PRINTED: 12/29/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	X* PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		056258	B WING_		C 12/29/2017
11-1/0/2/20	PROVIDER OR SUPPLIES			STREET ADDRESS CITY STATE ZIP CODE 2490 COURT STREET REDDING, CA 96001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT IEACH CORRECTIVE ACTION SHOU GROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 000	California Departr abbreviated stand and one entity rep Complaint numbe Entity Reported In The inspection was complaint and ent	ects the findings of the nent of Public Health during an ard survey for one complaint orted incident. r: 497485 cident: 498307 Is limited to the specific lity reported incident to the findings.	F 00	"Preparation, submission and/or execution of this Plan of Correct does not constitute admission or agreement by the Provider of the of the facts alleged or conclusion forth in this statement of deficie The Plan of Correction is prepa submitted and/or executed solely because it is required by the proof federal and state law."	tion e truth ns set ncies. red,
	29391, HFEN Four federal deficition complaint number and 514. No deficiency was	Department of Public Health encies were written for 497485 at F157, F247, F279 issued for entity reported		This Plan of Correction constitute facility's credible allegation of compliance. F-157 NOTIFY OF CHANGES (INJURY/DECLINE)	
	notident 498307. NOTIFY OF CHAI (INJURY/DECLIN CFR(s) 483 10(b)	E/ROOM, ETC)	F 15	7 How Corrective Action will be accomplished for residents affective Action will be action with the action of the action	cted:
	consult with the re known, notify the or an interested fa accident involving injury and has the intervention, a sig physical, mental, deterioration in he status in either life	mediately inform the resident: isident's physician; and if resident's legal representative amily member when there is an the resident which results in potential for requiring physician nificant change in the resident's or psychosocial status (i.e., a salth, mental, or psychosocial attreatening conditions or ons), a need to alter treatment.		Resident 1 no longer resides at facility. Identification of Residents with Potential to be affected: All residents who had a room c roommate change had the potential be affected.	the hange or

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 in 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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CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO 0938-039
	OF DEFICIENCIES OF CORRECTION	X*I PROVIDER SUPPLIER/CLIA IDENTIFICATION NUMBER	100, 100, 100, 100, 100, 100, 100, 100,	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		056258	B WING		12/29/2017
NAME OF F	PROVIDER OF SUPPLIES			STREET ADDRESS CITY STATE ZIP GODE	
WINDSOR REDDING CARE CENTER			2490 COURT STREET		
			REDDING, CA 96001		
PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION,	PREFIX TAG	"	OULD BE COMPLETION
F 157	existing form of tra- consequences or	age 1 need to discontinue an eatment due to adverse to commence a new form of ecision to transfer or discharge	F 15	Measures to Prevent Recurrence Social Services Director was edu by the Administrator on 1/22/20 regarding the facility policy title	ucated 018
	the resident from t §483.12(a) The facility must a	he facility as specified in		"Room or Roommate Change," will follow this policy effective 1/22/2018 for all residents who ra a room change and/or roommat	require
	or interested family change in room or specified in §483 resident rights und	resident's legal representative y member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or offied in paragraph (b)(1) of		Monitoring Corrective Action a Responsibility: Medical Records will audit all r	room
	The facility must re the address and pi legal representative	ecord and periodically update none number of the resident's e or interested family member NT is not met as evidenced		changes for proper notification report findings to stand up daily Social Services Director will repfindings to QA for 6 months for intervention and follow up as no	y. oort - further
	by: Based on observa review, for one of t	ation, interview, and record hree sampled residents, the		<u>Date of compliance:</u> 1/29/18	
	interested family m	mptly notify the resident's nember or responsible party change her room assignment ent 1)		F-247 RIGHT TO NOTICE BEI ROOM/ROOMMATE CHANGE	
	This failure had the residents, interests responsible parties	e potential for the rights of the ed family members, and s to be denied as well as of all parties involved.		How Corrective Action will be accomplished for residents affective. Resident 1 no longer resides at facility.	

A facility policy titled. "Room or Roommate Change." dated 12/1/13, was reviewed and read.

