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	555316	A. BUILDING _____ B. WING _____	03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPER RIDGE CARE CENTER	201 HARTNELL AVENUE REDDING, CA 96002

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted on 3/11/19 to 3/14/19. Eight facility reported incidents were investigated during the survey. Facility Reported Incidents: 627136, 626212, 624655, 621978, 621178, 618761, 600710, and 578916. Representing the Department: 29391, Health Facilities Evaluator Nurse (HFEN) 39737, HFEN 40204, HFEN 39942, HFEN 22705, HFEN No deficiencies were written for facility reported incidents 627136, 626212, 624655, 621978, 621178, 618761, 600710, and 578916. Census: 120 Sample Size: 24	F 000	Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 19, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Copper Ridge Care Center's credible allegation of compliance.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 4/18/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment when a cabinet/closet in one patient room (Room 28) had exposed particle board and rough edges. This failure had the potential for residents to feel	F 584	**F 584** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The exposed particle board and rough edges on the cabinet/closet in Room 28 have been smoothed and painted. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Environmental services inspected all rooms for a homelike environment. The inspection included exposed particle board or rough edges on the cabinets/closets in the patient rooms. Exposed particle board and rough edges were smoothed and painted when discovered. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur** The Environmental Services Supervisor in serviced Environmental Services department staff on April 3, 2019, and the Director of Nurses in serviced licensed nurses on March 28, 2019. The in-services covered the facility policies and regulations on maintaining a homelike environment in patient rooms, including prevention of exposed particle board or rough edges on patient cabinets/closets.	

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F 584	Continued From page 2 as if they were in an institutional setting and not at home. Findings: On 3/11/19 at 9:55 AM, during an observation of resident rooms 26-37, it was noted that the cabinet/closet in Room 28 was missing a large piece of trim on the left side of the upper door. The missing trim allowed the particle board of the door to be exposed. The area appeared to have been partially painted as evidenced by the difference in color of paint, and had sharp edges where the trim was no longer in place. The door also had a loose hinge which caused it to open at an odd angle. During a concurrent observation and interview on 3/11/19 at 2:55 PM with the housekeeper (HK), she was asked about the closet in Room 28 and how it was cleaned. HK stated she sprayed the area with disinfectant and then used a rag to clean it off. HK stated the area was "very rough" and that she believed the first time she noted the missing trim was 3-4 weeks ago. During a concurrent observation and interview on 3/13/19 at 10:09 AM, the Infection Control Nurse (ICN) was asked about the closet in Room 28, and was also informed of how the HK reportedly cleaned it. ICN stated that with the exposed wood, it probably wasn't being cleaned properly. ICN acknowledged the sharp edges and the loose hinge on the door were not appropriate, and stated maintenance either needed to repair it or replace it.	F 584	The Environmental Services Assistant designee will do monthly rounds in patient rooms to evaluate the rooms for a homelike environment, including exposed particle board or rough edges on the cabinets/closets. The inspection worksheets will be turned into the Administrator on a monthly basis. **How the facility plans to monitor its performance to make sure that solutions are sustained.** At the monthly and quarterly QA meetings, the Environmental Services Supervisor will report on whether the patient rooms have a homelike environment, including any rooms found to have exposed particle board or rough edges on the cabinets/closets, and what measures were taken to maintain a homelike environment. This information will be reported to the QA committee for action plan until 100% compliance is achieved for two or more quarters. **Date when corrective action will be completed.** 4/14/19	
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		

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F 636	Continued From page 3 §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636	**F 636** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** MDS assessments for residents 32, 46, 95 and 211 were already completed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** MDS assessments for residents currently in the facility were reviewed and are currently up to date and being timely completed. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur** The Director of Nurses in -serviced the MDS staff on March 27, 2019 and licensed nurses on March 28, 2019. The in-services covered facility policies and regulations on the timely completion of MDS assessments.	

