POC ACCEPTED 8/29/12 CK

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	08/03/2012

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

(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of two Entity Reported Incidents during the annual Recertification survey conducted 7/31/12 through 8/3/12. Representing the Department: HFES #11820 HFEN #29583 HFEN #31272 HFEN #31640 The facility's census was 88 residents plus 1 bed-hold, with a sample size of 18. Entity Reported Incident #CA00281299: No findings Entity Reported Incident #CA00312867: Refer to F-226	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement their policy and procedure guidelines for abuse consistent with the requirements of the California Health and Safety Code for a census of 89 when: 1. The facility failed to provide written evidence	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 9/6/12

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 226	Continued From page 1 that a pre-screening employment criminal background check was completed for LN 1. 2. An abuse investigation was not reported to the Department within 24 hours. 3. An on-site investigation for Entity Self-Reported Incident #CA00312867 indicated Random Resident 19 was not protected during the investigation when CNA 3 (The alleged perpetrator) was not reassigned to duties not involving the resident during the time of the investigation. Findings: 1. During the Abuse Prohibition Review on 8/2/12 at 8:30 a.m., a review of the personnel file for LN 1 indicated a pre-employment criminal background check had not been completed prior to hiring her on 3/19/12. In a concurrent interview with the DSD during the Abuse Prohibition Review on 8/2/12 at 8:30 a.m., she stated that she could not locate the criminal background check for LN 1. Review of the facility's policy and procedure titled, Elder/ Dependent Adult Abuse, dated 7/20/05, indicated, "20. The facility will not knowingly hire any individual who has a history of abuse and will assure that no person will be employed who has been convicted of abusing, neglecting, mistreating or misappropriating the property of any individual by conducting employment background checks, reference checks and criminal conviction checks."	F 226	*Continued from page 1* **Direct responsibility:** The Director of Staff Development (DSD) will ensure criminal background checks are completed for new hires. The Administrator or designee is responsible to ensure abuse reports are faxed and received by the Department within 24 hours. He/she will also ensure alleged staff members will be removed from the facility during the investigation. **Systemic change:** Pre-screening criminal background checks will be completed for applicants and filed in their personnel files. Facility staff will receive in-service on the proper reporting procedure for all mandated reporting of abuse. Fax confirmation pages should be reviewed to ensure successful transmission to the Department. Allegations against a facility employee require that employee to be removed from the facility while the investigation is performed to ensure resident safety. **Monitoring process:** The DNS will periodically audit facility personnel files to ensure completion of the pre-screening background check. Any anomalies will be forwarded to the administrator for review.	

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F 226	Continued From page 2 In an interview with the Administrator on 8/3/12 at 3:05 p.m., he stated, "I contacted the agency our facility uses to do the criminal background checks and they could not find any record of it being done for LN 1." 2. During the Abuse Prohibition Review on 8/3/12 at 8:20 a.m. with the Administrator, an Entity Self-Reported Incident (ERI) was investigated. ERI #CA00312867 indicated the alleged abuse to have occurred on 5/31/12 at approximately 11:30 a.m. and the department did not receive the report until 6/2/12 at 2:38 p.m. Review of the facility Fax Usage Detail Report, Account 75237, dated 6/23/12, indicated the facility faxed the Department on 6/2/12 at 2:39 p.m. In a concurrent interview with the Administrator on 8/3/12 at 8:20 a.m., he stated that he could not confirm the facility informed the State within 24 hours. 3. Random Resident 19 was last admitted to the facility on 4/22/12. Review of Random Resident 19's annual MDS (an assessment tool) dated 3/10/12 indicated he was able to make himself understood, had the ability to understand others and did not have any disorganized thinking. According to the Entity Self-Reported Incident (ERI) received by the Department on 6/4/12, on 5/31/12 at approximately 11:36 a.m., CNA 3 argued with Resident 19 regarding his showering time, and telling him to "shut up."	F 226	*Continued from page 2* The administrator will review allegations of abuse to ensure timely reporting and to assure patient safety is maintained. Anomalies will be forwarded to the Quality Assurance committee for review and recommendation. *To be completed: August 31, 2012*	