Findings

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

PRINTED: 12/29/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO 0938-0391
	T OF DEFICIENCIES OF CORRECTION	X1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	4 4 4 4 4 4	TIPLE CONSTRUCTION	X3 DATE SURVEY COMPLETED
		056258	s WING		C 12/29/2017
.,	NAME OF PROVIDER OR SUPPLIER WINDSOR REDDING CARE CENTER			STREET ADDRESS CITY STATE ZIP 0 2490 COURT STREET REDDING, CA 96001	
PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG	PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE DOMPLETION
F 157	exercise their right roommates. Price roommate assignment resident's represent resident's new room current roommate wontice of such chan room transfers will resident's medical resident's medical resident's medical resident 1's record was admitted to the diagnoses that inclus Parkinson's Diseas with symptoms inclurigidity stiffness mule eventual mobility procompleting activities record also read the blind in both eyes. Resident 1's "Admissions reviewed and in was her Responsible decisions. Her last resident assessment identified that she hunable to walk, and extensive assist with A nurse's progress pm, when Resident original room, was reviewed and in the control of the con	that a resident is able to to change rooms or or to changing room or rent. the resident, the tative (if available), the nmate and the resident's will be given timely advanced age Information regarding be documented in the record" I was reviewed Resident 1 to facility on 11,11/15 with uded diabetes and a ranervous system disease uding tremors muscle uscle weakness, pain, and roblems and difficulty in sof daily living). Resident 1's at she was considered legally said some mild memory loss, required moderate to	F 1	All residents who had a ro roommate change had the be affected. Measures to Prevent Recurse Social Services Director why the Administrator on 1 regarding the facility police. Room or Roommate Chawill follow this policy effect 1/22/2018 for all residents a room change and/or roomed change. Monitoring Corrective Act Responsibility: Medical Records will audichanges for proper notification report findings to stand under the standard standard for the further intervention and the standard standard for the standa	om or potential to rrence: as educated /22/2018 ey titled, ange," and etive who require mmate etion and it all room eation and p daily. will monitor 6 months for follow up as

An Interdisciplinary Team (IDT) note, dated 8/2/16 at 8.59 am, was reviewed and read, "IDT review

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CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO 0938-039
	T OF DEFICIENCIES OF CORRECTION	X1 PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION G	X3 DATE SURVEY COMPLETED
		056258	B WING_		C 12/29/2017
	OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CO 2490 COURT STREET REDDING, CA 96001				
X4 ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLET ON
F 157	22 per her request was moved to Roo move due to issue During an interview 1's Family Member was moved to a ne notification or consher Responsible P when she visited R learned that Resider room. FM A stated 1's RP on 7/27/16 that Resident 1 had During an interview Director of Nursing RP was not notified room change and a moved Resident 1 due to FM A's com	Resident moved back to Room On Monday 7-25 resident om 11 C per her request to s with roommate of on 8/10/16 at 4 pm. Resident of (FM) A stated that Resident 1 of ew room, without facility sent from either Resident 1 or arty (RP) FM A stated that desident 1 on 7/27/16 she had ent 1 was moved into a new of that she contacted Resident who stated he was unaware of bean moved of on 8/11/16 at 8/30 am, the of (DON) stated Resident 1's of on the day of the original of few days later she had back into her original room	F 15	F-279 DEVELOP COMPREH CARE PLANS How Corrective Action will b accomplished for residents af Resident 1 no longer resides a facility. Identification of Residents will Potential to be affected: All residents who had a room roommate change had the pobe affected. Measures to Prevent Recurred IDT members and social serveducated by the Administrate 1/22/2018 regarding creating comprehensive care plans spor room changes and or roomm changes. Monitoring Corrective Action	e fected: at the th the change or tential to ence: cices were or on ecifically to ate
	had been moved o stated that she had staff to move her a move 7/25/16 that	k in her original room that she ut of on 7/25/16. Resident 1 for not "given permission" for nd her belongings on the first she felt that her roommated due to their conflict.		Responsibility: Medical Records will audit a changes for comprehensive c and report findings to stand	ll room are plans
	acknowledged that monitoring was ma	on 8/11/16 at 11,40 am, DON no care planning or ide related to the room		DON/Designee will monitor through QA for 6 months for follow up and intervention as	further
	Changes and that v	when the decision to move		Date of compliance: 1/29/18	

Resident 1 was actually made that no contact was made with her RP DON stated that the facility did not follow it's policy on room changes

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES.