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F 636	Continued From page 4 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met,as evidenced by: Based on interview and record review, the facility failed to complete the Comprehensive Minimum Data Set (MDS, a standardized resident assessment) within 14 calendar days of admission for four of 24 sampled residents (Residents 32, 46, 95, and 211). This failure had the potential to delay the development of a comprehensive care plan necessary to provide appropriate individualized care and services for each resident related to the care areas that would have been identified on the Comprehensive MDS. Findings: The Resident Assessment Instrument (RAI)	F 636	**How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nurses or ADON designee will report on status of timely completion of MDS assessments at weekly CSSR, and at the monthly and quarterly QA meetings. This information will be reported to the QA committee for action plan until 100% compliance is achieved for two or more quarters. **Date when corrective action will be completed.** 4/14/19	

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F 636	Continued From page 5 Manual gives clear guidance about how to complete the MDS. According to the RAI, Chapter 2 - page 7, "Assessment completion refers to the date that all information has been collected and recorded for the particular assessment type and staff have signed and dated that the assessment is complete." Page 9 of the RAI indicated that Comprehensive MDS assessments include Admission assessments. Page 15 of the RAI indicated that the Admission assessment completion date (Item Z0500B) must be no later than the 14th calendar day of the resident's admission (admission date +13 calendar days). A review of the facility's policy titled, "Comprehensive Assessments and the Care Delivery Process," dated 12/2016, indicated "Complete the Minimum Data Set within 14 days after admission.... These assessments are used to develop, review and revise the resident's comprehensive care plan." A review of Resident 32's clinical record indicated he was admitted to the facility on 10/23/18 with diagnoses that included anemia (a deficiency of red blood cells), coronary artery disease (blockage of one or more arteries that supply blood to the heart), peripheral vascular disease (a blood circulation disorder that causes the blood vessels to narrow, block, or spasm), and diabetes. A review of Resident 32's Admission MDS, dated 10/27/18, indicated that Item Z0500B was completed on 11/13/18. The 14th calendar day after Resident 32's admission was 11/5/18. The Comprehensive MDS assessment was completed eight days late.	F 636		

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F 636	Continued From page 6 A review of Resident 46's clinical record indicated she was admitted to the facility on 2/20/19 with diagnoses that included anemia, congestive heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), pneumonia, and chronic (long lasting) lung disease. A review of Resident 46's Admission MDS, dated 2/27/19, indicated that Item Z0500B was completed on 3/7/19. The 14th calendar day of Resident 46's admission was 3/5/19. The Comprehensive MDS assessment was completed two days late. A review of Resident 95's clinical record indicated he was admitted to the facility on 1/21/19 with diagnoses that included stroke (when the blood supply to part of your brain is interrupted or reduced, depriving brain tissue of oxygen), atrial fibrillation (an irregular, rapid heart rate), and urinary tract infection. A review of Resident 95's Admission MDS, dated 1/28/19, indicated that Item Z0500B was completed on 2/5/19. The 14th calendar day of Resident 95's admission was 2/3/19. The Comprehensive MDS assessment was completed two days late. A review of Resident 211's clinical record indicated he was admitted to the facility on 2/18/19 with diagnoses that included hip fracture (broken bone) and high blood pressure. A review of Resident 211's Admission MDS, dated 2/25/19, indicated that Item Z0500B was completed on 3/5/19. The 14th calendar day of	F 636		

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F 636	Continued From page 7 Resident 211's admission was 3/3/19. The Comprehensive MDS assessment was completed 2 days late. During an interview on 3/12/19 at 4:45 PM, the MDS Coordinator (MDSC) stated she collected and recorded information for the MDS. The MDSC stated she was aware the facility had not completed all Admission assessments within the 14 calendar day timeframe. The MDSC stated the facility had many admissions and there was a period of time that she was out sick. The MDSC confirmed that the Admission assessments for Residents 32, 46, 95, and 211 were not signed within 14 calendar days. The MDSC stated the assessments were signed by the Assistant Director of Nursing (ADON) and that she was often busy and out of the office frequently. During an interview on 3/12/19 at 4:55 PM, the ADON stated she was unaware that Admission assessments were not completed timely. The ADON stated that she cannot sign the assessments until they have been completed by the MDSC. During an interview on 3/14/19 at 7:55 AM, the facility Administrator stated the facility had three MDS nurses and it was his expectation that Admission assessments would be completed within 14 days of admission for all residents.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

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F 656	Continued From page 8 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 656	**F 656** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The care plan of Resident 23 was reviewed and revised accordingly. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All resident care plans for fall interventions, including call lights within reach, were reviewed and revised as necessary. The care plans will be reviewed and updated as necessary to include all care and services required for the residents. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur** An in-service was given the by DON to licensed nurses on March 28, 2019 on the facility's policy and regulations for the development and implementation of a comprehensive care plan for each resident.	

