PRINTED: 08/10/2015
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	06/18/2015

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 a Recertification survey Representing the Department of Public Health HFEN, 31701 HFEN, 34980 HFEN, 34271 HFEN, 34979 HFEN, 31979 Nutrition Consultant, 31472 The facility's census was 88, with a sample size of 18, and 4 random residents	F 000	*The preparation and/or execution of this plan of correction does not constitute admission of 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 the provisions of Federal and State Law require it.*	
F 364 SS=B	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by Based on observation, resident, group and staff interviews, and document review, the facility failed to ensure residents received food items at temperatures considered palatable for 1 of 18 sampled residents (12) and 4 random residents (21, 22, 19, 20) of a census of 88 when the residents complained they received food that was cold This failure to serve food considered unpalatable by the residents had the potential to result in the	F 364	***F364 483.35(d)(1)-(2)*** ***NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP*** ***How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.*** Food trays were passed and the food temperatures could not be corrected for the date in question. ***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 residents have the potential to be affected by the temperature of the food. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.*** Dietary staff members were in-serviced on June 18, 2015. The in-service included, but was not limited to "Meal Service and Acceptable Serving Temperatures."	

ACCEPTED 8/12/15 CK

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
MICHAEL SMITH	ADMINISTRATOR	07/10/2015

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 364	Continued From page 1 residents not eating their meals and experiencing weight loss. Findings: During resident interviews conducted during initial 6/16/15, the following four residents complained about the temperature of their food being cold: > At 7:05 a.m., Resident 21 stated the food was cold at times. > At 7:06 a.m., Resident 22 stated the food was too cold. > At 7:10 a.m., Resident 19 stated the food was cold. > At 7:15 a.m., Resident 20 stated breakfast was cold. > During the group interview on 6/17/15, at 10 a.m., 1 of 10 residents present (12) complained about the temperature of their breakfast was cold.. During a sample of a regular diet test tray transported from the kitchen on cart 3 to the nursing unit where residents 21, 22, 19, 20, and 12 resided on 6/18/15 at 7:40 a.m., the Administrator (ADM), Director of Dietary Services (DDS), Nutrition Services Director (NSD), and two surveyors were present when the temperatures of the food was taken and tasted. A review of the tray line temperature log for breakfast dated 6/18/15 indicated, the initial temperature for the breakfast meat (sausage) was recorded as 190° F. The sausage on the test	F 364	Dietary staff members will provide food prepared by methods that conserve nutritive value, flavor and appearance; and food that is palatable, attractive and at the proper temperature. Dietary staff members will use the facility "Test Tray Evaluation" form to record temperatures of food products on the trayline prior to serving food. Additionally, dietary staff members will evaluate the food for acceptable flavor, texture, portion size and ensure the accuracy of the diet order from the physician. Trays will be delivered to the residents in a timely manner to ensure the proper temperature is achieved and exceeded on the unit. ***How the facility plans to monitor its performance to make sure that solutions are sustained.*** Dietary supervisor will monitor trayline to ensure compliance with the facility policies and procedures related to preparation of foods, food quality and serving temperature. Dietary supervisor will follow a test tray on the unit three times per week. The food temperatures of the test tray will be measured for compliance. Additionally, the food will be tasted for flavor, palatability and texture. The temperatures will be recorded on the "Test Tray Evaluation" form. This form will be reviewed by the dietary supervisor	

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F 364	Continued From page 2 tray was 116° F. This represented a temperature drop of 74° F. According to the tray line temperature log for breakfast dated 6/18/15 indicated the French toast was 160° F prior to leaving the kitchen. The temperature of the french toast on the test tray was 102° F. This represents a drop in temperature of 58° F. Neither the sausage links nor the french toast was palatable to the testers in temperature due to them tasting lukewarm. Review of the facility undated document titled "Test Tray Evaluation", from [Name of organization] indicated, "Acceptable temperature for hot entree greater than or equal to 120° F, and french toast greater than or equal to 120° F."	F 364	and administrator for compliance and follow up as needed. ***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.*** This plan will be evaluated for its effectiveness. Discrepancies noted will be reviewed by the QA Committee at the next quarterly meeting. ***Correction date: July 18, 2015***	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and document review, the facility failed to prepare food in a safe, sanitary manner for a census of 88	F 371	***F371 483.35(i)*** ***FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY*** ***How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.*** No residents were affected as the uncut cantaloupe was discarded by the dietary staff. There was no negative outcome. ***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.*** No other residents were affected as the uncut cantaloupe was discarded by the	