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DENTIFICATION AND MED		IPLE CONSTRUCTION	X3 DATE SURVEY COMPLETED			
		056258	B. WING_		C 12/29/2017	
	NAME OF PROVIDER OR SUPPLIER WINDSOR REDDING CARE CENTER			STREET ADDRESS CITY STATE ZIP DODE. 2490 COURT STREET REDDING, CA 96001		
X1 ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF COR IEACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY	SHOULD BE COMPLETICA	
F 157	Continued From p	age 4	F 15	7		
	developed	notes or care plans were		F-514 RECORDS COMPLETE/ACCURATE/ E	ACCESSIBL	
	1's RP, stated that 1's move and that	v. on 8/11/16 at 2 pm. Resident he was angry about Resident the facility did not notify him ecided to move her. RP stated		How Corrective Action will accomplished for residents		
F 247	that Resident 1 did being moved RIGHT TO NOTIC	not understand why she was	F 24	Resident 1 no longer reside facility.	es at the	
SS=D	ROOM/ROOMMAT CFR(s): 483.15(e)			Identification of Residents Potential to be affected:	with the	
		right to receive notice before nor roommate in the facility is		All residents who had a ro- roommate change had the be affected.		
				Measures to Prevent Recur	rence:	
	by: Based on observa review for one of t facility failed to pro	NT is not met as evidenced tion, interview, and record hree sampled residents, the perly notify the resident when a her room assignment was		Licensed Nursing Staff wer by the DON/Designee on 1/2 regarding appropriately do conflicts between room mat they occur including but no when they lead to a room cl	22/2018 cumenting tes when of limited to	
	This failure had the avoidable psychological	e potential to cause residents ogical distress		Monitoring Corrective Acti Responsibility:	on and	
	Findings			Medical Records will audit changes for documentation	of conflicts	
	Change," dated 12	policy "Room or Roommate /1/13, was reviewed and read		between room mates if they and report findings daily in		
	exercise their right roommates Proroommate assignment	that a resident is able to to change rooms or or to changing room or nent, the resident, the		DON/Designee will monitor QA for 6 months for furthe and intervention as necessar	r follow up	
	resident's represen	tative (if available), the		D . P . P . 1/20/1	0	

Date of compliance: 1/29/18

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

PRINTED: 12/29/2017 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. 056258	A BUILDING		co	TE SURVEY MPLETED C 2/29/2017
	OVIDER OR SUPPLIE			STREET ADDRESS, CITY STATE ZIP CODE 2490 COURT STREET REDDING, CA 96001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE

F 247 Continued From page 5

resident's new roommate and the resident's current roommate will be given timely advanced notice of such change Information regarding room transfers will be documented in the resident's medical record"

Resident 1's record was reviewed. Resident 1 was admitted to the facility on 11/11/15 with diagnoses that included diabetes, and Parkinson's Disease (a nervous system disease with symptoms including tremors, muscle rigidity/stiffness, muscle weakness, pain, and eventual mobility problems and difficulty in completing activities of daily living). Resident 1's record also read that she was considered legally blind in both eyes.

Resident 1's "Admission Record", dated 11/11/15, was reviewed and identified that her family member was her Responsible Party (RP) for health care decisions. Her last Minimum Data Set (MDS, a resident assessment tool), dated 5/15/16, identified that she had some mild memory loss, unable to walk, and required moderate to extensive assist with hygiene.

A nurse's progress note, dated 7/29/16 at 6:10 pm, when Resident 1 returned back to her original room, was reviewed and read. "Resident moved rooms she is ok with the room, getting along with roommate, no complaints at this time."

