STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. BUILDING _____ B. WING _____	03/12/2020

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 from 3/9/20 through 3/12/20. One facility reported incident was investigated during the survey. Facility reported incident: 678447 Representing the Department: 22705, Health Facilities Evaluator Nurse (HFEN) 40091, HFEN 40204, HFEN 41288, HFEN 41940, HFEN No deficiencies were written for facility reported incident 678447. Census: 123 Sample size: 24	F 000	Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 25, 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=E	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 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 4/8/20

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 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 clean and sanitary conditions when: 1. Two clean utility room under-sink cabinets were observed to be soiled. 2. Two room fans were observed to have lint on the fan blades and wire cage of the fan.	F 584	**F 584** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The two clean utility room under-sink cabinets were cleaned. The two room fans were cleaned. **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.** Housekeeping services inspected all utility room cabinets and all room fans and therapy gym fans, and they were cleaned 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** The Housekeeping Services Supervisor inserviced housekeeping staff and the Director of Nursing inserviced licensed nurses. The inservices covered the facility policies and regulations on maintaining a safe and clean environment, including cabinets and fans.	

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F 584	Continued From page 2 These failures created the potential for environmental contamination with bacteria, viruses and allergens, not facilitating a homelike environment that could lead to negative clinical outcomes. Findings: 1. During an initial tour of the Cherry wing and concurrent interview on 3/9/20 at 9:37 AM, the clean utility room was observed with Certified Nursing Assistant (CNA) 2. CNA 2 confirmed the area under the sink was soiled with a blackish brown substance and trash bags in a corrugated cardboard box were being stored. CNA 2 stated items should not be stored under the sink. During an observation and concurrent interview on 3/9/20 at 9:47 AM, CNA 2 returned to the clean utility room and removed the box of trash can liners that were being stored under the sink and stated she would notify housekeeping to clean under the sink. During an observation on 3/11/20 at 10:30 AM, the Peach wing clean utility room was observed. The under-sink cabinet, where items were being stored, was soiled with a blackish brown substance. 2. On 3/10/20 @ 10:30 AM during an observation of the facility utility rooms and physical therapy gym, two wall mounted room fans were observed to have dust accumulation on the fan blades and wire blade cover. The fan in the physical therapy room had a strand of dust, approximately 2 ½ inches long hanging from a fan blade. On 3/10/20 @ 10:40 AM CNA 3 was asked about	F 584	The Environmental Services department added inspection and cleaning of the fans and cabinets to their weekly checklist. The inspection checklists 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 utility rooms, patient rooms and therapy gym have a safe and clean environment, including cabinets and fans, and what measures were taken to maintain a safe and clean environment. This information will be reported to the QA committee for action plan until compliance is achieved. **Date when corrective action will be completed.** 4/8/20	

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F 584	Continued From page 3 the condition of the fan and stated, "It looks kind of gross. Lint, yes. It needs to be cleaned. I will get housekeeping; they should have cleaned it." Shortly after, Housekeeper 2 entered the utility room and viewed the fan. "I will take care of it right now" was her response when viewing the condition of the fan. On 3/10/20 at 10:45 AM the fan in the physical therapy gym was called to the attention of staff. Physical Rehabilitation Aid acknowledged lint present on the fan. Housekeeping staff were summoned to clean the fan.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657	**F 657** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The care plan of Resident 7 was reviewed and corrected as necessary. **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 skin tears were reviewed and revised as necessary. The care plans will be 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**	

