28/25 at 2:39 p.m. observed CNA 2 again enter Resident 85's room without putting on gown or gloves. During an interview on 1/29/25 at 8:47 a.m. with LN 10, LN 10 stated staff need to wear gown, gloves, and mask when caring for either patient in room with positive influenza and droplet precautions. During an interview on 1/29/25 at 9:29 a.m. with the Infection Preventionist (IP), the IP stated all staff are to wear full PPE with all residents in transmission based precaution (infection control precautions used in addition to standard precautions) rooms. The IP stated, Should know by now to wear full PPE. Have had several inservices. The IP stated staff must switch PPE between residents in same room and should wear N-95 masks (mask worn to protect against airborne particles) due to airborne and droplet precautions. The IP confirmed an Influenza outbreak in the facility. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy and Procedure (P&P) titled Infection Prevention and Control Program, revised 10/18, indicated . An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Prevention of Infection .instituting measures to avoid complications or dissemination .educating staff and ensuring that they adhere to proper techniques and procedures .implementing appropriate isolation precautions when necessary . A review of the facility's P&P titled Influenza Outbreak, revised 10/19, indicated .Contact and droplet precautions are implemented during care of residents with suspected or confirmed cases of influenza, in addition to standard precautions used with all residents regardless of symptoms . A review of the facility's P&P titled Personal Protective Equipment, revised 10/18, indicated .PPE required for transmission-based precautions is maintained outside and inside resident's room, as needed .Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with personnel policies . 38834 2. During an observation and interview on 1/28/25, at 8:15 a.m., Resident 108 was observed sitting in bed. Resident 108 stated that there was a big issue with handwashing. Resident 108 added, Lots of us use our hands to push our wheelchairs around and the floors are not always clean. Our hands are dirty and we are never offered to wash our hands or to sanitize with wipes before breakfast, lunch, and dinner. I literally have to beg for one to clean my hands. During an observation and interview on 1/29/25, at 8:55 a.m., Resident 3 was observed awake and sitting in bed. Resident 3 stated the staff were too busy, They bring the food, leave and disappear .They never offer to wash my face and hands before meals . unless I specifically request it, and it might take a while until they come and bring me washcloth to refresh my hands before eating .You push the call button to ask for wipes or washcloth, wait and wait and eat without washing hands because by the time they come, the food is cold. I literally have to beg my CNA [Certified Nursing Assistant] to wash my face and hands. During an observation on 1/29/25, at 12:20 p.m., the Department observed staff starting to pass lunch trays in 20's hall. A plastic caddy with two containers of hand sanitizer wipes and two bottles of alcohol sanitizer was observed on top of the food cart. The staff were observed sanitizing their hands before taking the tray to residents and after serving food. CNA 2 sanitized her hands before placing lunch in front of resident sitting in wheelchair next to room [ROOM NUMBER]. CNA 2 removed plate cover, opened milk but did not offer to sanitize residents hands. CNA 2 sanitized her hands and placed lunch tray for a resident sitting in the hall between room [ROOM NUMBER] and 26. CNA 2 did not offer to sanitize residents hands. During an observation and interview on 1/29/25, at 12:20 p.m., Resident 48 was observed in bed with clean cloth napkin worn around her neck. Resident 48 stated, They brought a bib but did not offer handwashing. They never do. Nobody offers handwashing to clean my hands. No wipes. Never. A few minutes letter CNA 2 brought Resident 48's lunch and placed on the table in front of the resident. CNA 2 did not offer Resident 48 sanitizing wipes or alcohol hand sanitizer to refresh her hands. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Casa Coloma Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10410 Coloma Rd Rancho Cordova, CA 95670	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25, at 12:36 p.m., staff started passing lunch trays in 30's hall. A plastic caddy with two containers of hand sanitizer wipes and two bottles of alcohol sanitizer was placed on top of the food cart. Several staff started passing trays and sanitized hands before and after serving a tray, but did not offer to sanitize hands when serving lunch to three residents in room [ROOM NUMBER]. On 1/29/25, at 12:39 p.m., observed staff delivering lunch tray to Resident 16. Resident 16 was sitting on the edge of bed with her tray in front of her. Resident 16 was observed wiping her hands with sanitizing wipes. Resident 16 stated, Today was the first time ever they offered wipes to clean my hands. Feels so good and refreshing to have clean hands