An Interdisciplinary Team (IDT) note, dated 8/2/16 at 8:59 am, was reviewed and read, "IDT review of room changes: Resident moved back to Room 22 per her request. On Monday 7-25 resident was moved to Room 11 C per her request to move due to issues with roommate"

F 247

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		056258	B WING		C 12/29/2017
	PROVIDER OR SUPPLIED			STREET ADDRESS CITY STATE ZIP (2490 COURT STREET REDDING, CA 96001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION EAPPROPRIATE DATE
F 247	1's family membe was moved to a n notification or conher Responsible F During an intervie Resident 1, on 8/3 was observed bachad been moved stated that she has staff to move her move 7/25/16. During an intervie acknowledged that documentation in the meeting with Foccurred on 7/22/DON acknowledge move Resident 1 contact was made the facility did not	w, on 8/10/16 at 4 pm, Resident r (FM) A stated that Resident 1 ew room without facility sent from either Resident 1 or		47	
	A facility must use to develop, review comprehensive pl The facility must of plan for each residual objectives and timmedical, nursing,	the results of the assessment and revise the resident's	F 2	79	
	The care plan mu	st describe the services that are			

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CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO	0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		TE SURVEY
		056258	B. WING		1:	C 2/29/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE		
WINDSO	R REDDING CARE O	CENTER		2490 COURT STREET REDDING, CA 96001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	highest practicable psychosocial well- §483.25; and any some prequired under due to the resident §483.10, including under §483.10(b)(c) This REQUIREMED by: Based on observative facility failed to develop for addressing diffication (Residents 1 and 2) This failure had the psychosocial need Findings: A facility policy, "Ridated 12/1/13, was to ensure that a regist to change roochanging room or resident, the resident's current redivanced notice of the sychosocial need available), the resident's current redivanced notice of the sychosocial need available of the resident's current redivanced notice of the sychosocial need available of the resident's current redivanced notice of the sychosocial need available of the resident's current redivanced notice of the sychosocial need th	attain or maintain the resident's e physical, mental, and being as required under services that would otherwise §483.25 but are not provided t's exercise of rights under the right to refuse treatment 4). ENT is not met as evidenced ation, interview, and record hree sampled residents, the velop psychosocial care plans culties between roommates. 2). Be potential that residents's may be neglected. Coom or Roommate Change," serviewed and read, "Purpose sident is able to exercise their oms or roommates	F 2	279		

Resident 1's record was reviewed. Resident 1 was admitted to the facility on 11/11/15 with diagnoses that included diabetes, and

Parkinson's Disease (a nervous system disease

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CENTER	RS FOR MEDICAR	RE & MEDICAID SERVICES				0. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		A. BUILDI	TIPLE CONSTRUCTION NG	co	(X3) DATE SURVEY COMPLETED	
		056258	B WING_			2/29/2017
	PROVIDER OR SUPPLIE			STREET ADDRESS CITY STATE ZIP C 2490 COURT STREET REDDING, CA 96001	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 279	Continued From	page 8	F 27	79		
	eventual mobility completing activity record also read in blind in both eyes. Resident 1 "Admit was reviewed and member was her health care decisi (MDS, a resident 5/15/16, identified memory loss, una moderate to exter	ission Record", dated 11/11/15, didentified that her family Responsible Party (RP) for ions. Her last Minimum Data Set assessment tool), dated that she had some mild able to walk, and required nsive assist with hygiene.				
	at 8:59 am, was r room changes: R per her request.	ry Team (IDT) note, dated 8/2/16 eviewed and read "IDT review of esident moved back to room 22 On Monday 7-25 resident was 1 C per her request to move due mmate"				
	was admitted to the diagnoses that income encephalopathy (selectrolytes, vitam	rd was reviewed. Resident 2 he facility 8/22/15 with cluded metabolic abnormalities of the water, nins, and other chemicals that train function), anxiety, and				

depression. Resident 2's care plans identified that she had thinking and memory (cognitive) problems with communication, and had a goal to