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F 657	Continued From page 4 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise the care plan and include interventions to prevent a skin tear for one of 24 sampled residents (Resident 7). This caused or contributed to an additional skin tear. Findings: A review of Resident 7's record indicated she was readmitted on 4/18/19, with diagnoses that included dementia, muscle weakness, Parkinson's (disease of the central nervous system that affects movement, often including tremors), and Rheumatoid arthritis (a chronic progressive disease in the joints and resulting in painful deformity and immobility especially in the fingers, wrists, feet, and ankles). During a concurrent observation and interview on 3/9/20 at 3:37 pm, Resident 7's responsible party said there was a new skin tear on Resident 7's right elbow arm area. She pulled up the resident's sleeve and there was a bruise with a horseshoe shaped skin tear with four steri-strips. The shirt sleeve had a reddish-brown stain. She said Resident 7 has had other prior skin tears and staff were supposed to use "sleeve covers" during transfers to prevent skin tears. The notes for skin tears which had happened since readmission and care plan revisions were	F 657	An inservice was given the by DON to licensed nurses beginning March 23, 2020 on the facility's policy and regulations for the development and implementation of an comprehensive care plan for each resident. The inservice covered the facility policy that skin care plans are individualized, appropriate, and implemented for each resident. **How the facility plans to monitor its performance to make sure that solutions are sustained.** On a weekly basis the licensed nurse will audit the clinical record of each resident for an individualized, appropriate and implemented skin prevention care plan. The DON and ADON's will review a sample of 3 care plans each week for the next 90 days, and correct as necessary. The results of the audits will be reported in the weekly IDT fall meeting. This information will be reported to the QA committee at the monthly and quarterly meetings for action plan until compliance is achieved. **Date when corrective action will be completed.** 4/8/20	

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F 657	Continued From page 5 reviewed. On 11/5/19 a skin tear occurred during a Hoyer (assistive device that allows patients to be transferred between bed and chair) transfer. The care plan was not revised. On 12/11/19, another skin tear occurred and the reason was not clear but the care plan was revised to include "sleeve covers" during Hoyer transfers. No skin tears during Hoyer transfers occurred after this intervention was started. Another skin tear occurred on 3/9/20 while dressing Resident 7 with a tight long sleeve shirt and the care plan was revised to use only loose long sleeves. During an interview on 3/12/20 at 8:20 am, the Director of Nurses (DON) confirmed Resident 7's care plan was updated to include additional interventions after the skin tear on 12/11/19 and 3/9/20, but the care plan had not been revised after the initial skin tear on 11/5/19.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688	**F 688** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** Resident 7 was rescreened and is receiving RNA therapy per MD orders. **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 met with licensed nurses and RNA staff on March 23, 2020 and April 8, 2020 to review whether residents with a physician's order for RNA are receiving therapy as ordered. The DON also reviewed the orders with the physician and therapists to ensure that each resident is receiving RNA services necessary for maintenance of the resident's optimum level of function. Adjustments to the RNA orders and schedule were made as necessary to ensure the resident's would receive appropriate RNA services.	

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F 688	Continued From page 6 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. 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 a resident's range of motion (ROM) did not decrease) to one of two residents (Resident 7), as often as ordered by the physician. This had the potential to result in a decrease in Resident 7's range of motion and optimum level of functioning. Findings: A review of Resident 7's record indicated she was readmitted on 4/18/19, with diagnoses that included dementia, muscle weakness, Parkinson's (disease of the central nervous system that affects movement, often including tremors), and Rheumatoid arthritis (a chronic progressive disease in the joints and resulting in painful deformity and immobility especially in the fingers, wrists, feet, and ankles). The physician's orders included RNA therapy for ROM five times per week to maintain joint mobility. During an interview on 3/9/20 at 3:53 pm, Resident 7's responsible party (RP) said she was unsure how often ROM exercises were being done with Resident 7. A review of the RNA weekly notes since 1/1/20 indicated for nine of eleven weeks, Resident 7 received RNA therapy from three to four times per week, instead of five times per week, as ordered by the physician.	F 688	**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 licensed nurses and RNA staff on March 23, 2020 and April 8, 2020 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. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The DON or designee will do monthly RNA audits to check that RNA services are being provided per physician's order. This information will be reported to the QA committee for action plan until compliance is achieved. **Date when corrective action will be completed.** 4/8/20	

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F 688	Continued From page 7 During a concurrent interview and record review on 3/12/20 at 1 pm, the Director of Nursing (DON) confirmed there were two weeks, during the period from 1/1/20 to present, when Resident 7 had RNA therapy five times per week. DON stated they have been short staffed due to illness and some staff being on a leave of absence. She said she will have Resident 7 rescreened by Physical Therapy.	F 688	**F 689** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.**	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of six residents (Resident 74) who smoked received adequate supervision. This had the potential to result in an accident related to smoking including burns. Findings: A review of Resident 74's record indicated he was admitted on 12/13/19, with diagnoses that included peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), muscle weakness, and heart disease. A review of the	F 689	Resident 74 has discharged. **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 Administrator reviewed smoking schedule and residents who smoke to ensure they are smoking only at designated times. **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 licensed nurses on March 23, 2020 and CNA's on April 8, 2020 on the facility policies and procedures on accidents and supervision, including supervised smoking, and what to do if they find a resident with smoking paraphernalia in their room.	

