

OK 1/19/12

PRINTED: 12/23/2011
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA03000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 AUBURN BLVD SACRAMENTO, CA 95841
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	<p>Initial Comments</p> <p>The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident # CA00262828.</p> <p>Representing the Department of Public Health: HFEN, 2450/29328</p> <p>The investigation was limited to the specific entity reported incident(s) investigated and does not represent the findings of a full inspection of the facility.</p> <div style="background-color: black; width: 200px; height: 40px; margin-top: 10px;"></div>	B 000		
B 223	<p>T22 DIV5 CH2 ART3-71213(d) Psychiatric Nursing Srv General Requirements</p> <p>(d) There shall be a written patient care plan developed for each patient in coordination with the total mental health team. This plan shall include goals, problems/needs and approach and shall be available to all members of the mental health team.</p> <div style="background-color: black; width: 300px; height: 60px; margin-top: 10px;"></div>	B 223		

Licensing and Certification Division

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

TITLE *CEO*
[Signature]

(X6) DATE
1/19/12

000

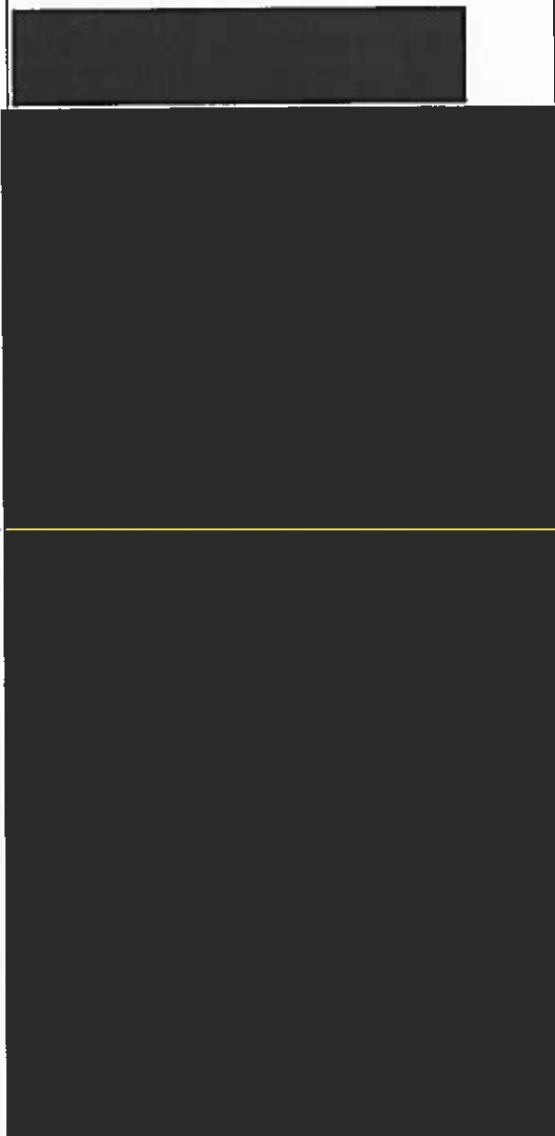
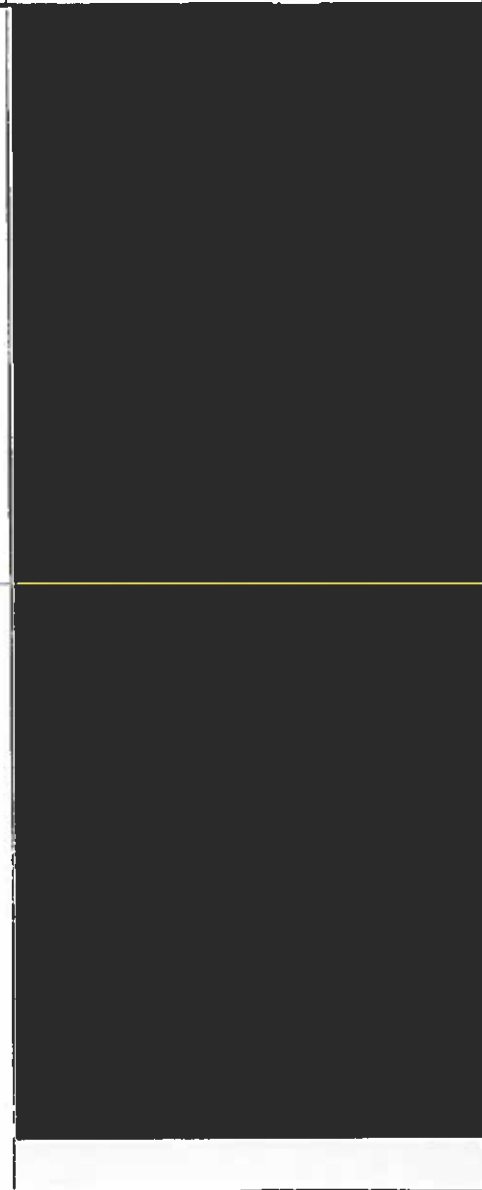
M3F011

