STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056098	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTHCARE CENTER	625 COTTONWOOD STREET WOODLAND, CA 95695

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of facility reported incident #CA00894998. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 17069 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550	F550 How corrective actions will be accomplished for those residents found to have been affected by the deficient practice; The C.N.A. was sent home and suspended pending investigation of this matter on 4/15/24. C.N.A. was terminated from the facility effective 4/22/24. Resident was monitored for any psychosocial and emotional distress x 72 hours. How the facility will identify other residents having the potential to be affected by a deficient practice and what corrective action will be taken; All residents have the potential to be affected by a deficient practice	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: May 7th 2024

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record review, and facility documents review, the facility failed to ensure one of three sampled residents (Resident 1) was treated with dignity and respect when Certified Nursing Assistant (CNA) 1 refused to assist Resident 1 with cleaning, pulling up his brief, and sat him in his wheelchair with his pants down while still soiled with feces. This failure resulted in Resident 1 to feel "sad" and left soiled. Findings: Resident 1 was admitted to the facility on 4/26/23 with diagnoses that included cerebral infarction (stroke), hemiplegia (paralysis of one side of body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting left non-dominant side, repeated falls, muscle	F 550	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; DSD will in-service all staff on Resident Rights on 5/10/24 How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; DSD to in-service all staff on Resident Rights on 5/10/24 and annually. Will review in Resident Council monthly. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. May 10th, 2024	

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F 550	Continued From page 2 weakness. During a review of Resident 1's Quarterly Minimum Data Set (MDS-an assessment tool), dated 2/1/24, described him as having clear speech, able to make himself understood and as able to understand others. Resident 1's Brief Interview for Mental Status (BIMS-a brief screening that aids in detecting cognitive impairment) score was "13" which indicated he was cognitively intact. The MDS described Resident 1 as having no signs or symptoms of delirium or behavioral symptoms. The MDS also described Resident 1 as needing setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following activity). During a review of a Social Services (SS) Note, dated 4/15/24 at 3:13 p.m., the SS Note, indicated, "Met with resident regarding an incident that was reported by the DON [Director of Nursing] relating patient care. Resident verbalized he asked for assistance getting to the bathroom when a CNA answered his Call light accompanied with 2 students'. Resident was brought to the restroom where he moved his bowels and could not reach to clean himself. He asked for assistance where the CNA encouraged him to do it himself, but resident kept saying he couldn't. Resident was brought back in the room with his brief by his knees. Per resident there was bowels all over the wheelchair. The CNA who attended to the call light left the room without providing help. Resident was very emotional when talking about the incident. Later there was other CNA that attended to his call light and cleaned him." Review of the facility's "5 Day Summary," dated	F 550		

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4/24/24, indicated, "On 4/15/24 It was witnessed by 2 Student Nurses that [CNA 1] was witnessed being verbally inappropriate to resident after using the bathroom. [CNA 1] as telling the resident he could pull his brief up by himself when he was unable too. Resident was still soiled, when she told to sit down into his w/c and then back into his bed where the CNA finished cleaning him up. On interview with [Resident 1] he was very tearful and relayed the same information."

During a review of Licensed Vocational Nurse Student 2's (LVN Student 2) statement, dated 4/15/24, the statement indicated Resident 1's call light was on, and they (LVN Student 1 and LVN Student 2) went to Resident 1's room. Resident 1 stated he needed help getting up to the bathroom. They transferred Resident 1 to his wheelchair and rolled him into the bathroom. Resident 1 "grabbed the pole to pull himself up, but was unable to do it." LVN Student 1 told LVN Student 2 to grab a nurse/CNA. The medication nurse helped them transfer Resident 1 to the toilet. The medication nurse left the room due to it would take Resident 1 awhile to finish using the bathroom. Before LVN Student 2 and LVN Student 1 left the room, LVN Student 2 told Resident 1 to call if he needed anything. Per LVN Student 2's statement, a few seconds later Resident 1's call light was on. Her and LVN Student 1 went back into Resident 1's room. Resident 1 was finished using the bathroom. They were going to clean Resident 1 up when CNA 1 came in and was going to assist them. CNA 1 told Resident 1 to stand up, wiped him, and then told him to pull up his brief by himself. Resident 1 "looked like he was struggling. He had one hand holding the pole and the other hand on

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the sink." LVN Student 2 stated to CNA 1 that she could help him pull up his brief. CNA 1 responded "that he can do it himself." Resident 1 "was struggling to pull up his brief but the CNA did not want me to help him. Instead, she was yelling at him and stomping the ground to pull up his brief. He only did it half way and the CNA just put him on the wheelchair. I saw there was feces on the seat, and I said I can help clean that up. She said no and told us to leave." LVN Student 1 and LVN Student 2 left the room.

During a review of LVN Student 1's statement, dated 4/15/24, the statement indicated LVN Student 1 and LVN Student 2 saw Resident 1's call light was on, and they went to Resident 1's room. Resident 1 stated he needed to use the bathroom. They transferred Resident 1 to his wheelchair and took him to the bathroom. When Resident 1 stood up they noticed his leg was shaking, so they helped him sit back in his wheelchair. Per LVN Student 1's statement she went to get help and had the medication nurse help them get Resident 1 onto the toilet and the nurse then left the room. CNA 1 then came into the room and told Resident 1 to get up but his legs were shaking. CNA 1 cleaned the resident up and told Resident 1 to pull up his brief but Resident 1 couldn't, then CNA 1 "yelled at him" to pull up his brief. Resident 1 tried to pull up his brief, but he couldn't and then sat back in his wheelchair.
Resident 1's brief was half way pulled up. They asked CNA 1 if she wanted them to help clean the bathroom. CNA 1 stated no and told them they could leave.

During an interview on 4/24/24 at 10:33 a.m. with Resident 1, via an interpreter, Resident 1 stated

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F 550	Continued From page 5 this was the first time CNA 1 had provided care for him. Resident 1 stated after going to the bathroom he need help wiping himself and pulling up his brief. CNA 1 told him he could do it, but resident kept saying he couldn't. Resident 1 stated he got tired and sat back down in the wheelchair with his brief still by this knees. He also stated he got wheelchair dirty from not being cleaned up. Resident 1 stated they left him in his wheelchair with his brief and pants still down. Resident 1 stated, the two other people, along with CNA 1 left him. Resident 1 was asked how this made him feel. Resident 1 stated he felt "sad." During an interview on 4/24/24 at 11:47 a.m. with the DON, the DON stated they substantiated the allegation. The DON stated CNA 1 never gave a statement and her last day of work at the facility was on 4/15/24. During a review of the facility's policy and procedure titled, "Resident Rights," revised 08/2002, indicated, "Facility staff shall treat all residents with kindness, respect, and dignity ...These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity ..."	F 550		