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F 689	Continued From page 8 smoking assessment and interdisciplinary team note, indicated Resident 74 was safe to smoke and agreed to smoke only with a designated smoking aide or family member present. On 3/9/20 at 4:06 pm, Resident 74 was observed out in the smoking area with another resident. Resident 74 was smoking and ash fell from his cigarette onto the ground. He stopped smoking as soon as the surveyor arrived at the smoking area. No staff were present. A very short time later (approximately one minute), two other residents came out as well as the designated smoking aide (AA 1) who offered Resident 74 a smoking apron. Resident 74 accepted the smoking apron and put it on prior to starting to smoke again. The above observation was discussed with the Director of Nurses (DON) on 3/10/20 at 8:59 am. The DON said staff from various departments are assigned to be with residents at designated smoking times. She said according to their policy, staff should be present when residents are smoking, although their policy does allow a visitor to be present at times. She said they try to get residents to wear smoking aprons and Resident 74 was willing to wear one. The DON said Resident 74 had a visitor yesterday and she would see if he left cigarettes for this resident, but otherwise the cigarettes were kept locked up in a box in the medication room. The facility's "Smoking Policy - Residents," revised 9/2017, was reviewed. It indicated, "all residents with smoking privileges shall have the direct supervision of a staff member, resident representative, family member, volunteer worker, or other person deemed safe by the facility at all	F 689	**How the facility plans to monitor its performance to make sure that solutions are sustained.** The Administrator will do random audits of the smoking schedule compliance to monitor that the schedule is being followed according to the facilities polices and procedures. This information will be reported to the QA and Safety committees for action plan until compliance is achieved. **Date when corrective action will be completed.** 4/8/20	

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F 689	Continued From page 9 times while smoking."	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 755	**F 755** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The medicated gel resident 42 was refusing was discontinued. **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 medications of each resident were reviewed and if chronically refused referred to the MD to determine if it should be discontinued. **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 licensed nurses on March 23, 2020 on the facility policies and procedures for Pharmacy services, including chronic refusal of medications.	

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F 755	Continued From page 10 review, the facility failed to consistently follow a medication order and did not follow medication administration policy when they did not notify the doctor or pharmacist of a pattern of refusal for diclofenac ointment (Nonsteroidal anti-inflammatory drug) for one of 24 sampled residents (Resident 42). This failure delayed the doctor from assessing and adjusting an individualized medication regimen that met the wishes and needs of Resident 42. Findings: A review of the medical record for Resident 42 indicated he was last admitted on 10/9/19 from the hospital with heart and lung problems, back pain, swollen legs, peripheral neuropathy (nerve pain in the hands and fingers). Resident 42 was his own responsible party. A review of a facility policy, titled, "Administering Medications," revised 4/2019, indicated that medications should be administered in accordance with prescriber orders. Identified concerns should be communicated to the prescribing doctor. A review of a facility policy, titled, "Medication Regimen Reviews," Revised 7/2018, indicated the Pharmacist will identify any irregularities and provide timely communication to the attending physician, the facility's Medical Director and to the Director of Nursing (DON). A review of the physician orders for Resident 42 indicated, on 12/26/19, the doctor ordered diclofenac sodium gel 1%, 4 grams, topically	F 755	**How the facility plans to monitor its performance to make sure that solutions are sustained.** The Medical Records Supervisor or Medical Records Assistant designee will do weekly audits of medication refusals and report chronic refusals to the DON or ADON designee. This information will be reported to the QA committee for action plan until compliance is achieved. **Date when corrective action will be completed.** 4/8/20	

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(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) COMPLETION DATE
F 755	Continued From page 11	F 755		

applied twice a day to the left thumb joint area due to gout (inflammatory arthritis characterized by recurrent attacks of a red, tender, hot, and swollen joint).