If continuation sheet 1 of 9

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA030000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
--	---	--	---

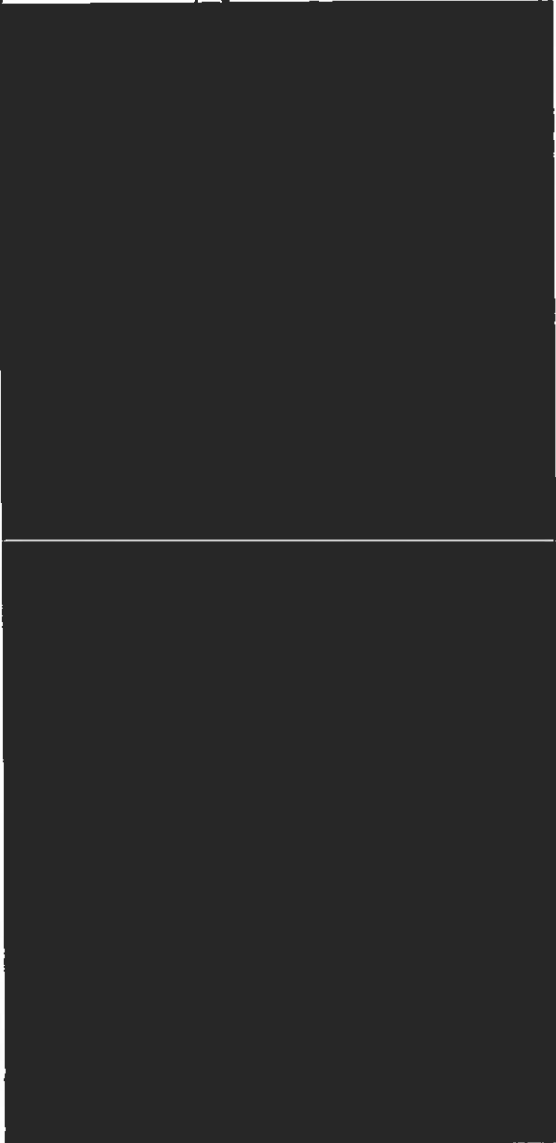
NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 AUBURN BLVD SACRAMENTO, CA 95841
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 223	Continued From page 1 	B 223		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA030000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
--	---	--	---



NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 AUBURN BLVD SACRAMENTO, CA 95841
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 223	Continued From page 2 	B 223		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA03000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
--	--	--	---

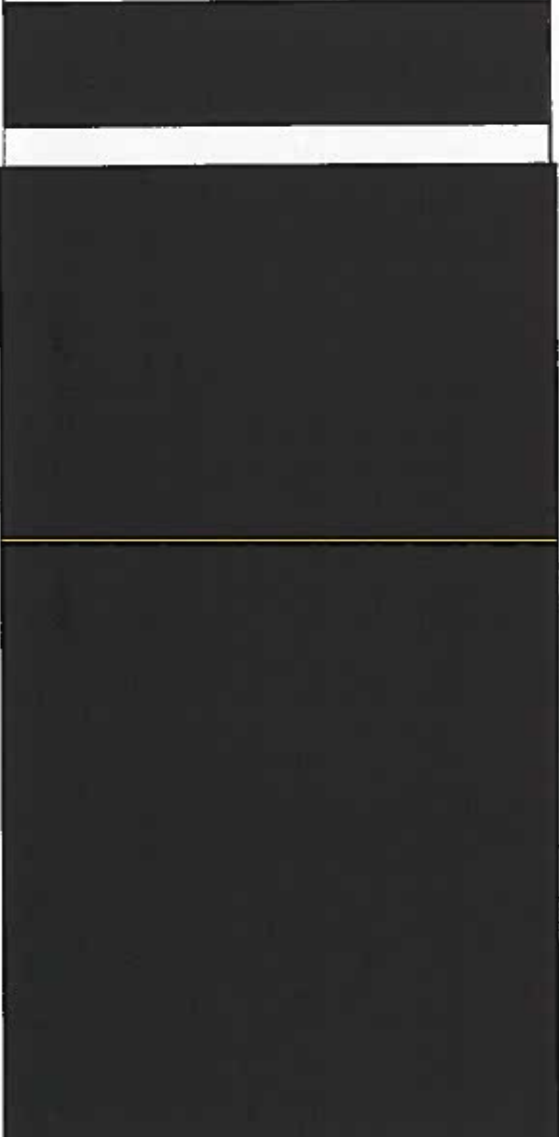

NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 AUBURN BLVD SACRAMENTO, CA 95841
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 223	Continued From page 3 	B 223		
B 451	T22 DIV5 CH2 ART6-71501(a)(6) Governing Body (6) Require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter. 	B 451		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA030000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
--	---	--	---