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F 226	Continued From page 3 Review of the facility Staffing and Assignment Sheets indicated that on 6/1/12 and 6/4/12, CNA 3 was assigned to care for multiple residents including Random Resident 19. According to the facility's Resident Abuse Investigation Report, the investigation was not completed until 6/5/12. Review of the facility's policy and procedure titled, Elder/ Dependent Adult Abuse, dated 7/20/05, indicated, "Guidelines-Investigation, #5. The facility will make every attempt to prevent further potential abuse while the investigation is in progress...Procedure 1. Facility Investigations...c. Immediately reassign any involved employee to duties that do not involve resident contact. Assignment will not be in a part of the facility that the resident normally frequents." In a concurrent interview with the Administrator on 8/3/12 at 8:20 a.m., he confirmed that CNA 3 had been assigned to care for Random Resident 19 on 6/1/12 and 6/4/12.	F 226	*Continued from page 3*	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	**F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** **Specific action:** 1. The Nitrofurantoin was changed to a more appropriate treatment for resident #5. 2. a. Resident 6's physician will be contacted regarding the recommendation for a gradual dose reduction of the Depakote. b. Resident 6's care plan was updated to include behavioral interventions.	

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F 329	Continued From page 4 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were free from unnecessary drugs for 2 of 18 sampled residents (5, 6) when: 1. Resident 5 was administered nitrofurantoin (an antibiotic) for an excessive duration. 2 a. Resident 6 received an increase of the drug Depakote instead of a gradual dose reduction, and b. Resident 6 did not receive behavioral interventions for his mood disorder. Findings: 1. Resident 5, an 88 year old, was admitted to the facility on 7/24/11 with diagnoses of chronic indwelling urinary catheter for obstruction secondary to benign prostatic hypertrophy (a nonmalignant overgrowth of the prostate gland), multiple recurrent urinary tract infections (UTI)	F 329	*Continued from page 4* **Direct responsibility:** The Director of Nursing Services (DNS) is responsible to ensure residents are free of unnecessary drugs. **Systemic change:** A review of residents on antibiotics is routinely performed by the infection control nurse (DSD) to ensure appropriate treatments are in place. The DNS routinely reviews residents on psychotropic medications for gradual dose reductions. Recommendations are forwarded to be reviewed by the residents attending physicians. **Monitoring process:** The DNS will periodically review the residents receiving antibiotics and psychotropic medications to ensure they are being utilized appropriately. Concerns will be discussed with the physician and forwarded to the Quality Assurance committee for review and recommendation. *Completed: August 23, 2012*	

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F 329	Continued From page 5 and renal failure. An MDS (minimum data set,an assessment tool) dated 3/23/12 indicated he had no UTIs in the last 30 days. Review of the facility's Pharmacy "Consultation Report," dated 4/1/12 through 4/30/12 indicated Resident 5 had been taking "nitrofurantoin since 3/26/12 with a creatinine clearance (Crcl, the amount of blood plasma that is cleared of creatinine per unit of time by the kidneys) of 39 milliliters (ml) per minute with no stop date. Nitrofurantoin fails to achieve therapeutic concentration in the urine with a Crcl less than 40 ml. per minute and has the potential for developing renal impairment when Crcl falls below 60 ml. per minute". The pharmacist's report was signed by the physician on 5/1/12 with the box checked that read "I have re-evaluated this therapy and DO NOT wish to implement any changes due to reasons below", which was left blank. The pharmacy "Consultation Report" dated 4/1/12 through 4/30/12 was re-faxed to the physician on 6/1/12. The pharmacist's report was signed by the physician and dated 6/2/12 with the box checked that read "I have re-evaluated this therapy and DO NOT wish to implement any changes due to the reasons indicated below", which indicated "it's working." Upon further record review for Resident 5, a lab report dated 7/19/12 showed Resident 5 developed a UTI and was started on ciprofloxacin (an antibiotic). An interview was conducted with the physician assistant (PA) on 8/1/12 at 11:58 a.m. The	F 329		

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F 329	Continued From page 6 Department's concerns of Resident 5 continuing to receive nitrofurantoin for an unspecified amount of time was validated. At 1:25 p.m. the PA stated she had spoken with the resident's physician, and in light of the Crcl and subsequent UTI while on nitrofurantoin, they agreed with the Department's assessment and would discontinue the drug. 2. Resident 6 was admitted to the facility on 10/15/07 with a diagnoses that included left sided paralysis, seizure disorder, schizophrenia and bi-polar disorder. Review of the clinical record titled Psychiatric Evaluation indicated the following: > On 11/20/11 Resident 6 was receiving Depakote ER (Extended Release) 1500 mg/hs (at bedtime). Dose reduction? "Not indicated currently." > On 2/17/12 Resident 6 was receiving Depakote ER 1500 mg/hs. Dose reduction? "Not indicated currently." Review of the Social Service's Progress Notes dated 4/13/12 indicated "Resident (6) noted to make verbally inappropriate statement to another resident. Resident (6) very agitated and started yelling towards other resident." Review of the Nurse's Notes dated 4/14/12 through 4/21/12 indicated the following: > 4/14/12- 3:47 a.m., "No agitation or inappropriate threatening comments." 10:41 a.m., "Has had no emotional or verbal outbursts at this	F 329		