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F 656	Continued From page 9 review, the facility failed to revise and ensure all interventions in the fall care plan were individualized, appropriate, and implemented for one of 24 sampled residents (Resident 23). The call light was not within Resident 23's reach and she was unable to use it. This had the potential to result in a fall with serious injury and other unmet needs. Findings: A review of Resident 23's record indicated she was admitted to the facility on 7/6/18, with diagnoses that included a fractured left femur (broken thigh bone) and Alzheimer's disease (type of dementia that causes problems with memory, thinking, and behavior). Resident 23 was assessed as being at risk to fall and a fall care plan was started on 7/7/18. One of the interventions included keeping the call light within reach. On 3/11/19 at 9:35 AM, Resident 23 was observed in her room sitting in a wheelchair. Her call light was attached to the upper side rail of the bed and was not within reach. On 3/12/19 at 7:45 AM, Resident 23 was again observed in her room sitting in a wheelchair. The call light was not within reach, and was attached to the upper side rail of the bed. During an interview on 3/12/19 at 7:45 AM, the Director of Nurses (DON) confirmed the call light was not within Resident 23's reach. DON was asked if Resident 23 was able to use her call light. DON put the call light in Resident 23's hand and asked her to use it, but Resident 23 did not	F 656	The in-service covered the facility policy that fall care plans are individualized/resident-centered, and implemented for each resident. Fall care plan shall be reviewed during IDT daily stand-up meeting to ensure that the care plan is resident-centered; individualized and interventions are appropriate. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Licensed nurses shall review and revise care plan for fall during weekly summary documentation to ensure that it is individualized, appropriate and implemented. Medical Records staff shall audit the charts for fall care plan development and submit report to the DON for review. The DON and ADON's shall review care plans to ensure that the care plan for fall is resident-centered; individualized and appropriately implemented. As part of the fall prevention program, the staff shall check the call light placement during room rounds. The results of the audits will be reported in the weekly IDT fall meeting.	

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F 656	Continued From page 10 know how to use the call light. DON told Resident 23 she would get a bell for her to use. During a concurrent interview and record review on 3/14/19 at 9:30 AM, DON confirmed the fall care plan was started on 7/7/18 and reviewed on 3/11/19 when the nurses weekly note was documented, but that the care plan intervention regarding the call light was not revised at that time.	F 656	This information will be reported to the QA committee for action plan until 100% compliance is achieved for two or more quarters. **Date when corrective action will be completed.** 4/14/19	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide restorative nursing aide (RNA) therapy (services to ensure maintenance of	F 825	**F 825** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** Residents 101 and 106 were re-evaluated for the continuation of the RNA orders. Both residents will continue to have RNA . **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** The DON and the therapy department went over on all residents identifying who needs to be on RNA program and evaluated residents on current RNA for its continuation on April 1, 2019.	