before touching my food. On 1/29/25, at 12:42 p.m., observed Resident 35 sitting in bed wiping her hands with sanitizing wipes. Resident 35 stated, It's something new. Today was the first time in many months I had wipes. They never do. During an interview, Resident 35 stated it felt so good to have her hands sanitized before a meal. Resident 35 stated the staff were great but there was an issue with handwashing. Resident 35 stated that nobody offered washcloth or wipes before meals and added, Sometimes I ask to wash my hands, sometimes eat without washing. During an interview on 1/29/25, at 12:56 p.m., Resident 110 stated, They never offer me to wash my hands before meals. I would love to have my face washed and hands washed before I eat breakfast but its not happening here. A review of the facility's policy titled, Handwashing/Hand Hygiene, revised 8/2019, indicated, The facility considers hand hygiene the primary means to prevent the spread of infections .Residents .will be encouraged to practice hand hygiene. A review of the 'Preparing the Resident for a Meal' policy dated 9/2010, directed staff to provide warm water . soap .wash cloth .towel .Fill the basin with warm water and take it to the resident's bedside .Encourage the resident to wash his or her face and hands. Assist as needed. Dry the face and hands with a towel. During an interview with Infection Preventionist nurse (IP) on 1/31/25, at 11:45 a.m., the IP verified staff should ensure hand hygiene was done for the residents before and after meals. IP stated hand hygiene was very important step to prevent infections. 36681 3. A review of the clinical record indicated Resident 36 was admitted [DATE] with diagnoses including encounter for attention to gastrostomy (surgically inserted stomach tube for feeding) and dysphagia (difficulty swallowing). A review of Resident 36's Order Summary Report indicated the following: - a physician order dated 1/22/25 indicated, .TUBE FEEDING: .Provide ISOSOURCE 1.5 @45 ML/HR [hour] VIA PUMP X 8 HRS - to provide 360 ml .Off @ 0300am and On @ 1900 or until dose met .; and, -a physician order dated 2/14/24 indicated, .every 4 hours Free WATER FLUSHES at 100 ml via G-tube. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/28/25 at 8:48 a.m., inside Resident 36's room, the G-tube feeding was off. Resident 36's feeding bag was labeled with the name, date & time started 1/26 @ 0200. There was no label and cover on the feeding tube. In a concurrent observation and interview on 1/28/25 at 2:16 p.m. with Licensed Nurse 7 (LN 7), inside Resident 36's room. The LN 7 confirmed there was no date and cover on the feeding tube. The LN 7 stated the feeding bag should have been discarded within 24 hours. The LN 7 further confirmed there was no date on the 60 milliliter (ml, unit of volume) syringe at Resident 36's bedside. The LN 7 further stated the syringe should have been dated. A concurrent interview and record review was conducted on 1/31/25 at 7:37 a.m. with the Director of Nursing (DON), the DON stated her expectation was for the feeding bag, feeding tube, and syringe to be dated. The DON stated the feeding, bag, the tubing and the syringe should be changed daily. The DON further stated the nurses were trained to have the cover on the tip of the tubing and to label the syringe with a permanent pen once used. The DON added this was an infection control issue. In a follow-up interview on 1/31/25 at 10:34 a.m., the DON stated Resident 36's feeding was good for 48 hours. A review of the facility's policy and procedure (P & P) revised November 2018 and titled, Enteral Feedings - Safety Precautions indicated, To ensure the safe administration of enteral nutrition .The facility will remain current in and follow accepted best practices in enteral nutrition .Maintain strict adherence to maximum hang times .Sterile formula in a closed system has a maximum hang time of 48 hours. The facility was unable to provide P & P for Labeling/Dating of feeding bag, tubing and syringe used for water flush upon request. 50282 4. During a concurrent observation and interview on 1/28/25 at 12:51 p.m. with Licensed Nurse 1 (LN1), LN 1 wiped an EvenCare G3 glucometer after testing a resident's blood sugar with a Micro Kill One wipe. LN 1 wiped the glucometer then placed the glucometer on top of the medication cart. LN 1 stated she was told by the Director of Nursing (DON) to use Micro Kill One wipes to clean the glucometers. During an interview on 1/29/25 at 10:46 a.m. with Infection Preventionist (IP), IP stated any equipment used during resident care was to be disinfected after each use. She stated nursing staff were provided training to use the Micro Kill with Bleach wipes to sanitize and disinfect glucometers. During an interview on 1/29/25 at 11:03 a.m. with LN 8, LN 8 stated it was safe and effective to use either a Micro Kill One or a Micro Kill with Bleach wipe to clean glucometers after resident use. During an interview on 1/29/25 at 11:05 a.m. with LN 1, LN 1 stated Micro Kill One wipes were the ones she used to sanitize and disinfect glucometers. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/29/25 at 2:04 p.m. with DON, DON stated the guideline for cleaning and disinfecting the glucometer after use was to use a Micro Kill with bleach wipe for one minute, then dry before use on the next resident. DON stated there were monthly in-services regarding the use and cleaning of glucometers. A review of the Evencare G3 glucometer manufacturer's cleaning and disinfecting instructions indicated, The following products have been approved for cleaning and disinfecting the Evencare G3 Meter: Dispatch Hospital Cleaner Disinfectant towels with bleach, Medline Micro-Kill+ Disinfecting, Deodorizing, Cleaning Wipes with Alcohol, Clorox Healthcare Bleach Germicidal and Disinfectant Wipes, Medline Micro-Kill Bleach Germicidal Bleach Wipes. According to the Centers for Disease Control and Prevention (CDC, a nationally recognized leader in science-based, data driven, service organization that protects the public's health) in an article titled, Considerations for Blood Glucose Monitoring and Insulin Administration, undated, the article indicated, Recommend practices in healthcare settings . Blood glucose meters . If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents . During a review of the facility's P&P titled, Obtaining a Fingerstick Glucose Level, revised 10/2011, the P&P indicated, 18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice . 43258		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43247 Based on observation and interview, the facility failed to ensure 32 resident rooms (rooms 21-29, 31-38, 40, 42-49, 53, 55-59) met the required 80 square feet (sq. ft.) per resident. This failure had the potential to result in inadequate space for the provision of care and decreased quality of life for residents residing in these rooms. Findings: Multiple observations were conducted throughout the facility of resident care in rooms with less than 80 sq ft during the survey. During an interview on 1/28/25 at 8:50 a.m. with the Administrator (ADM), the ADM stated there are no rooms with a current room waiver. During an interview on 1/29/25 at 8:26 a.m. with the ADM, the ADM stated the facility does not have any current room waivers. Requested room measurements for rooms with three residents. The ADM provided room measurements, all rooms with three residents: room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 223.9 with 74.6 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 219.6 with 73.2 sq. ft. per resident room [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per resident room [ROOM NUMBER] at 219.8 with 73.2 sq. ft. per resident room [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per resident (continued on next page)		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] at 219.8 with 73.2 sq. ft. per resident room [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per resident room [ROOM NUMBER] at 226.9 with 75.6 sq. ft. per resident room [ROOM NUMBER] at 226.3 with 75.4 sq. ft. per resident room [ROOM NUMBER] at 230.2 with 76.7 sq. ft. per resident room [ROOM NUMBER] at 217.2 with 72.4 sq. ft. per resident room [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per resident room [ROOM NUMBER] at 217.2 with 72.4 sq. ft. per resident room [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per resident room [ROOM NUMBER] at 217.2 with 72.4 sq. ft. per resident room [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per resident room [ROOM NUMBER] at 217.2 with 72.4 sq. ft. per resident room [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per resident room [ROOM NUMBER] at 225.7 with 75.2 sq. ft. per resident room [ROOM NUMBER] at 225.7 with 75.2 sq. ft. per resident During an interview on 1/29/25 at 9:58 a.m. with Resident 15, Resident 15 stated with three people to a room, your care needs affect the other two people because the room is so small. Resident 15 stated she sometimes knocks over other resident's bedside table, garbage can, and personal belongings. Resident 15 stated she is fine with the room, but feels bad for the other two residents. During an interview on 1/29/25 at 10:00 a.m. with Resident 104, Resident 104 stated that she feels her privacy is compromised with three people to a room. Resident 104 stated there is no privacy for personal conversations and some subjects are embarrassing so does not want everyone to hear about it. Resident 104 stated it bothers her a lot, but there's nothing she can do about it. (continued on next page)		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 1/29/25 at 10:02 a.m. with Resident 83, Resident 83 stated it is very crowded with three residents to a room because everyone has a wheelchair. Resident 83 stated that it is hard when staff bring food in and difficult because there is only one television so they have to agree on what to watch. Resident 83 stated privacy during conversations is terrible, because everyone in the room can hear what you are saying. Resident 83 further stated having visitors is difficult because there is no privacy. During an interview on 1/29/25 at 2:03 p.m. with Resident 87, Resident 87 was sitting at bedside in wheelchair with transfer pole at