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F 329	Continued From page 7 time." 11:49 p.m. "Had an argument with nurse aide at 6:50 p.m. demanding to get up to smoke. Resident was moody and tried to hit nurse." > 4/15/12- 3:16 a.m.,"...No agitation or behavioral outburst." 3:28 p.m., "No agitation or allegation against others noted." 7:52 p.m., "No agitation at this time." > 4/16/12- 2:25 p.m., "Interacts appropriately. No agitation or allegation against others noted." 10:16 p.m., "No episodes of agitation noted, cooperative to care." > 4/19/12- 7:45 p.m., "No s/s (sign/symptoms) of mood swings noted." > 4/20/12- 10:29 p.m., "No mood swings noted." > 4/21/12- 7:59 p.m., "No signs of mood swings noted during shift." > On 4/22/12 Resident 6 was receiving Depakote ER 1500 mg/hs. Medication management: "Add Depakote 500 mg qam (every morning)." Review of the clinical record titled Psychopharmacologic Drug Summary (A monthly behavioral monitoring chart based on the Medication Administration Record for daily behavioral monitoring) dated 8/11 through 6/12 indicated the following: >12/11- Number of Behavior Episodes per shift-0. > 1/12- Number of Behavior Episodes per shift-0. > 2/12- Number of Behavior Episodes per shift-0.	F 329		

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F 329	Continued From page 8 > 3/12- Number of Behavior Episodes per shift-0. > 4/12- Number of Behavior Episodes per shift-0. > 5/12- Number of Behavior Episodes per shift-0. > 6/12- Number of Behavior Episodes per shift-0. Review of the Pharmaceutical Consultation reports dated 8/17/11 and 5/2/12 did not indicate the resident was recommended for a gradual dose reduction for Depakote. Review of the Nurse's Notes dated 4/13/12 through 4/22/12 did not indicate any non-pharmacological interventions had been made before the increase of Depakote on 4/22/12. Review of the facility policy and procedure titled Psychopharmacological Medication Use, revised 5/1/10, indicated the following, "1. Facility should comply with the Psychopharmacologic Dosage Guidelines created by the Centers for Medicare and Medicaid Services, the State Operations Manual, and all other Applicable Law relating to the use of psychopharmacologic medications including gradual dose reductions." In an interview with the DON on 8/2/12 at 11:10 a.m., she stated, "I looked for a gradual dose reduction of the Depakote (for Resident 6). I could not find anything."	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	**F 441 483.6 INFECTION CONTROL, PREVENT SPREAD, LINENS**	

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F 441	Continued From page 9 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	*Continued from page 9* **Specific action:** Licensed Nurse 2 received in-service on the facility infection control policy from the DNS to ensure her understanding of the proper procedures when providing patient care. **Direct responsibility:** The DNS is responsible to ensure that the facility infection control policies are observed. **Systemic change:** Licensed staff will receive in-service on the facility infection control policy by the DNS. Periodic monitoring of hand washing is performed by the infection control nurse (DSD) to verify infection control policies are in use. **Monitoring process:** Infection control monitoring will be periodically reviewed by the DNS. Anomalies will be forwarded to the Quality Assurance committee for review and recommendation. *To be completed: August 31, 2012*	

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F 441	Continued From page 10 Based on observations, interviews and record review, the facility failed to maintain an Infection Control Program to prevent the transmission of disease and infection when Licensed Nurse 2 (LN 2) did not wash her hands prior to wound care for 1 of 18 (7) residents. Findings: According to the 8/3/12 Quarterly Minimum Data Set (an assessment tool) Resident 7 had been diagnosed with: heart failure, diabetes mellitus and dementia. The resident also had a surgical wound. A review of Resident 7's August 2012 Physician Orders revealed a list of diagnoses including: dehiscence (bursting open) of [an] operative wound. A 7/4/12 treatment order read, "Zinc Oxide Cream Topical [as needed] to Right Surgical Hip to maintain skin integrity". The same order was reflected on Resident 7's August 2012 Treatment Record. On 8/2/12 at 3:15 p.m., Resident 7's right hip wound was observed. The wound was a hole measuring approximately 11/2 inches deep, 11/2 inches long and 1/2 inch wide. Using a flashlight to look inside the hole, the tissue appeared pink. The scar surrounding the wound measured approximately 4 inches long by 2 inches wide. During an observation on 8/2/12 at 3:30 p.m., LN 2, a treatment nurse provided wound care to Resident 7. LN 2 proceeded to take a container of zinc oxide from the treatment cart without washing her hands. The LN then took a tongue depressor from the cart, scooped some zinc	F 441		