During observation of a medication administration on the Plum Wing, on 3/11/20 at 9:18 AM, Licensed Nurse (LN) A stated she was going to ask Resident 42 if he wanted to refuse the diclofenac gel that the doctor had ordered.

During an interview with LN A, on 3/11/20 at 9:35 AM, she stated she did not give this ointment to him daily as he usually did not want it.

During an observation of LN A interacting with Resident 42, on 3/11/20 at 9:40 AM, she instructed Resident 42 that he should let her give him the diclofenac ointment since surveyors wanted to watch her conduct a medication administration. Resident 42 agreed to let her apply the ointment but stated that he did not need it. LN A applied the diclofenac gel to Resident 42's left thumb.

During an interview with Resident 42, on 3/11/20 at 09:48 AM, he stated he did not want to rely on pain medications, so he refused them often. Resident 42 stated he would rather just ask for the ointment when he felt he needed it. He stated the nurses and doctors had never discussed changing the medication from routine to "as needed."

During an interview with LN A, on 3/11/20 at 9:55 AM, she stated she had not spoken to the doctor about how often Resident 42 refused the medication. She stated she usually did not get the medication ready to offer as Resident 42 as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 12	F 755		

he usually refused it. When asked if he would be more likely to accept the ointment if it were ready to apply, LN A said possibly but it would still get thrown away most of the time.

During a concurrent interview and review of Resident 42's orders, medication administration records (MAR) and progress notes with the DON, on 3/11/20 at 3:00 PM, the MAR indicated several stretches of refusals that started in 1/2020 and continued through 3/2020. When asked if a care conference should recognize and address patterns of medication refusal, DON stated they should have reviewed current medications and discussed with Resident 42 if any medications should be changed or discontinued. There should have been a referral to the doctor to change the diclofenac gel to PRN (as needed) and then Resident 42 would have to ask for it. DON confirmed there had been a pattern of refusal. She stated they should have identified the root cause for the refusals, but that the pattern had not been captured in the progress notes. Nurses would not know about the pattern of refusal unless they printed out the MAR and did an intentional review. It should have been the responsibility of the nurse to notify the doctor of three or more days in a row of refusal to accept the ointment.

A review of the 2020 Medication Administration History for Resident 42 indicated the following refusals for the diclofenac sodium gel:

January 10, 17-19, 24-26
February 1, 2, 7-9, 14-16, 21-23, 28-29
March 1, 2, 4, 6-8

A review of the Pharmacy Consultant's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETION DATE
F 755	Continued From page 13 Medication Regimen Review indicated, for 1/2020 and 2/2020, she did not address the pattern of refusal by Resident 42 for the diclofenac gel. During an interview with the Pharmacy Consultant (PC), on 3/12/20 at 8:36 AM, she stated that the nurses were responsible to alert the doctors and pharmacist if a chronic medication had a pattern of refusal. PC stated the pharmacists checked PRN medications (ordered "as needed") for patterns of refusal, but did not check routine medications for patterns of refusal.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761	**F 761** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The expired bottle used to refill solutions was discarded. The undated testing strips and control solution bottles were 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.** The testing strips and control solutions on each med cart were reviewed to see if dated and if not discarded. **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 licensed nurses on March 23, 2020 on the facility policies and procedures for labeling of drugs and biologicals, including labeling test strips and control solutions when opened.	

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	555316	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 14 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the standard of practice and manufacturer's recommendations for identifying expiration dates when it did not label blood sugar testing strips and solutions with the date they were opened, and when an expired bottle of Hibiclens (a solution used to kill germs on skin) was not labeled with the date it was opened and was still in use. This failure had the potential to cause inaccurate blood sugar test results and insulin medication errors, and to ineffectively kill germs during wound care treatments, increasing the risk of infection. Findings: A review of a facility policy, titled, "Storage of Medications," revised 4/2019, indicated that all drugs and biologicals would be stored in a safe, secure and orderly manner. Nursing staff was responsible for maintaining medication storage in a clean, safe and sanitary manner. Outdated drugs or biologicals would be destroyed. Antiseptics, disinfectants and germicides used in any aspect of resident care must be clearly labeled with directions for use. During an observation of a Treatment Nurse's (TN) treatment cart, on 3/10/20 at 3:45 PM, a bottle of Hibiclens solution had an expiration date of 12/2019. During an interview with TN, on 3/10/20 at 3:50	F 761	**How the facility plans to monitor its performance to make sure that solutions are sustained.** The DON or ADON designee will audit med carts for proper labeling and storage of medications, including test strips and control solutions. This information will be reported to the QA committee for action plan until compliance is achieved. **Date when corrective action will be completed.** 4/8/20	

