California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA230000351	A. BUILDING: _____ B. WING _____	C 04/24/2019

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) COMPLETE DATE
B 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint number: 523571 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: 29391, Health Facilities Evaluator Nurse One deficiency was issued for complaint 523571 at B 4495.	B 000	Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 5, does not constitute an admission or 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 it is required. In response to the Department's findings we submit the following Plan of Correction which shall constitute Copper Ridge Care Center's credible allegation of compliance.	
B4495	T22 DIV5 CH3 ART5-72527(d) Patients' Rights (d) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid Durable Power of Attorney for Health Care, patient's next of kin, other appropriate surrogate decisionmaker designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, a person lawfully authorized to represent the minor. This Statute is not met as evidenced by: Based on interview and record review the facility	B4495	**B 4495** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** The resident has passed away. **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 will review all residents that have a Durable Power of Attorney to determine whether they have had a change in capacity which would require notifying persons listed as the POA, and will make such notifications as needed.	

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B4495	Continued From page 1 failed to honor the patient's right to designate a Durable Power of Attorney for Health Care (POA) for one of one sampled patient (Patient 1), when the facility physician changed an assessment of the resident's capacity to make his own decisions, without informing the family members listed as POA. This resulted in the patient's designated POA not being included in the health care decisions, near the final days of Patient 1's care, despite the patients preference to have a POA involved in making his decisions. Findings: The facility policy titled "Advanced Directives," dated 4/2013, read "The residents Attending Physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the resident's condition changes in an effort to clarify and adhere to the residents wishes...The Interdisciplinary Team will conduct ongoing review of the resident's decision-making capacity and communicate significant changes to the resident's legal representative. Such changes will be documented in the care plan and medical record..." Patient 1's record was reviewed. Patient 1 was admitted to the facility on 3/3/15 with diagnosis that included a stroke with one side weakness, difficulty walking, kidney failure, history of reoccurring urinary tract infections, and high blood pressure. Patient 1's record contained a copy of a document titled "California Advance Health Care Directive," signed by Patient 1, on 2/15/15 and notarized (making the document legal) the same day. This form identified family	B4495	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** The DON gave an in-service to Medical Records staff on May 21, 2019. The in-service covered the documentation of capacity and POA's, and notification to family members of changes in capacity. The Medical Records Supervisor will report at standup any orders changing the capacity of a resident, and ask the remaining staff to notify her of any changes. **How the facility plans to monitor its performance to make sure that solutions are sustained.** At the monthly and quarterly QA meetings, the Medical Records Supervisor will report on whether changes in capacity are documented timely and whether the POA was notified timely. This information will be reported to the QA committee for action plan until compliance is achieved for two or more quarters. **Date when corrective action will be completed.** 5/24/19	

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B4495	Continued From page 2 members that Patient 1 wanted to make his decisions for him (regardless of his condition) and included the statement "My health care agent can make decisions for me right after I sign this form... I want my health care agent to work with my doctors and to use her/his best judgement..." Patient 1's POA and Patient 1's alternate POA (APOA- who was also assigned in the health care directive, dated 2/15/15), had been involved in his care throughout his stay until 2/2017 when the facility changed Patient 1's status. Patient 1's physician's orders, dated 10/15/15 at 10:48 am, read "Resident is not capable of understanding rights, responsibilities, and informed consent." This order remained in place, renewed monthly, until 2/3/17, when the order was discontinued. A "Resident Progress Notes," dated 2/6/17 at 9:28 am, read "IDT (Inter-Disciplinary Treatment Team) met to review current status of resident. Review of orders and on 02/03/2017 physician re-evaluated capacity orders it was determined at this current time he (Patient 1) is capable of making his own decisions at his request still would like other family members (POA/APOA) to remain involved..." No documentation read that Resident 1's POA or APOA was notified of the change in Patient 1's status or participated in the meeting. On 2/9/17 at 3:29 pm, a progress note read "Quarterly Care Conference" this note included "...We attempted to include (APOA) by telephone, but was unable. Message left for her to call if she had any questions..." No further notes were written related to Patient 1 as his own responsible party or discussions with POA/APOA related to the change in status.	B4495		

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B4495	Continued From page 3 On 2/17/17 at 7:32 am, and 7:55 am, progress notes read that Patient 1 had multiple convulsions (seizures) and was non-responsive and that he was sent to out of the facility with paramedics and POA and physician had been notified. During an interview, on 2/23/17 at 1:55 pm, APOA stated that Patient 1's physician made Patient 1 his own responsible party on 2/3/17 without notifying or discussing it with her or POA. She stated that Patient 1 had a decline in his health during that time and had a seizure on 2/17/17 that required transfer to an acute care hospital where he passed away. APOA stated that in the past she could participate in meetings but was recently only able to do telephone conference for the meetings. APOA stated that she was not included in the IDT meeting done in February 2017 because facility could not get a phone at Patient 1's bedside, and had told her they would leave a message which she had not received. APOA stated that she had concerns in 2/2017 about a strong odor in Patient 1's urine and his history of reoccurring urinary tract infections, and that she had requested that he have an analysis of his urine to assess him that was not conveyed to Patient 1's physician, or done before his discharge. APOA stated that she was concerned that Patient 1 would get sepsis (a life threatening condition from infections that get into the blood). During an interview and concurrent record review, on 3/21/17 at 2:45 pm, Licensed Vocational Nurse (LVN) A stated that she sets up care conference meetings and acknowledged that POA and APOA had not been present for Patient 1's last care meeting, and that the telephone care conference did not work as there was no answer on the phone during the care conference, but that	B4495		

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B4495	Continued From page 4 she had left a message to APOA. LVN A acknowledged that the record did not contain documentation that APOA and/or POA had been involved in the physician and IDT decision to change Patient 1's capacity to make his own decisions.	B4495		