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

PRINTED: 02/12/2016
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 _____	C 02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH CARE CENTER	625 COTTONWOOD STREET WOODLAND, CA 95695 acceptable POC 3/2/16 CDPH HFES

(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 an abbreviated survey for the investigation of a complaint #CA00471110. Representing the Department of Public Health: HFEN 35598 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	**"This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery."** **Preparation and/or execution of this Plan of Correction does not constitute admission by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it's required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 483."**	
F 514 SS=D	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 by: Based on staff interview, clinical record review, and facility policy review, the facility failed to maintain complete and accurate clinical records for 2 of 3 sampled Resident's (1 and 2) in accordance with professional standards when:	F 514		

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

ADMINISTRATOR - MICHAEL SMITH 2/26/16

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 514	Continued From page 1 1) Multiple Licensed Nurses (LN) did not sign the Medication Administration Record for Resident 1's (MAR) with a full signature to correspond with their initials and 2) Two Resident's (1 and 2) names were omitted on a Fall Risk Assessment document in the clinical record. This failure prevented other members of the healthcare team from having access to accurate, complete and vital medical information, potentially affecting clinical decision making and ensuring safe, effective care. Findings: 1) A review of Resident 1's MARs dated "11/06/2015- 11/30/2015" included an order as follows: "Order date: 11/06/15 Morphine Sulfate (opioid pain medication) 20 mg/ml (unit of measure) solution... give 0.5 mg = 10 mg oral...". The bottom portion of the document contains the signature of 1 LN to correspond to the initials indicating the medication was administered to Resident 1. Two additional initials of LNs are present on the MAR but do not have a full signature of the LN administering the medication. The MAR page with the order written as, "11/02/15 Pain assessment q (every) shift. Chart using pain scale 0-10...." reflects two LN initials with no corresponding full signatures at the bottom portion of the document. The MAR page with the order written as "11/2/15 Morphine Sulfate 20 mg/5 ml solution... give 5	F 514	**F514 483.75(l)(1) RECORDS-COMPLETE/ACCURATE/ACCESSIBLE** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility will review resident's MAR and Fall Risk Assessment's for accuracy and completion. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what the corrective action will be taken.** The facility will review resident's MAR and Fall Risk Assessment's for accuracy and completion. **3. What measure 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 given to Licensed Nurses by the Director of Nursing Services or designee regarding accuracy and completion of Medical Records,	3/10/16

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F 514	Continued From page 2 mg" was administered twice as indicated with an LN's initials. The bottom portion has no signatures of the full LN name. In a telephone interview with the Director of Nursing (DON) on 2/3/16 at 1:43 p.m., she verified the MAR records for Resident 1 did not have full signatures of LNs administering medications or monitoring for pain. The DON further stated the expectation is for LNs to completely document on MARs including the signature on the bottom. The DON confirmed LN 1 had omitted her signature on MAR documents. In a telephone interview with LN 1 on 2/4/16 at 7:16 a.m., she stated "I do not remember if I signed the bottom or not". LN 1 stated the expectation is the "bottom is signed with your full name". A review of the facility policy titled "Charting and Documentation", revised April 2008, stipulated "...6. Documentation of procedure and treatments shall include care specific details and shall at a minimum:...b. The name and title of the individual(s) who provided care...". 2) A review of Resident 1's clinical record document titled "Fall Risk Evaluation" included entries on 11/2/15 and again on 11/6/15. The document had a section in which the Resident's name, attending physician, record no., and room/bed are to be completed. The line was blank. There was no Resident name on the document in any location. Additionally, a review of Resident 2's clinical record document titled " Fall Risk Assessment" with an entry on 11/21/15 also did not have the	F 514	including the MAR and Fall Risk Assessments. **4. 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. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Monitoring shall be ongoing done by the Director of Nursing or designee through audits which occurs Monday-Friday. Director of Medical Records or designee through the audit process will ensure all MAR and Fall Risk Assessment's are completed and accurate. Any audit found to be out of compliance will be forwarded to the appropriate license nurse for action and to the Director of Nursing for follow up. Any trends identified will be forwarded to the QAPI program and a plan of correction will be implemented and tracked until threshold is met. **5. Date when the corrective action will be completed.**	

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F 514	Continued From page 3 Resident's name in any location on the document. During a telephone interview with the DON on 2/3/16 at 1:43 p.m., she verified there was no Resident name or identifier on either Resident 1's "Fall Risk Evaluation" or on Resident 2's "Fall Risk Assessment". The DON stated the expectation is for clinical record documents to have Resident names to be complete. The facility policy provided did not include any specific guidance on including a resident's name on clinical record documents.	F 514	**3/10/2016**	