During an interview on 8/11/16 at 8:30 am, the Director of Nursing (DON) stated that she was aware of a previous roommate incompatibility complaint made from Resident 1's RP. She stated the RP's complaint alleged there was an

stop taking things from other residents.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD		(X3) DATE SURVEY COMPLETED		
	NAME OF PROVIDER OR SUPPLIER WINDSOR REDDING CARE CENTER		B WING	STREET ADDRESS CITY STATE ZIP CODE 2490 COURT STREET REDDING, CA 96001			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD BE COMPLETION DATE		
F 279		etween Resident 1 and her prior ent 2) over the window shades	F 2	.79			
	acknowledged that documentation in the meeting with Foccurred on 7/22/the roommate con Resident 1's or Rethat the facility did progress notes or related to the resident.	w, on 8/11/16 at 11:40 am, DON at the facility had no Resident 1's record related to Resident 1 and her RP that had 16. Also no documentation of affict was made in either esident 2's record. DON stated not follow it's policy when no care plans were developed dents' conflicts.					
F 514 SS=D		PLETE/ACCURATE/ACCESSIB	F5	14			
	resident in accord standards and pra	naintain clinical records on each ance with accepted professiona actices that are complete; ented; readily accessible; and anized.					
	information to ider resident's assessr services provided	I must contain sufficient ntify the resident; a record of the ments; the plan of care and the results of any eening conducted by the State; es.					
	by: Based on observa review, for two of	ENT is not met as evidenced ation, interview, and record three sampled residents, the cument ongoing allegations of					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILDI	TIPLE CONSTRU	UCTION		TE SURVEY MPLETED C
		056258	B WING			12	2/29/2017
	PROVIDER OR SUPPLIER			2490 COUR	DRESS CITY STATE, ZIP C RT STREET , CA 96001	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF COF ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 514	Continued From p	age 10 roommates (Residents' 1 and	F 5	14			
	2).						
		e potential that the medical urately reflect the status of care needs.					
	Findings:						
	was admitted to the diagnoses that incomparkinson's Disease with symptoms incomigidity/stiffness, meventual mobility prompleting activities	ord was reviewed. Resident 1 e facility on 11/11/15 with luded diabetes, and se (a nervous system disease luding tremors, muscle uscle weakness, pain, and roblems and difficulty in es of daily living). Resident 1's eat she was considered legally					
	was reviewed and member was her F health care decision (MDS, a resident a 5/15/16, identified memory loss, unab	sion Record" dated 11/11/15 identified that her family Responsible Party (RP) for ons. Her last Minimum Data Set assessment tool), dated that she had some mild ble to walk, and required sive assist with hygiene.					
	at 8:59 am, read "0	Team (IDT) note, dated 8/2/16 On Monday 7-25 resident was C per her request to move roommate"					
		ord was reviewed, Resident 2 e facility 8/22/15 with uded metabolic					

encephalopathy (abnormalities of the water, electrolytes, vitamins, and other chemicals that

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		E & MEDICAID SERVICES			OMB NO 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		056258	B. WING		12/29/2017
NAME OF	PROVIDER OR SUPPLIER	3		STREET ADDRESS CITY STA	
WINDSC	R REDDING CARE	CENTER		2490 COURT STREET REDDING, CA 96001	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE HENCY)
F 514	Continued From p	age 11	F 5	514	
	depression. Resident that she had think problems with con	rain function), anxiety, and dent 2's care plans identified ing and memory (cognitive) nmunication, and had a goal to from other residents.			
	Director of Nursing aware of a previous complaint made fr stated the RP's co- ongoing conflict be	w on 8/11/16 at 8.30 am, the g (DON) stated that she was is roommate incompatibility om Resident 1's RP. She implaint alleged there was an etween Resident 1 and her priore window shades being open on.	c		
	Resident 1, on 8/1 was observed in h	v and observation with 1/16 at 11.15 am, Resident 1 er room. Resident 1 stated tha ommate should have moved t.	t		
	acknowledged that documentation of Resident 1's or Re	w, on 8/11/16 at 11:40 am, DON t the facility had no the roommate conflict in either esident 2's records. DON missing documentation related onflicts.			