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F 371	Continued From page 3 residents when the cook thawed raw chicken under continuous running water next to a sink containing fresh uncut cantaloupe. This failures placed the residents at risk for food borne illness due to cross contamination. Findings: During an observation of food production in the kitchen on 6/16/15 at 1:20 p.m., one sink containing several fresh uncut cantaloupes with bruised spots and broken skin, was located immediately next to a sink with raw chicken in plastic bags submerged in a pan being thawed by continuous running water. The pan was located at the lip of the sink and water, with the potential for splashing as the water ran over the raw chicken onto the cantaloupe. Review of the undated facility document titled "Food Preparation" indicated, "Policy: Thawing Of Meats ... 3C avoid cross-contamination from the water dripping from food or splashing onto other foods or preparation sites..." According to the Federal Food Code 2013, to avoid cross-contamination, sinks and food preparation areas should not facilitate opportunities for cross-contamination. It further states, food should be protected from cross-contamination by separating raw animal foods during preparation from other raw foods such as fruits and vegetables. These items should be prepared at different times or in different areas. Contaminates may be present on the outside of packaged food containers through the packing, storing, and handling process. Whenever water comes into contact with fresh	F 371	dietary staff. There was no negative outcome. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.*** Dietary staff members were in-serviced on the following topics: • "Thawing and Storage of Raw Meat" - in-service completed on June 17, 2015. • "Preventing Food-Borne Illness" – in-service completed on June 17, 2015. Dietary staff will follow the policies and procedures outlined in the above two referenced in-services. Dietary supervisor will review daily menus to identify meats to be thawed. Staff will be observed thawing and storing the meat to ensure compliance. Dietary supervisor will follow up with staff members to ensure that the thawing and storage procedures are being followed. Additionally, this will include following the policies and procedures related to preventing food borne outbreaks. ***How the facility plans to monitor its performance to make sure that solutions are sustained.*** Dietary supervisor will follow up with staff members to ensure that the thawing and storage procedures are being followed.	

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F 371	Continued From page 4 produce, its quality dictates the potential for its contamination. A concurrent interview with Registered Dietitian (RD) 2 and Director of Dietary Services (DDS) on 6/16/15 at 1:20 p.m. When asked if it was okay to have fresh uncut cantaloupe in the sink next to the raw chicken thawing under running water, they said, "It's not ok to do this."	F 371	RD will monitor thawing and storage procedures when in the facility. This also includes monitoring procedures related to preventing food borne outbreaks. Any discrepancies will be corrected immediately and reported to the administrator. ***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.*** The plan will be evaluated for its effectiveness. Discrepancies noted will be reviewed by the QA Committee at the next quarterly meeting. ***Correction date: July 18, 2015***	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an 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	F 441	***F441 483.65)*** ***INFECTION CONTROL, PREVENT SPREAD, LINENS*** ***How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.*** Resident 3's wheelchair was repaired within 10 minutes of being identified by the surveyor. The wheelchair in question had been identified the need to replace the arm rests. The facility had already ordered the necessary replacement arm rests. The new	

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F 441	Continued From page 5 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: Based on observations, staff interview, and facility document review, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection when both arm rests of a wheelchair were cracked and unable to be adequately sanitized for 1 of 18 sampled residents (3). This failure had the potential of skin tears and transmission of disease. Findings: During the Initial Tour on 6/16/15 beginning at 7:30 a.m., the covering of the arm rests on Resident 3's wheelchair were observed to have been cracked. During the Environmental Tour with the Maintenance Supervisor (MS) on 6/17/15 beginning at 7:20 a.m., MS verified Resident 3's wheelchair arm rests were cracked. MS stated the arm rests would not be able to be cleaned properly due to the cracks exposing the foam and the cleaning solution going down into the foam.	F 441	arm rest was delivered and it was installed immediately. ***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.*** Within the first hour of the survey process commencing, a complete sweep of the facility was conducted to visually inspect all facility wheelchairs for torn or missing armrests. Additionally, the visual inspection included the entire wheelchair and not just the armrests. No additional wheelchairs were identified. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.*** Staff members were in-serviced on "How to Properly Report Broken or Worn Equipment." Additionally, the in-service included notifying their supervisor of any equipment that posed a safety hazard or risk to any resident or employee. ***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.*** Facility employees will continue to communicate identified equipment or	