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F 825	Continued From page 11 resident's optimum level of function) to two of 24 sampled residents (Residents 101 and 106), as often as ordered by the physician. This had the potential to result in a decrease in residents' range of motion, strength, ability to ambulate (walk), and ability to complete activities of daily living (activities related to personal care, including bathing, dressing, eating, toileting, transferring, and maintaining bladder and bowel function). Findings: 1. A review of Resident 101's record indicated he was admitted to the facility on 1/14/19, with diagnoses that included muscle weakness and difficulty walking. The record contained a physician's order, dated 2/21/19, for RNA therapy five times per week to start on 2/22/19. There was also a RNA therapy referral, dated 2/21/19, from the physical therapist, to start on 2/22/19. During an interview on 3/11/19 at 10:20 AM, Resident 101 said he has had RNA therapy only twice. A concurrent interview and record review was conducted with the Director of Nurses (DON) on 3/12/19 at 8:40 AM. A review of the RNA daily charting, in the electronic record and paper copy and weekly nursing charting, indicated the RNA therapy was ordered to start on 2/22/19, per the physical therapist's referral and the physician's order, for five times per week. The RNA therapy was not started until 2/26/19, four days after the ordered start date. The DON confirmed RNA therapy was started late, so for the first five days from 2/22/19 through 2/26/19, the resident	F 825	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur** An inservice was given by the DON to RNA staff on April 1, 2019 on the facility policies and procedures for RNA services including starting RNA services timely, proper charting, and communicating refusals or missed treatments so they may be rescheduled. Monthly RNA meetings shall be conducted to review residents that are appropriate for RNA services and appropriate RNA orders. Residents with RNA orders will be reviewed on the frequency of services to ensure the care and services shall be provided accordingly. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Medical records shall audit the RNA treatment sheets monthly to identify missed RNA and refusals. Audits will be given to the DON for review and for re-evaluation of care and services that were provided. Audit findings shall be reported to the QA committee for action plan until 100% compliance is achieved for two or more quarters.	

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	555316	A. BUILDING _____ B. WING _____	03/14/2019

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F 825	Continued From page 12 received RNA therapy one time. 2. A review of Resident 106's record indicated she was admitted to the facility on 9/2/16, with diagnoses that included difficulty in walking. The record contained a physician's order, dated 4/12/18, for RNA training for Nustep or OmniCycle (specialized exercise machines) and walking with a walker up to 1000 feet, five times per week. No therapy was documented by the RNA in the electronic record for the week of 2/12/19 through 2/18/19. During an interview on 3/12/19 at 11:11 AM, Resident 106 said she used the bicycle today, but was unable to state how many times per week she received therapy. During an interview on 3/12/19 at 4:25 PM, the DON reviewed the paper copy of the RNA charting for the above referenced week. The documentation indicated two days left blank (no therapy given to Resident 106), two days scheduled off, two refusals, and one therapy day. RNA B who was also present said usually if a day was left blank, that meant they (the RNAs) didn't get to that resident that day. DON said they were aware of some issues and have been working on it.	F 825	**Date when corrective action will be completed.** 4/14/19.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

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F 880	Continued From page 13 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880	**F 880** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The used urinal was discarded. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Each resident room was inspected for compliance with infection control policies and procedures, and used items were discarded as needed. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur** An in-service was given by the DON to licensed nurses on 3/28/19 and by the DSD to CNA's on 4/3/19 on the facility's infection control policies and procedures, including discarding used items. Environmental Services added a task to their daily rounds to inspect patient rooms for used items that present a risk to infection control, including discarding used items that are stored in patient showers.	

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F 880	Continued From page 14 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a sanitary environment when a used urinal (a container usually used for a male to urinate in) was stored in a shared shower in a resident room (Room 37). This failure had the potential to allow the spread of germs. Findings: During the initial tour of the facility on 3/11/19 at 10:05 AM, a urinal was observed in the shower of Room 37. Room 37 was a double occupancy room with two female residents. The urinal had a small amount of amber colored fluid in the bottom. During an observation and interview with Licensed Nurse (LN) A on 3/11/19 at 10:10 AM,	F 880	**How the facility plans to monitor its performance to make sure that solutions are sustained.** At the monthly and quarterly QA meetings, the Environmental Services Supervisor will report the results of their daily patient room inspections, including rooms that have used items that are not in compliance with facility policies and procedures. This information will be reported to the QA committee for action plan until 100% compliance is achieved for two or more quarters. **Date when corrective action will be completed.** 4/14/19.	

