STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. BUILDING _____ B. WING _____	C 01/16/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an Abbreviated Standard Survey for a complaint. Complaint Number: 338999 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department: 28650, HFEN. One deficiency was written for complaint 338999 at F - 241.	F 000	This plan of correction is prepared and executed solely because it is required by 42 C.F.R. Part 483 et seq. and Health and Safety Code 1280. This plan of correction represents our credible allegation of compliance.	
F 241 SS=D	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 interview and record review, the facility failed to ensure that care was delivered in a manner and environment that enhanced dignity and respect in full recognition of Resident 1's individuality. This resulted in Resident 1 feeling "antagonized and frustrated," by facility staff. Findings: On 1/9/13 at 1:10 pm, the Department received a complaint of an alleged staff to resident abuse that occurred on 11/18/12, during the evening	F 241	1. The resident discharged more than two months prior to notice of complaint and complaint investigation. 2. Involved CNA was inserviced on proper customer care. CNA was inserviced on coordinating care to ensure comfort of resident for dressing changes. 3. Inservice all staff and new hires on standards of professional conduct and customer care. 4. DSD will be responsible for inservicing and orientation and charge nurse will be responsible for monitoring nursing staff. IDT will review concerns during standup. Any trends will be reported to the Quality Assurance Committee and monitored for effectiveness. 5. Corrective action will be implemented by 2/12/2013.	

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

ADMINISTRATOR 2/11/13

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 241	Continued From page 1 shift. Resident 1 was contacted and interviewed by telephone on 1/9/13 at 5:20 pm, she reported that on the evening of 11/18/12 Certified Nursing Assistant (CNA) 1 positioned her on her side in preparation for a dressing change to her hip. Resident 1 reported that she was in this position, waiting for a prolonged period of time and was in a great deal of pain. Resident 1 expressed her pain and frustration loudly to CNA 1. Resident 1 stated that CNA 1 told her, "I was shot in Vietnam, and even I did not cry this much!" Resident 1 stated that she felt that this comment was rude, insensitive and unprofessional. Resident 1 reported that she told her nurse that she did not want CNA 1 taking care of her and CNA 1 followed her request. Although, Resident 1 felt that CNA 1 made a big production of not being allowed to care for her when responding to her roommate's care needs. Resident 1 felt antagonized and frustrated by CNA 1's actions. On 1/11/13, Resident 1's record was reviewed. Resident 1 was admitted to the facility on 11/16/12 with diagnoses that included difficulty walking, rehabilitation following hip fracture and chronic pain. The facility's Minimum Data Set (an assessment tool), dated 11/20/12, described Resident 1 to be cognitively intact and able to make her own decisions. A nursing progress note dated, 11/18/12 at 1:32 am, read, "... Resident complaining about PM aide not being sensitive about her pain..."	F 241		

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F 241	Continued From page 2 During an interview with the Administrator and Director of Nurses (DON), on 1/11/13 at 11 am, they reported that CNA 1 is well liked by all the residents, but that he is stern and all military. The DON explained that CNA 1 can be very direct at times and this directness could be misinterpreted as him being insensitive or gruff. During an interview with CNA 1 by phone on 1/11/13 at 2:30 pm, he vaguely recalled positioning Resident 1 in preparation for a dressing change. CNA 1 remembered that she complained of pain but denied making that statement about his past military service. CNA 1 confirmed that he had been shot during his service in Vietnam, but does not speak of that to anyone because it is a very private matter. CNA 1 had no explanation as to how Resident 1 would have even known about that. CNA acknowledged that he is very direct and perhaps Resident 1 had misinterpreted his directness.	F 241		