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F 441	Continued From page 6 In a staff interview and facility document review on 6/17/15 at 8:30 a.m. with Rehab Aide (RA), RA stated she was responsible for identifying wheelchair repairs. During review of a facility document titled Audit: w/c (wheelchair), dated 6/12/15, and audited by RA, the RA did not identify Resident 3's wheelchair arm rests as being cracked and in need of repair or replacement.	F 441	physical plant repairs to the director of maintenance through the use of the maintenance logs, telephone, texting or face to face interactions. Random visual audits will be conducted by the management team to identify facility equipment and physical plant items in need of repair. Any discrepancies will be reviewed at the Quarterly Quality Assurance Committee Meeting.	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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: Based on observation and staff interview, the facility failed to provide a safe environment when paper stored in boxes in a storage closet were stacked below an automatic sprinkler system, not allowing for an 18" vertical clearance. This failure had the potential to lead to death due to not allowing the sprinkler system to properly function to extinguish a fire. Findings: During the Environmental Tour on 6/18/15 beginning at 7:20 a.m. with the Maintenance Supervisor (MS), a closet identified as "Storage" between Rooms 108 and 110 was opened by the MS. In the closet were boxes stacked from the	F 465	***Correction date: July 18, 2015*** ***F465 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON*** ***How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.*** The box was removed immediately to allow for the required 18" clearance below the fire sprinkler. ***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.*** A facility sweep of all closets, rooms, offices and other facility areas was conducted to identify fire sprinklers not having 18" clearance below the fire sprinklers.	

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F 465	Continued From page 7 floor to approximately 10" below the ceiling. On the ceiling was a fire sprinkler. Review of the National Fire Protection Association (NFPA) 13, 2002 Edition titled Installation of Sprinkler Systems indicated. "...Sprinklers shall be located so as to minimize obstructions to discharge as defined in...8.5.5.3...Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. [inches] (457 mm, [a unit of measure]) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with 8.5.5.3." During the continued interview with the MS on 6/18/15 at 7:20 a.m., the MS stated the boxes contained medical and financial records and verified they were not 18" below the fire sprinkler.	F 465	No additional fire sprinklers were identified as being out of compliance. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.*** Facility staff members were in-serviced on the key requirements in providing a safe and functional environment for residents, staff and visitors. This in-service was centered around the requirements of NFPA *"Sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.3.. Continuous or non-continuous obstructions that interrupt the water discharge in a horizontal plane more than 18" below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with 8.5.5.3."*	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	***How the facility plans to monitor its performance to make sure that solutions are sustained.*** The director of maintenance will conduct random audits of the facility storage closets, offices, rooms and common areas. These random checks will be completed bi-weekly to ensure compliance in providing a safe, functional, sanitary and comfortable environment for residents, staff and the public. ***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***	

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F 514	Continued From page 8 by: Based on staff interview and clinical record review, the facility failed to ensure clinical records were complete for 3 of 18 sampled residents (12, 13, and 4) when: 1. Indwelling urinary catheter care was not consistently documented for Resident 12; 2. Indwelling urinary catheter care was not consistently documented for Resident 13; 3. Indwelling urinary catheter care was not consistently documented for Resident 4; and 4. The facility failed to completely and accurately note physician's orders for Resident 4 when orders were not noted and brought forward. These failures prevented other members of the healthcare team from having access to accurate, vital medical information, potentially affecting clinical decision-making and ensuring safe, effective care. Findings: 1. Resident 12 was admitted for rehabilitation following a fracture and had an indwelling urinary catheter. a. Review of the catheter care records for the month of March 2015 for Resident 12 indicated the following shifts did not document that catheter care was provided: > NOC (night) shift: 3/27 and 3/28/15 > Day shift: 3/19, 3/20, and 3/23 through 3/26/15 > PM (afternoon/evening) shift: 3/19, 3/22, 3/25	F 514	***is integrated into the quality assurance system.*** Any discrepancies from the random audits will be noted and reviewed at the next Quality Assurance Meeting. ***Correction date: July 18, 2015*** ***F514 483.75(l)(1)*** ***RES RECORDS-*** ***COMPLETE/ACCURATE/ACCESSIBLE*** ***How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.*** The clinical records for those patients identified cannot be completed due to timeliness. ***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 clinical records for other patients identified cannot be completed due to timeliness. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.*** Education will be provided by the Director of Staff Development or designee to CNAs regarding the process of providing foley catheter care and the requirement to	