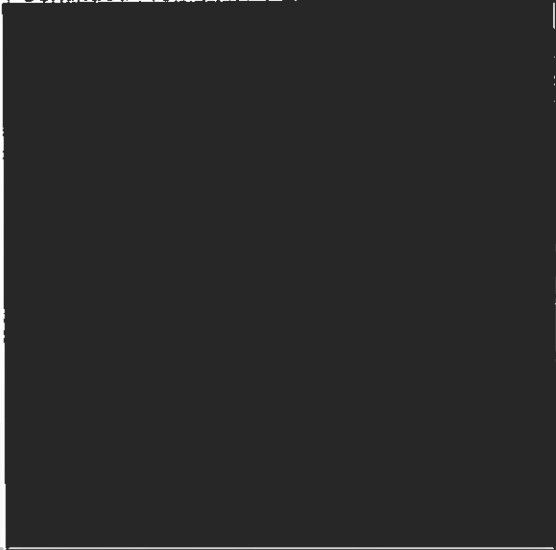

NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4260 AUBURN BLVD SACRAMENTO, CA 95841
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 451	Continued From page 4 	B 451		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA030000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 AUBURN BLVD SACRAMENTO, CA 95841
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 451	Continued From page 5 	B 451		
B 752	T22 DIV5 CH2 ART6-71641(a) General Safety and Maintenance 	B 752		

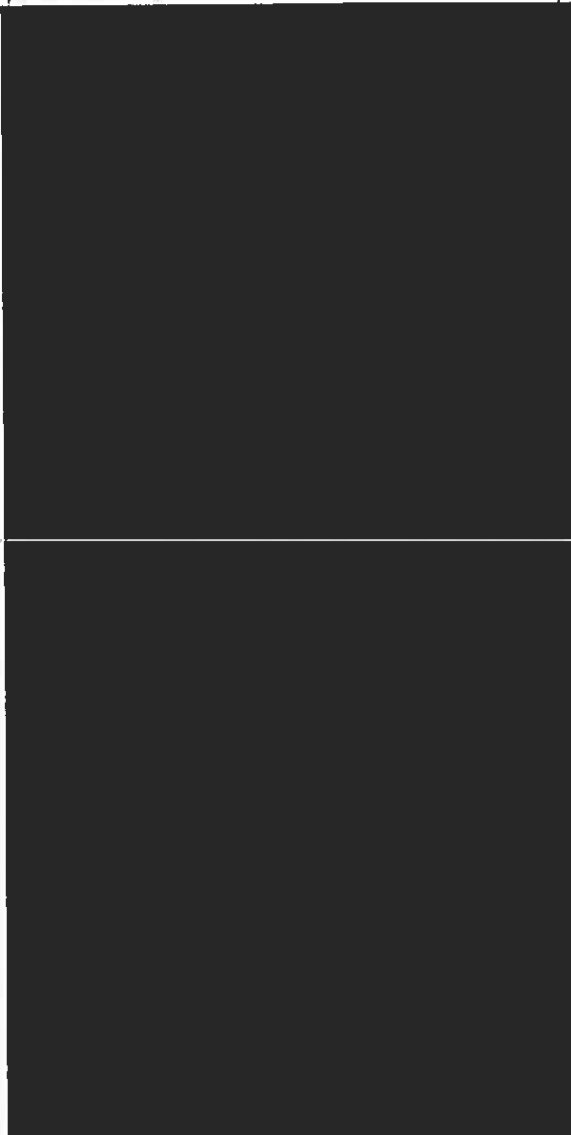
California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA030000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 4250 AUBURN BLVD SACRAMENTO, CA 95841		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 752	Continued From page 6 (a) The hospital shall be clean, sanitary, and in good repair at all times. Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors.	B 752		


California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA030000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4250 AUBURN BLVD SACRAMENTO, CA 95841
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 752	Continued From page 7 	B 752		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA030006822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2011
NAME OF PROVIDER OR SUPPLIER HERITAGE OAKS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 4250 AUBURN BLVD SACRAMENTO, CA 95841		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 752	Continued From page 8 	B 752		