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	555316	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 15	F 761		

PM, she confirmed that the bottle did not have a date written on it for when it was first opened and that the expiration date from the manufacturer had expired. TN stated that staff routinely refill the expired bottle with solution from a larger bottle. She discarded the expired bottle and stated they would change their process to avoid potential infection control issues.

During an observation of a medication cart on Cherry Wing, on 3/11/20 at 11:35 AM, the blood sugar device testing strips and control solution bottles (used to determine if the device is working accurately) were not labeled with the date when they were opened. The strips and solutions were in containers that identified the manufacturer.

During an interview with a Licensed Nurse (LN) C, on 3/11/20 at 11:40 AM, she confirmed the bottles of test strips and control solutions were not labeled with the date they were opened. She stated that staff would use the expiration dates stamped on the bottles by the manufacturer to stop using those bottles. LN C was not aware of any other time frame after they were opened where they should be considered expired.

During an interview with the Assistant Director of Nurses (ADON), on 3/11/20 11:49 AM, she stated that staff "go by the expiration date for test strips and solutions."

A review of the manufacturer's recommendation for the blood sugar device test strips and control solution, on 3/11/20 at 11:58 AM, indicated they were good for 3 months after opening.

During an observation of a medication cart in front of Apple Wing, on 3/11/20 at 12:25 PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. BUILDING _____ B. WING _____	03/12/2020

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 761	Continued From page 16 blood sugar device testing strips and control solution bottles were not labeled with the date when they were opened. During an interview with LN D and ADON, on 3/11/20 at 12:16 PM, they stated they do not label the test strips or control solutions with the date they are first opened. When advised of the manufacturer's recommendations to stop using them within three months of being opened, they stated all the bottles would need to be labeled for staff to identify when three months had passed. During an interview with the Pharmacy Consultant, on 3/12/20 at 8:36 AM, she stated all medications used in patient care should be labeled with the date they are opened, including glucometer control solutions (used to verify accuracy of blood sugar testing devices).	F 761	**F 880** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The staff member received a doctor's order to no longer use the wrist brace. All vital machines in the facility were wiped down with bleach wipes. **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 staff were reviewed to determine if any had a splint or similar device. None were discovered. All vital machines were wiped down with bleach wipes. **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 licensed nurses on March 23, 2020 and CNA's on April 8, 2020, and the Housekeeping Services Supervisor inserviced housekeeping staff on the facility's infection control policies and procedures.	
F 880 SS=E	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 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	F 880		

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	555316	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 17 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 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.	F 880	Environmental Services added a task to their weekly rounds to inspect vital machines and clean as needed. **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 vital machine inspections and DON or ADON designee will report on the use of splints or similar items. This information will be reported to the QA committee for action plan until compliance is achieved. **Date when corrective action will be completed.** 4/8/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 18 §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, interview, and document review, the facility failed to ensure it maintained an infection control and prevention program to provide a safe and sanitary environment when: 1. RNA (restorative nursing aide) 1 wore a wrist splint while providing care to residents; and 2. The portable vital signs machine had not been properly cleaned between residents. This had the potential to spread infection and communicable diseases between residents. Findings: 1. On 3/9/20 at 12:18 pm, RNA 1 was seen in the Assisted Dining Room wearing a wrist brace on her right hand, wrist, and forearm while feeding Resident 7. On 3/9/20 at 2:11 pm, RNA 1 was observed entering room 10 and closing the door. RNA 1 had used hand sanitizer to hands and brace before entering the room. During an interview on 3/10/20 at 9:58 am, RNA 1 said she works as an RNA not Certified Nursing	F 880		

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	555316	A. BUILDING _____ B. WING _____	03/12/2020