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F 880	Continued From page 15 she was asked about the urinal in the shower. LN A stated the Certified Nursing Assistants must have used the urinal to empty the Foley catheter (a tube inserted into the bladder to drain urine) and then left it the shower. She stated the urinal "should not have been left in shower." She stated the proper place to store the urinal was in the drawer of that resident's chest of drawers. During an interview on 3/13/19 at 10:10 AM with the Infection Control Nurse (ICN), she was asked about the urinal found in the shower. ICN stated it should not have been left there.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883	**F 883** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** Residents 22, 73, 82 and 106 were offered/received the second pneumonia vaccine. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** An audit to determine if any residents have not received the pneumonia revaccination was completed on 4/3/19. The revaccination will be offered to any residents that have not received the vaccine.	

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F 883	Continued From page 16 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure four of five sampled residents (Residents 22, 73, 82, and 106) had received or been offered the pneumonia vaccine according to Centers for Disease Control (CDC) and Advisory Committee on Immunization Practices (ACIP) recommendations, and facility policy.	F 883	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur** An in-service was given by the DON to the ICN on March 27, 2019. The in-service included the facility policies and CDC and ACIP recommendations for pneumonia vaccines. The ICN will review the medical history of new admits to the facility to determine whether they have received the pneumonia vaccine per CDC and ACIP recommendations. It will be offered as needed. The ICN will maintain a record of dates of administration of first and second doses of the immunization and offer booster doses as needed to comply with CDC and ACIP recommendations. The ICN will document and refusals. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The DON or ADON designee will audit 5 random charts monthly to determine whether the residents have been offered the pneumonia vaccine per CDC and ACIP recommendations.	

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F 883	Continued From page 17 This had the potential to result in these residents and other residents residing in the facility becoming ill with pneumonia. Findings: ACIP recommends pneumococcal (pneumonia) vaccinations, polysaccharide vaccine (PPSV 23) and 13-valent pneumococcal conjugate (PCV 13), should be given for all adults 65 years or older. For those adults who have not previously received a pneumonia vaccine, give a dose of PCV 13 to adults 65 years or older, then administer a dose of PPSV 23 six to 12 months later. For those adults who have received one dose of PPSV 23, a dose of PCV 13 should be given at least one year later. Both PPSV 23 and PCV 13 vaccines should be administered routinely. ACIP expects administration of both PCV 13 and PPSV 23 will provide optimal protection against pneumococcal infections. A review of the facility's, "Pneumococcal Vaccine" policy, dated 8/2016, indicated, "Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination." During an interview on 3/13/19 at 10:15 AM, the Infection Control Nurse (ICN) stated the national standards that the facility used were based on CDC guidelines. During a concurrent interview and record review on 3/13/19 at 11:13 AM, the immunization status for five long term care resident records were reviewed and discussed with the ICN.	F 883	For all residents the ICN will track the percentage of residents that have received the pneumonia vaccine per CDC and ACIP guidelines, and track the reason for any refusals The results of the DON audit and ICN tracking will be reported at the monthly and quarterly QA meeting for action plan until 100% compliance is achieved for two or more quarters. **Date when corrective action will be completed.** 4/14/19.	

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F 883	Continued From page 18 ICN confirmed the following: Resident 22 had received the pneumonia vaccine within the last five years, but was unable to verify the exact date; Resident 73 had received the pneumonia vaccine on 10/12/17; Resident 82 had received the pneumonia vaccine on 9/28/16; and Resident 106 had received the pneumonia vaccine on 9/7/2016. ICN confirmed the above residents had not received the second pneumonia vaccine. ICN said she was aware both the PPSV 23 and PCV 13 needed to be given one year apart but had not ensured all residents had received or been offered both vaccines, but had been working on it.	F 883		

COPPER RIDGE CARE CENTER

201 HARTNELL AVENUE, REDDING, CA 96002
PHONE (530) 222-2273
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VIA OVERNIGHT DELIVERY

April 18, 2019

Joanne Gilchrist, RN
District Manager II
CDPH, Licensing & Certification Program
126 Mission Ranch Blvd.
Chico, CA 95926

Dear Joanne Gilchrist,

Attached is Copper Ridge Care Center's revised plan of correction in response to the deficiencies found during the recertification survey completed on March 14, 2019. This revision includes changes agreed upon on April 17, 2019.

Please let us know if you have any questions or need additional information.

Sincerely,

Darrell Thompson
Administrator
Copper Ridge Care Center