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F 514	Continued From page 9 through 3/28 and 3/31/15 Of 59 total shifts, 15 shifts 25 (%) did not indicated catheter care was provided. b. For the month of April 2015, catheter care recorded by the CNA was documented in two parts on the form. The following shifts did not have documentation indicating catheter care was provided: > NOC shift: 4/1, 4/2, 4/7, 4/8, 4/13, 4/14, 4/19, 4/20, and 4/21 through 4/30/15 > Day shift: 4/1 through 4/9, 4/19, 4/25, and 4/30/15 > PM shift: 4/1 through 4/9, 4/11, 4/13 through 4/19, and 4/21 through 4/30/15 Of 90 total shifts, 57 (63%) did not document catheter care was completed. c. For May 2015, the following shifts did not indicated catheter care was provided: > NOC shift: 5/1 through 5/22, and 5/24 through 5/31/15 > Day shift: 5/1 through 5/13, 5/15 through 5/17, 5/19, and 5/26 through 5/31/15 > PM shift: 5/ through 5/18, 5/22, 5/23, and 5/27 through 5/31/15 Of 93 total shifts, 78 (87%) did not document catheter care was provided for Resident 12. According to the undated facility policy Catheter Care, Urinary, the policy described, under Catheter Care, Steps in the Procedure, "...7. Wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry. 8. Use a clean washcloth with warm water and soap to cleanse and rinse the	F 514	document the care provided in Care Tracker (the electronic system for CNAs to document the care provided). The CNAs will provide catheter care each shift and document that care in Care Tracker. If the CNA identifies impaired skin integrity, they will notify the charge nurse immediately. ***How the facility plans to monitor its performance to make sure that solutions are sustained.*** Monitoring shall be ongoing by the Director of Medical Records or designee through the Care Tracker System. Each patient with a foley will have special instructions to the CNA regarding the catheter care and the CNA will document in Care Tracker when catheter care is delivered. Medical Records will audit the documentation of patients with foley catheters Monday-Friday with the exception of holidays. Any audit found to be out of compliance will be forwarded to the Director of Nursing for follow up. ***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.***	

PRINTED: 08/10/2015
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	06/18/2015

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COTTONWOOD HEALTH CARE	625 COTTONWOOD STREET WOODLAND, CA 95695

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F 514	Continued From page 10 catheter from insertion site to approximately four inches outward. 9. Check drainage tubing and bag to insure that the catheter is draining properly." During an interview with the Director of Staff Development (DSD) on 6/18/15 at 11:45 a.m., the DSD stated the new forms were instituted in March 2015 when the computerized system for CNA charting could not be changed to add catheter care. The CNAs were inserviced on the new forms and were to document the cleansing of the perineum and catheter, emptying the catheter bag, and securing the tubing to prevent injury each shift. During an interview with the Acting Director of Nursing (ADON) on 6/18/15 at 11:15 a.m., she stated she monitored and interviewed the CNAs regarding catheter care and knew the care was being given, though not documented completely. When asked what her expectation was for the documentation, she stated, "They [CNAs] should document their care every shift on the new ADL [activities of daily living] form [same as the catheter care form named in this document]." 2. Resident 13 was admitted for multiple health issues including chronic pain and had an indwelling urinary catheter. The form, used by the Certified Nurse Assistants (CNAs) to document the catheter care they performed each shift, was reviewed for Resident 13. The forms for March through June 2015 were incomplete or missing regarding catheter provided during each shift.	F 514	Any discrepancies will be noted and reviewed at the next Quality Assurance Meeting. ***Correction date: July 18, 2015*** ***F517 483.75(m)(1)*** ***WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS*** ***How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.*** The dietary disaster plan that was located in the dietary department (with the key to the emergency food closet) was copied and placed with the emergency food in the emergency food closet. The dietary disaster plan is now located in two separate areas of the facility. ***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.*** No other residents were affected. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.*** The dietary supervisor will keep a copy of the dietary disaster plan in both locations as previously noted in this plan of correction. When the disaster plan is updated, it will be updated in both locations.	