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F 441	Continued From page 11 oxide from the container and into a medication cup. The LN then took a stack of 4 x 4 gauze, a saline bullet (capsule) and some gloves from the treatment cart. LN 2 walked with supplies in hand from Stations 1 and 2 to Stations 3 and 4 (down the back hall, passing the dining/activities room). LN 2 did not wash hands prior to entering the room or prior to performing wound care for Resident 7. On 8/3/12 at 11:20 a.m., the 5/29/12 facility Infection Control Hand Hygiene Monitor Tool was reviewed . It was an educational tool used by the Director of Staff Development (DSD) to monitor whether staff were practicing appropriate hand hygiene. On the specific form reviewed, handwritten at the top of the page were the words "Treat Nurse" and documentation that 3 staff members had been monitored. LN 2 was not one of them. In a concurrent interview with the DSD, she acknowledged LN 2's name was not listed on the Infection Control Hand Hygiene Monitor Tool. According to an undated facility infection control policy and procedure titled "Hand Washing", the purpose of the policy was to prevent the spread of infection. The policy verified "hand washing is the single most important method of infection control. Hand washing is mandatory before and after resident contact and before leaving the work area and upon return". During an interview with LN 2 on 8/2/12 at 3:45 p.m., LN 2 confirmed she did not wash her hands before doing the treatment for Resident 7. LN 2 recognized the cart needed to be brought to the resident's door to prepare for treatment rather than walking down the hall with the supplies.	F 441		

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F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to train employees in emergency procedures when staff were unable to locate emergency supplies for a census of 89. Findings: On 8/2/12 at 10 a.m. LN 3 was asked to find the Emergency Kit in the event of a disaster. LN 3 escorted the surveyor to the medication room and pointed out the "E-kits" or boxes with medications. At this point, LN 3 did not know where to find the Emergency/Disaster kit. After being cued by another nurse regarding its location, LN 3 attempted to look for a set of keys in the top drawer of Medication Cart #1, which she could not find. LN 3 walked over to CN 1 at Medication Cart #2. CN 1 looked through the top drawer of Medication Cart #2, but could not find the keys. The surveyor asked what the keys in the Medication Cart were for and how many sets of keys were there. LN 3 said the keys opened the "Emergency Room" and that there was one set of emergency keys per nurses' station. When the keys were found, LN 3 escorted the surveyor to the "Emergency Supply Water Closet". LN 3 was able to open the door to the	F 518	**F 518 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS** **Specific action:** Facility staff will receive in-service on the facility disaster response including the locations of appropriate disaster supplies. The disaster kit supply list was updated in the Fire and Disaster Manual. **Direct responsibility:** The administrator or designee is responsible to ensure that facility staff is trained in the facility disaster response. **Systemic change:** Periodic disaster drills are performed on all shifts to verify emergency staff response. Disaster drills will be revised to include a review of the facility disaster help sheet which lists locations and procedures for commonly used emergency supplies including key locations. The Fire and Disaster Manual was updated with a current disaster kit supply list. **Monitoring process:** Emergency preparedness monitoring will be periodically reviewed by the DNS. Anomalies will be forwarded to the Quality Assurance committee for review and recommendation. *To be completed: August 31, 2012*	

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 _____	08/03/2012

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F 518	Continued From page 13 closet with a manager's assistance. On the floor of the closet was the Disaster Kit. The surveyor then asked if LN 3 could show her the emergency food supply. LN 3 initially pointed to a closet on Hallway 4, and upon opening it realized it was a linen closet. LN 3 proceeded to walk further down Hallway 4 and unlocked a second linen closet. On 8/2/12 at 10:45 a.m., LN 3 located the Emergency Food Supply closet, having difficulty unlocking it. Further review the facility's emergency preparedness on 8/3/12 at 6:30 a.m., CN 1 was asked to locate the Disaster Kit. CN 1 was observed walking to Medication Cart #1, and with the help of the night nurse looked for the keys in the top drawer of the cart. The keys were not there. CN 1 asked the night nurse (who at the time was using Medication Cart #1) for a different set of keys to open Medication Cart #2. CN 1 walked down the hall to Medication Cart #2 with the set of keys, unlocked the cart and found a set of keys in the top drawer. In an interview with CN 1 on 8/3/12 at 6:45 a.m., CN 1 acknowledged she could not determine which Medication Cart contained the emergency keys. In an interview with LN 4 on 8/3/12 at 6:50 a.m., LN 4 stated there was one [master disaster kit] at each nurses' station. LN 4 escorted the surveyor into the Medication Room but was unable to find a Disaster Kit. She said she could refer to the Disaster Manual located at the nursing station or in the front office. LN 4 agreed it would have taken her a while to find the Disaster Kit. When asked, "Where is the emergency food supply?", LN 4 responded, "outside". During an interview on 8/3/12 at 7 a.m., the	F 518		