bedside. When Resident 87 was asked about the size of the room, Resident 87 stated, Could have more room, but don't move around much in the room. During an interview on 1/29/25 at 2:04 p.m. with Resident 115, Resident 115, when asked about the size of the room, stated it was pretty small with not a lot of room to get in and out of bed. During an interview on 1/29/25 at 2:05 p.m. with Resident 41, Resident 41, when asked about the size of the room, stated there was not enough room. Resident 41 stated, Too crowded in here. During an interview on 1/29/25 at 2:08 p.m. with Licensed Nurse (LN) 1, LN 1 stated they have to position the beds to have enough room to get residents in and out of bed. LN 1 stated she has not heard any complaints from residents about the size of the rooms. During an interview on 1/29/25 at 2:09 p.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 stated she makes sure there is enough room to get residents in and out of bed. During an interview on 1/29/25 at 2:11 p.m. with Resident 101, Resident 101, when asked about the size of the room, stated there is a lot of people in this room. Resident 101 stated the cubicles are a drawback. During an interview on 1/29/25 at 2:14 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated the room size is a little bit of an issue with moving beds to make room for transfers. CNA 3 stated she has not heard any complaints from residents about the size of the rooms. During an interview on 1/29/25 at 2:20 p.m. with CNA 1, CNA 1 stated, on individual occasions the room size can slow work down because you have to stop and move equipment. CNA 1 stated some of the things to be moved are residents' personal items and it makes her nervous to move them. CNA 1 further stated that overall the rooms are not bad to work in. During an interview on 1/29/25 at 2:25 p.m. with Resident 137, Resident 137 stated she moves in her wheelchair by pedaling and the main part of the room has equipment and other things in the way. Resident 137 stated it is sometimes hard to move in the wheelchair and she has to ask for help to move in and out. During an interview on 1/29/25 at 2:30 p.m. with Resident 32, Resident 32 stated she goes to physical therapy and relies on staff for Activities of Daily Living (ADSL). Resident 32 stated the room size is fine and does not feel tight to her. Resident 32 stated staff have not had a problem helping her. (continued on next page)		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Room observations and interviews with available staff, and residents currently residing in the rooms containing less than 80 square feet per resident, reflected adequate space for the provision of care. A review of the facility's past recertification surveys indicated the facility had a Change of ownership (CHOW) after 2019's recertification survey when the waiver continuation was recommended. On 2/12/25, the Administrator in an email reported he was requesting a continuation of room waiver for all the rooms listed. The Department recommends continuation of the waiver for the above mentioned rooms		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 43247 Based on observation, interview, and record review, the facility failed to provide one of 33 sampled residents (Resident 117) with an accessible call light, when Resident 117's call light was bundled up and attached to the call light plate out of Resident 117's reach. This failure resulted in Resident 117 not able to call for assistance for care needs causing an increased risk for falls. Findings: A review of Resident 117's Admission Record indicated Resident 117 was admitted to the facility in April 2024 with multiple diagnoses including protein calorie malnutrition (inadequate intake of protein and calories causing adverse effects on the body), weakness, and abnormality with gait and mobility. A review of Resident 117's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 12/27/24, indicated Resident 117 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 11 out of 15 that indicated Resident 117 was moderately cognitively impaired. A review of Resident 117's MDS, Functional Abilities, dated 12/27/25, indicated Resident 117 required moderate assistance or supervision for toileting, bathing, dressing, and hygiene and supervision for bed mobility and transfers. A review of Resident 117's Care Plan, initiated 4/28/24, . At risk for falls/injury due to ADM DX [Admission Diagnosis]: OTHER ABNORMALITIES OF GAIT AND MOBILITY .interventions/Tasks .Encourage/Remind resident to ask for help when needed if able .Keep environment free of hazards, clutter free, call light within reach . A review of Resident 117's Care Plan, initiated 4/28/24, .Resident requires assistance from staff for bed mobility related to weakness and decreased strength. Unable to turn and reposition self in bed without physical assistance from staff .Interventions/Tasks .Educate resident to call for assistance using call light in case to get up or reposition . During an observation on 1/28/25 at 6:01 a.m. of Resident 117, observed Resident 117 in bed and call light not in reach. Observed to the right of Resident 117's