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F 514	Continued From page 11 a. There were no March or April 2015 catheter care documentation provided upon request for Resident 13. b. During the month of May 2015 the following shifts did not document catheter care was completed: > NOC shift: 5/1 through 5/15, 5/18 through 5/22, 5/24, 5/25, 5/28, and 5/31/15 > Day shift: 5/1 through 5/18, 5/21, 5/22, 5/27, 5/30, and 5/31/15 > PM shift: 5/1 through 5/17, 5/22, 5/23, and 5/28/15 Of 93 total shifts, 67 shifts (72%) did not document catheter care was completed. c. From June 1, 2015 through the NOC shift of June 16, the following shifts did not document that catheter care was provided: > NOC shift: 6/1 through 6/12/15 > Day shift: 6/1 through 6/10, 6/15, and 6/16/15 > PM shift: 6/1 through 6/11, 6/15, and 6/16/15 Of 52 total shifts, 37 (71%) did not document catheter care was provided. During an interview with the Director of Staff Development (DSD) on 6/18/15 at 11:45 a.m., the DSD stated the new forms were instituted in March 2015 when the computerized system for CNA charting could not be changed to add catheter care. The CNAs were inserviced on the new forms and were to document the cleansing of the perineum (The area between the anus and the scrotum in the male and between the anus and the vulva in the female) and catheter, emptying the catheter bag, and securing the tubing to prevent injury each shift.	F 514	***How the facility plans to monitor its performance to make sure that solutions are sustained.*** Each quarter the administrator or designee will audit the dietary disaster plan for completeness and to ensure that there is a copy in the dietary department and the emergency food closet. ***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.*** Any discrepancies will be noted and reviewed at the next Quality Assurance Meeting. ***Correction date: July 18, 2015***	

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F 514	Continued From page 12 3. Resident 4 was admitted for diabetes, heart disease, and dementia. Resident 4 had an indwelling urinary catheter. a. During the month of March 2015, the following shifts did not document catheter care was provided for Resident 4: > NOC shift: 3/26, and 3/28/15 > Day shift: 3/13, 3/15, 3/16, 3/22, 3/23, and 3/28/15 > PM shift: 3/13, 3/15, 3/19, 3/22, 3/26, and 3/28 through 3/31/15 This represents 17 shifts (29%) in which catheter care was not documented as being provided. During a review of clinical records, a new form, created to enable Certified Nurse Assistants (CNAs) to document the catheter care they performed each shift, was reviewed for Resident 4. b. For April 2015 two different catheter care forms were found. The newly implemented form indicated the following shifts did not document catheter care: > NOC shift: 4/1 through 4/30/15 > Day shift: 4/1 through 4/6, 4/8 through 4/27/, 4/29, and 4/30/15 > PM shift: 4/1 through 4/19, 4/21 through 4/27, and 4/30/15 c. A second, handwritten April 2015 "Catheter Care" document, included the following shifts with no documentation of catheter care: > NOC shift: 4/1, 4/2, 4/7, 4/8, 4/14, 4/15, 4/20,4/21, 4/26, and 4/27/15 > Day shift: 4/1 through 4/3, 4/6 through 4/8, 4/15,	F 514		

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F 514	Continued From page 13 4/18 through 4/21, and 4/26/15 > PM shift: 4/1 through 4/ 3, 4/9, 4/11 through 4/15, 4/17, and 4/18 through 4/30/15 Of 90 total shifts, 45 shifts (50%) failed to document catheter care was completed. d. During the month of May 2015, the following shifts did not document catheter care was completed: > NOC: 5/1 through 5/11, 5/14 through 5/16, 5/18, and 5/20 through 5/31/15 > Day shift: 1, 2, 3, 7, 11, 17, 26, 27, and 5/31/15 > PM shift: 5/1 through 5/11, 5/16 through 5/18, and 5/20 through 5/31/15 Of 93 total shifts, 62 shifts (67%) failed to document catheter care was provided. e. For June 2015, the following shifts did not indicate catheter care was provided: > NOC shift: 6/1, 6/2, 6/11, and 6/12/15 > Day shift: 6/1, 6/2, 6/6, and 6/12/15 > PM shift: 6/1 through 6/6, 6/9, 6/10, 6/13, and 6/14/15 Of 42 total shifts 18 shifts (43%) did not document catheter care was completed. During a review of the undated facility policy Catheter Care, Urinary, the policy described, under Catheter Care, Steps in the Procedure, "...7. Wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry. 8. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. 9. Check drainage tubing and bag to insure that the catheter is draining	F 514		