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F 880	Continued From page 19 Assistant. She said she can put her wrist splint in the washer and does so frequently. She also said she can take it off to wash her hands and it can be wiped down with alcohol. She said she does not change residents or shower them but only does RNA services like taking residents down to therapy room and helping them onto the bicycle. During an interview on 3/10/20 at 11:09 am, the infection control nurse (ICN) said portable equipment that is used for multiple residents, such as a vital sign machine, was cleaned between residents with bleach germicidal wipes. RNA 1's splint was discussed with ICN since RNA 1 was providing RNA services to more than one resident. ICN said she would expect RNA 1 to clean her splint between residents with a bleach germicidal wipe and would give her packets to keep in her pocket. 2. A review of a facility policy, titled, "Cleaning and Disinfection of Resident-Care Items and Equipment," revised 10/2018, indicated that reusable items were to be cleaned and disinfected between residents. Reusable resident care equipment would be decontaminated between residents according to manufacturer's recommendations. During observation of the Plum Wing hallway, on 3/11/20 at 9:20 AM, a vital signs machine plugged into the wall by the medication cart was observed to have yellow-brown fluid, partially dried, and splattered around the base of the machine. During an observation of medication administration on Plum Wing, on 3/11/20 at 10:09 AM, a Licensed Nurse (LN A) did not wipe down the vital signs machine before or after she used it on Resident 19 and placed it in the hallway.	F 880		

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F 880	Continued From page 20 During an interview with LN A, on 3/11/20 at 10:15 AM, she stated that each resident has their own blood pressure cuff that did not need to be wiped down between uses. LN A stated the vital signs machine should be wiped down between patients if soiled or if it contacts a resident. She stated she did not need to wipe down the entire machine at that time. During an interview on 3/11/20 at 3:22 PM, the Infection Control Nurse said the portable vital sign machine should be cleaned with a bleach wipe between residents. During concurrent observation and interview with the Director of Nurses (DON), on 3/11/20 at 3:24 PM, she confirmed that the vital signs machine on the Plum Wing was visibly dirty around the base and should have been cleaned. DON stated that the nurses and aides were responsible to clean the devices between patients. During an interview with LN B, 03/12/20 10:05 AM, she sated the vital sings machine should be cleaned between patients. She would wipe down any parts that were touched. LN B stated that if visibly soiled, she would clean the machine down to its base.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 921		

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	555316	A. BUILDING _____ B. WING _____	03/12/2020

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

(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) COMPLETION DATE
F 921	Continued From page 21 Based on observation, interview and document review, the facility failed to provide a safe and sanitary environment when: 1. Two sit-to-stand patient lifts were observed with visibly dirty foot sections. 2. The bathroom toilet shared by Residents 104 & 109, was visibly soiled with a brown substance. 3. A partially filled corrugated box of isolation gowns was stored on top of a clean linen cart, within approximately eight inches of the ceiling, in a clean utility room. These failures had the potential for cross-contamination of bacteria and viruses between residents and to impede the function of the fire suspension sprinklers in the event of a fire. Findings: 1. Review of the facility's policy and procedure titled "Cleaning and Disinfection of Resident-Care Items and Equipment," dated 10/1/18, indicated "reusable items are cleaned and disinfected or sterilized between residents." "Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions." Manufacturer instructions provided by the facility for the sit-to-stand lifts, titled "Disinfection, Cleaning and Maintenance," not dated, indicated "Unless otherwise stated, before each and every use follow the cleaning, care and inspection procedures..." "The lift should be cleaned before it is used by another patient."	F 921	**F 921** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The non-skid strips on the sit to stands were replaced. The bathroom toilets were cleaned. The box of gowns was moved. **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 nonskid strips of all sit to stand lifts were replaced. All bathrooms were inspected for cleanliness and cleaned as needed. The facility storage rooms were inspected for ceiling clearance and supplies moved 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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 921	Continued From page 22 ULINE Anti-Slip Tape application instructions, provided by the facility, not dated, indicated to keep tape surface clean. Use mild floor cleaners as directed. During an initial tour of the facility on 3/9/20 at 8:51 AM, a sit-to-stand patient lift was observed in the exit hallway on the Cherry wing with a visibly soiled foot section, with what looked like skin flakes. During an observation and concurrent interview on 3/09/20 at 9:34 AM with Certified Nursing Assistant (CNA) 1, a sit-to-stand lift was observed in the hallway, across from the nurse's station on the Cherry wing. CNA 1 confirmed the foot section of the lift was dirty. She stated the lifts were wiped down with bleach wipes between use and deep cleaned by housekeeping. CNA 1 stated the lift had been deep cleaned last week. She agreed the dirty foot section of the lift was an infection control issue and that she would deep clean the lift. CNA 1 stated it was difficult to clean the foot sections of the lifts, due to the anti-slip surface. During an observation and concurrent interview on 3/09/20 at 10:37 AM with Housekeeper (HSK) 1, a sit-to-stand lift was observed outside of Room 58. HSK 1 confirmed the foot section of the lift was dirty. She stated she was not sure if housekeeping cleaned the lifts and would need to check with her supervisor. During an observation and concurrent interview on 3/09/20 at 11:28 AM with Administrator (Admin), he confirmed the lift in the hallway outside of resident Room 58 was dirty.	F 921	An inservice was given by the DON to licensed nurses on March 23, 2020 and CNA's on April 8, 2020, and the Housekeeping Services Supervisor inserviced housekeeping staff. The inservices included the facility's policies and procedures on safe, functional and sanitary environments. Environmental Services added a task to their weekly rounds to inspect nonskid strips on sit to stands, daily rounds to clean and inspect bathrooms and storage rooms. **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 inspections. This information will be reported to the QA committee for action plan until compliance is achieved. **Date when corrective action will be completed.** 4/8/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. BUILDING _____ B. WING _____	03/12/2020