bed on the wall, a call light plate with a call light cord coiled and bundled up with plastic tie and a call light cord cut off with no call light attached. During a joint observation and interview on 1/28/25 at 6:54 a.m. with Licensed Nurse (LN) 1 and LN 9, LN 1 confirmed that Resident 117 did not have an accessible call light. LN 1 stated the call light with the cord cut was working yesterday but broke. LN 9 stated the broken call light should have been put in the maintenance log, but had not been done yet and will do it this morning. LN 1 provided coiled up call light to Resident 117. When asked what is the potential harm to the resident if does not have accessible call light, LN 1 stated the resident could fall. LN 1 stated, The expectation is that they will have a call light within reach. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 7:10 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated the expectation is that residents will have a call light within reach so they can call for assistance. A review of the facility's policy and procedure (P&P) titled Call Systems, Resident, dated 9/22, indicated . Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station .Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/ bathing facilities and from the floor .The resident call system remains functional at all times .The resident call system is routinely maintained and tested by the maintenance department .		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38834 Based on observation, interview, and record review, the facility failed to ensure 5 out of 33 sampled residents (Resident 3, Resident 108, Resident 137, Resident 20, and Resident 110) were provided with hot water in the bathroom sinks. In addition, the entire Hall 30's which housed 24 residents had no hot water in bathroom sinks when the heater pump was turned off for over 20 days period. This failure resulted in multiple residents not having comfortable water to wash their hands and faces and negatively impacted their physical wellbeing, and had the potential to result in delayed provision of care. Findings: During an observation and interview on 1/29/25, at 8:55 a.m., Resident 3 was observed awake and sitting in bed. Resident 3 stated it took 15 - 20 minutes to get luke warm water from the bathroom sink. Resident 3 added, I can never wash my face and hands there. I have rheumatoid arthritis [RA, an autoimmune disease that affects joints, causing pain and stiffness] and ice cold water in the sink is very uncomfortable on my hands . I can't stand that long waiting for water to get warm, I am not that strong. Resident 3 stated that she had observed Certified Nursing Assistants [CNAs] turning water on and let it run for long time while going around and doing other things and added, Some of the CNAs told me that it's an issue with the entire hall. Resident 3 continued, I have talked to maintenance and was told that something wrong with the plumbing and it will take long time to fix the issue .Nobody offers us washcloth or wipes unless I specifically request it and it might take a while until they come and bring me washcloth to refresh my hands before eating. Resident 3 added that she even wrote a letter regarding issues with cold water and asked one of the CNAs to give it to the administrator. On 1/29/25, at 8:59 a.m., the Department turned water on in the shared bathroom sink between room [ROOM NUMBER] and 38. The cold water was running for 14 minutes until it became lukewarm. The Department let the water run for another 10 minutes, but it never warmed up to be warm and comfortable. A review of the admission record indicated the facility admitted Resident 3 in 2024. Resident 3's medical history indicated that the resident had multiple diagnoses which included rheumatoid arthritis versus lupus (autoimmune disorder with symptoms similar to RA). Resident 3's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 11/18/24, indicated Resident 3 was cognitively intact and had no delusions or hallucinations. During an observation on 1/29/25, at 9:07 a.m., the faucet in the bathroom sink between room [ROOM NUMBER] and 34 was observed on for unknown period of time running cold water while the CNA assisted resident in room [ROOM NUMBER]. The water run cold for another 8 minutes and then started getting lukewarm. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Casa Coloma Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 108 on 1/29/25, at 9:15 a.m., Resident 108 stated the she liked to have her face and hands washed before eating breakfast, but it took at least 20-30 minutes to get the water lukewarm. Resident 108 stated it had been a few weeks that this hall had issues with cold water and added that the staff were aware about it. A review of the admission record indicated the facility admitted Resident 108 in 2023 with multiple diagnoses which included heart and kidney diseases. Resident 108's MDS dated [DATE] indicated Resident 108 was cognitively intact and had no delusions or hallucinations. During an interview on 1/29/25, at 9:14 a.m., CNA 1 stated it took longer to get the water to warm up in bathroom