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F 514	Continued From page 14 properly." During an interview with the Acting Director of Nursing (ADON) on 6/18/15 at 11:15 a.m., she stated she monitored and interviewed the CNAs regarding catheter care and knew the care was being given, though not documented completely. When asked what her expectation was for the documentation, she stated, "They [CNAs] should document their care every shift on the new ADL [activities of daily living] form [same as the catheter care form named in this document]." 4. Resident 4 was admitted for diabetes, dementia, and urinary retention. During a review of Resident 4's clinical record, the following orders located on the Telephone Orders Sheet and Physician Orders for Resident 4 did not include the date, time, and /or signature of the nurse receiving the orders: a. D/C (discontinue) Med Pass/FSBS (fasting blood sugar) and sliding scale Humolog (insulin to decrease blood sugar); b. May be comfort care. Resident refuses to eat and drink. Low intake and output; c. DC (discontinue) Coumadin orders and labs; and d. May crush all meds (medications) unless otherwise specified. A review of the facility policy titled Administrative Manual revised 4/28/2004 included, "12. Physician's Treatment Plan (Physician's Orders) and Progress Note b. Verbal/telephone orders for drugs and treatment will be accepted/received	F 514		

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F 514	Continued From page 15 only by licensed nurses... g. Telephone orders are to be recorded immediately in the resident's record by the person receiving the order(s) and shall be dated and included the time of the order." During an interview with the DON on 6/16/15 at 2:35 p.m., the DON verified the physician's orders for Resident 4 located on the Telephone Orders Sheet and Physician Orders did not include the date, time, and /or signature of the nurse receiving the order. The DON stated, the physician orders were to be "noted" which was to included the date, time and signature of the nurse receiving the order.	F 514		
F 517 SS=C	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and document review, the facility failed to have a detailed, accessible, and complete emergency and disaster plan when: The dietary disaster plan did not include instructions for special dietary needs for residents who were on gluten free, renal, and vegetarian diets. These failures had the potential to cause staff confusion during an emergency or disaster situation.	F 517		

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F 517	Continued From page 16 Findings. Review of the dietary emergency plan indicated there were no instructions or menus for residents with special dietary needs such as gluten free, renal, and vegetarian diets. During an interview with Registered Dietitian (RD) 2 on 6/16/15 at 1:40 p.m., RD 2 stated these instructions were developed and available in the dietary office, but further stated they were not included in the dietary emergency plan, and facility's staff did not have access to them. RD 2 further stated, "The disaster plan should be kept in with the emergency food supply."	F 517		

California Department of Public Health

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ACCEPTED 7/13/15 CH

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during a Recertification survey. Representing the Department of Public Health: HFEN, 31701 HFEN, 34980 HFEN, 34271 HFEN, 34979 HFEN, 31979 Nutrition Consultant, 31472 The facility's census was 88 with a sample size of 18, and 4 random residents.	A 000		
A 969	T22 DIV5 CH3 ART5-72543(a) Patients' Health Records (a) Records shall be permanent, either typewritten or legibly written in ink, be capable of being photocopied and shall be kept on all patients admitted or accepted for care. All health records of discharged patients shall be completed and filed within 30 days after discharge date and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no case less than 7 years. All exposed X-ray film shall be retained for seven years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending physician, the facility staff or any authorized officer, agent, or employee of either, or any other person authorized by law to make such request. This Statute is not met as evidenced by:	A 969	***A969*** ***T22 DIV 5 CH3 ART5-72543(a) PATIENTS' HEALTH RECORDS*** ***How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.*** The Discharge Summary was signed by the physician. The signature and date cannot be corrected. ***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.*** Medical records audited discharge files over a 30 day period to identify any discrepancies pertaining to the physician signature and date on the Discharge Summary. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.*** July 10, 205	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