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F 921	Continued From page 23 During an interview on 3/12/20 at 8:20 AM with Assistant Director of Nursing (ADON) at the nurse's station on the Cherry wing, she stated staff were expected to clean the patient lifts between each use, using bleach wipes. ADON stated that maintenance staff were responsible for deep cleaning the lifts weekly and kept a cleaning log. Review of the facility's "Resident Council Minutes", dated 4/9/19, indicated "Hoyer & sit-to-stand wheels need to be cleaned clogged with excess hair." 2. Review of the facility's policy and procedure titled "Cleaning and Disinfecting Residents' Rooms," dated 8/1/13, indicated "environmental surfaces will be disinfected (or cleaned) on a regular basis...and when surfaces are visibly soiled." During an observation and concurrent interview on 3/09/20 at 10:33 AM, the bathroom in Room 57, shared by Residents 104 and 109 was observed. The toilet and elevated toilet were not clean. A brown substance was smeared on the toilet seat and the toilet bowl was splattered with what appeared to be fecal material. There was no liner in trash can. HSK 1 confirmed the toilet and elevated seat were not clean. She stated the toilet had been used since she cleaned it earlier and confirmed the trash can should have had a liner. During an observation on 3/11/20 at 7:34 AM the bathroom in resident Room 57 was observed. The sides of the toilet bowl were splattered with a brown substance that appeared to be fecal material.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 24 3. Review of the facility's policy and procedure titled "Receipt and Storage of Supplies and Equipment," dated 11/1/09, indicated "...must be properly stored and labeled in accordance with current regulations." During an observation and concurrent interview on 3/09/20 at 9:37 AM the Cherry wing clean utility room was observed. A corrugated cardboard box with isolation gowns was observed on top of the clean linen cart, within approximately eight inches of the ceiling and a fire suppression sprinkler head. Certified Nursing Assistant (CNA) 2 confirmed the box was stored too close in proximity to the sprinkler head. She did not know the specific distance standard for storage of supplies in proximity to a sprinkler and stated she would need to ask someone. During an observation and concurrent interview on 3/09/20 at 9:47 AM, the Cherry wing clean utility room was observed. CNA 2 returned to the room and stated storage was supposed to be 18" from the ceiling. She removed the box of isolation gowns stored on top of the linen cart. Review of the National Fire Protection Agency (NFPA) Standard 13 for the Installation of Sprinkler Systems 2019 indicated there needs to be a minimum clearance to storage of 18 inches between the top of storage and ceiling sprinkler.	F 921		