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F 518	Continued From page 14 Activities Director stated there was a disaster kit was found at "each station". Review of an undated facility "Emergency Tour" document given to each employee upon hire revealed the following question: "Where is the emergency equipment located? Extension cords are in the medication rooms at Station 1 and 2 and Station 3 and 4". The specific locations of the Disaster Kit and Emergency Food Supply were not identified. The facility's 3/17/12 and 4/10/12 "Disaster Rehearsal Reports" were reviewed. The specific locations for emergency "water, food, essential medical supplies and supportive materials" within the facility were not addressed on the reports. The facility's 6/21/12 and 7/19/12 "Fire/Internal Disaster Drill" documentation was also reviewed. Although items found in the disaster kit were documented as discussed, neither the location of the disaster kit, food or water, specific to the facility were documented. In addition, no information within the Fire and Disaster Manual or documentation requested of the facility on Emergency Preparedness contained anything specific to simple and fast access to keys and supplies in the event of an emergency/disaster. The facility had two separate undated lists describing the disaster kit contents; one was found in the facility's Fire and Disaster Manual and the other was requested of the facility (copy of the list of items on the kit itself). Neither of these documents revealed the location of the disaster kit within the facility. The contents from each list did not match. The facility's Fire and	F 518		

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F 518	Continued From page 15 Disaster Manual recommended, "the contents of the disaster kit be inspected and inventoried after each use and/or disaster rehearsal".	F 518		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 056098	DATE SURVEY COMPLETE: 08/03/2012
NAME OF PROVIDER OR SUPPLIER **COTTONWOOD HEALTH CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **625 COTTONWOOD STREET WOODLAND, CA. 95695**	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This Requirement is not met as evidenced by:
Based on observation and record review the facility failed to ensure each resident was cared for in a manner in which each resident's dignity and respect was maintained for 2 of 18 sampled residents (1,13) when:

1. Staff entered the rooms without knocking on the door and requesting permission to enter for 2 of 18 sampled residents (1, 13).

2. Staff was observed repositioning Resident 1 without addressing him first and explaining to the resident what care they were going to provide.

Findings:

1 a. Resident 1 was most recently admitted to the facility on 2/5/12 with a diagnoses that included persistent vegetative state and pressure ulcer.

Review of the resident's MDS (Minimum Data Set, an assessment tool) indicated Resident 1 was totally dependent on staff for his bed mobility, transfers, personal hygiene and turning, sitting up or lying down.

On 8/2/12 at 11:05 a.m., CNA 1 was observed entering the resident's room without knocking on the door first. CNA 1 then proceeded to touch and move Resident 1 without introducing herself or explaining to the resident what type of care she was going to provide for him before she proceeded.

On 8/3/12 at 10:27 a.m., CNA 2 was observed entering Resident 1's room without knocking on the door first.

1b. Resident 13 was admitted to the facility on 12/29/11 with diagnoses that included debility/decline.

Review of the resident's Admission MDS dated 1/5/12, indicated the resident had the ability to make herself understood and was able to understand others.

On 8/3/12 at 10:12 a.m., and again at 10:27 a.m., CNA 2 was observed entering the resident's room without knocking and/or requesting permission to enter.

Review of the un-dated facility policy and procedure titled, Quality of Life-Dignity, indicated, "1. Residents shall be treated with dignity and respect at all times..6. Residents' private space and property shall be respected at all times. a. Staff will knock and request permission before entering residents' rooms."

2. On 8/2/12 at 11:05 a.m., CNA 1 was observed to touch and move Resident 1 without introducing herself or explaining to the resident what type of care she was going to provide for him before she proceeded

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 056098	DATE SURVEY COMPLETE: 08/03/2012
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 241	Continued From Page 1 Review of the un-dated facility policy and procedure titled, Quality of Life-Dignity, indicated, "8...Procedures shall be explained before they are performed.."

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.

The above isolated deficiencies pose no actual harm to the residents