JAMES ELLIS-SHERINIAN | VICE PRESIDENT OF OPERATIONS

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A 969	Continued From page 1 Based on staff interview, clinical record review, and facility policy review, the facility failed to complete a health record within 30 days of a residents discharge for one of 18 sampled residents (16). This failure resulted in insufficient information, which may be necessary to facilitate future care needs of the residents. Findings: In a concurrent clinical record review and staff interview for Resident 16 on 6/17/15 at 3 p.m. with Medical Records (MR), MR verified a facility document titled Physician's Discharge Summary and Physician Orders for April 2015 were signed and dated by the physician nine days after the 30 day requirement. A facility policy titled Health Information/Record Manual revised 7/11/2003 indicated, "The physician shall complete, sign and date a Discharge Summary upon discharge/within 30 days of discharge..."	A 969	Medical records provided the physicians with a copy of the facility policy pursuant to Discharge Summary requirements. ***How the facility plans to monitor its performance to make sure that solutions are sustained.*** Medical records will conduct audits on discharged medical records. This audit will include, but not be limited to the physician signing the Discharge Summary within 30 days. Any discrepancies will be noted to the administrator and to the physician who was not in compliance. ***The facility must develop a plan for ensuring that correction is achieved and sustained. This plan mnst be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.*** Any discrepancies will be noted and reviewed at the next Quality Assurance Meeting. ***Correction date: July 18, 2015***	

California Department of Public Health

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A 000	W&I 15655 Initial Comments The following reflects the findings of the California Department of Public Health during a Recertification survey. Representing the Department of Public Health: HFEN, 31701 HFEN, 34980 HFEN, 34271 HFEN, 34979 HFEN, 31979 Nutrition Consultant, 31472 The facility's census was 88, with a sample size of 18, and 4 random residents.	A 000	*A002* ***W&I 15655 W&I 15655(a)(2)*** ***How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.*** Upon hire and on a yearly basis all employees are trained pursuant to the Department of Justice curriculum titled, "Your Legal Duty…Reporting Elder and Dependent Abuse." The employees in question were not given the post-test after completing the referenced pre-test and required training program. These employees were given the post-test and this document is in their employee file. ***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.*** Employees not completing the post-test assessment after completing the referenced pre-test and required training program were given the post-test. The completed post-test is in their employee file.	ACCEPTED 7/14/15 AO
A 002	W&I 15655 W & I 15655(a)(2) 15655. (a) (2) Each long-term health care facility as defined in Section 1418 of the Health and Safety Code and each community care facility as defined in Section 1502 of the Health and Safety Code shall comply with paragraph (1) by January 1, 2001, or, if the facility began operation after July 31, 2000, within six months of the date of the beginning of the operation of the facility. Employees hired after June 1, 2001, shall be trained within 60 days of their first day of employment. This Statute is not met as evidenced by: Based on staff interview, document reviews, and facility policy review, the facility failed to provide complete training for reporting of elder and dependent adult abuse within 60 days of hire for 30 of 43 employees hired since the previous survey. This failure placed the residents at risk for abuse	A 002		

July 10, 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JAMES ELLIS-SHERINIAN | TITLE: VICE PRESIDENT OF OPERATIONS | (X6) DATE

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COTTONWOOD HEALTH CARE	625 COTTONWOOD STREET WOODLAND, CA 95695

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A 002	Continued From page 1 going unreported to the facility, Ombudsman, and regulatory agencies. Findings: During document reviews on 6/17/15 at 2:30 p.m., the facility's employment records indicated that 30 of it's employees hired since 7/11/14, had not received a post-test for mandated abuse reporting. According to the facility's policy titled "Elder/Dependent Abuse" dated 5/6/13, all employees must receive training on abuse within 60 days of employment, "utilizing the Department of Justice (DOJ) training materials." Review of the Department of Justice curriculum Titled "Your Legal Duty... Reporting Elder and Dependent Abuse" indicated the training program was to include a pre and post-test and must be administered to all employees within 60 days of hire. During an interview with the Director of Staff Development (DSD) on 6/17/15 at 10 a.m., she stated, "No employees had a post-test for abuse given within 60 days of hire since the last survey" on 7/11/14.	A 002	***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 has been instructed to follow the training requirements for the Department of Justice curriculum entitled, "Your Legal Duty…Reporting Elder and Dependent Abuse." This includes, but is not limited to the pre-test, training program and post-test. This process will be followed for all new hires within 60 days of hire. Additionally, this training protocol will be followed annually for all employees. ***How the facility plans to monitor its performance to make sure that solutions are sustained.*** The administrator will review new hire employee files to ensure that all required training programs have been completed. This includes, but is not limited to the Department of Justice curriculum entitled, "Your Legal Duty…Reporting Elder and Dependent Abuse," pre-test, training program and post-test.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000008	A. BUILDING: _____ B. WING _____	06/18/2015

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

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