sinks in this hall. CNA 1 stated, 7-10 minutes, some rooms longer . Turn water on, get supplies, and do other things and let the water run .Reported to maintenance and administrator. Was told they are working on it. CNA 1 stated residents in this hall complained of cold water and that they could not wash their faces and hands. During an interview on 1/29/25, at 9:42 a.m., Resident 137 was observed in wheelchair in the hall next to her room. Resident 137 stated, The water is always so cold. I have rheumatoid arthritis and can't even wash my hands after using the bathroom. Resident 137 added, I use wipes, washing my hands in warm water is a luxury here. A review of the admission record indicated the facility admitted Resident 137 in 2024 with multiple diagnoses which included rheumatoid arthritis and heart disease. Resident 137's MDS dated [DATE] indicated Resident 137 was cognitively intact. During an interview, observation and record review on 1/30/25, commencing at 7:50 a.m., the Director of Maintenance (DM) confirmed that the facility had issues with hot water in 30's hall and added, Water heater pump is leaking, we need to replace it. The DM stated the water heater leak in affected area was identified 20 days ago and the pump that warms water was turned off. The DM stated the facility's water temperatures were checked at least once a month and provided the water temperature log for January 2025. According to the log dated 1/24/25, the water temperatures were not checked in bathroom sinks between room [ROOM NUMBER] and 33, 32 and 34, 35 and 37, 36 and 38 due to water heater doesn't work, need to replace. On 1/30/25, at 7:58 a.m., accompanied by DM and Administrator (ADM) the water temperature testing was conducted in the shared bathroom sink between room [ROOM NUMBER] and 34. At 8 a.m., water was chilly cold and the temperature indicated 61 degree F (Fahrenheit). At 8:04 a.m., the water temperature indicated 57 degree F, and at 8:08 a.m., the water temperature was 55 degree F. The DM stated there was no reason to test the water longer because water won't get warm. The ADM acknowledged that 55 to 61 degrees F indicated the water was freezing cold and not at unacceptable range. The ADM was asked how the facility responded to the issue with cold water and what alternatives were used to ensure the water was comfortable for residents. The ADM stated that the facility staff was in-serviced recently on what to do if no hot water available and were instructed to get the hot water from utility room and provide for each resident to wash face and hands before breakfast. On 1/30/25, at 8:03 a.m., Resident 20 was interviewed in presence of DM and ADM. Resident 20 was sitting in bed and had her breakfast tray in front of her. Resident 20 stated, Nobody offered me water or washcloth to wash my face and hands this morning. Resident 20 declined to explain if the staff offered her warm water to refresh face and wash hands in the past. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Casa Coloma Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25, at 8:05 a.m., Resident 137 pulled up in her wheelchair to the entrance of her room and stated, It takes 20 minutes to get water lukewarm. I am unable to wash my face and hands due to freezing cold water. Nobody ever offers us warm water to wash our faces and hands. On 1/30/25, at 8:10 a.m., Resident 110 was observed sitting in bed and eating breakfast. Resident 110 stated, I was not offered warm water to wash my face and hands. They never do, except yesterday at lunch, they gave me wipes to sanitize my hands. During a continued interview on 1/30/25, commencing at 7:58 a.m., ADM acknowledged that Resident 20, Resident 137, and Resident 110 responses regarding the CNAs offering them warm water in the morning to wash faces and hands. The ADM did not provide answer when asked if the staff followed the instructions and provided each resident with warm water before breakfast to wash their faces and hands. During an interview on 1/30/25, at 8:35 a.m., CNA 5 stated there was an issue with cold water in bathroom sinks in Hall 1 and the administration was aware about it. CNA 5 stated she offered warm water to refresh residents' faces and hands before serving breakfast in some of her rooms earlier today. During a continued interview, CNA 5 changed her story and stated, I gave them breakfast and then will provide basins with warm water to wash faces and hands. During a follow up interview on 1/30/25, at 9:25 a.m., the ADM stated the facility was working to have the water heater pump replaced and provided two quotas obtained on 1/15/25 and 1/26/25. A review of the facility's 'Water Supply' policy dated 12/2009, indicated, Water temperatures are monitored by the Director of Maintenance or Director of Environmental Services. Temperatures should be monitored at least monthly and logged by the facility .Hot water distribution systems serving resident care area will be continuously recirculated .Should there be no access to hot water due to an emergency or broken equipment, facility shall work with local vendors to repair or replace broken equipment.		