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 11/02/2011

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
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint number: 288215 and 288348 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: 29582, HFEN No deficiency was issued for entity reported incident 288348 A deficiency was written for complaint 288215 at A 164 and A 822.	A 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. RECEIVED 2011 DEC -1 AM 10:29 CDPH, L&C CHICO, DO	
A 164	T22 DIV5 CH3 ART3-72311(a)(1)(B) Nursing Service--General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to develop a plan of care while providing treatment to lower Patient 1's blood pressure and treat congestive heart disease. This had the potential for developing adverse changes in Patient 1 blood pressure that could have effect on	A 164	1. Patient 1 was discharged. 2. Comprehensive care plans for every resident will be reviewed and revised to match current status. 3. Licensed nurses will review plan of care for deletions and updates when addressing weekly progress note. 4. MDS nurse will review care plans quarterly. ADON or designee will review care plan with resident and/or responsible party at the care conference. 5. Any trends will be reported to the Quality Assurance Committee. 6. Corrective action will be implemented by 11/30/2011.	11/30/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 11/30/11

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A 164	Continued From page 1 overall health status. Findings: Patient 1 was a 93 year old female admitted to the facility on 7/18/11. The Minimum Data Set (MDS, an assessment tool, dated 7/25/11, indicated that the patient had no memory loss, and was able to understand and make her own decisions. Diagnoses included high blood pressure and congestive heart failure. On 11/2/11 Patient 1's record was reviewed, and no care plan was found that for the treatment of high blood pressure, congestive heart failure, or the administration of Coreg. Coreg, a medication used to treat high blood pressure and congestive heart failure was ordered on admission. The medication flow sheet (for 7/18/11 through 8/13/11) showed that Patient 1's blood pressure was being monitored, although there were no parameters instructing the nursing staff on when to hold the medication or when to notify her physician. There was documentation in the vital report sheet or the medication flow sheet that Patient 1's blood pressure fluctuated between 94/53 and 179/81. Normal blood pressure range is 110-130/75-85 mm/Hg (millimeters of mercury). On 11/9/11 at 9:15 am, during an interview and a concurrent record review, Administrative Staff A confirmed that a written care plan, that indicated care to be provided, parameters for treatment, or when nursing staff should notify the physician, had not been developed for Patient 1's diagnoses of high blood pressure, congestive heart failure, or the administration of Coreg.	A 164		

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A 822	Continued From page 2	A 822	1. Patient 1 was discharged. 2. Current residents on I&O were reviewed by ADON's. 3. Licensed nurses were inserviced on I&O policy and procedure 4. ADON or designee will be responsible to monitor and will assess I&O prior to it being discontinued. 5. Any trends will be reported to the Quality Assurance Committee. 6. Corrective action will be implemented by 11/30/2011.	11/30/11
A 822	T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to measure and record intake and output for Patient 1 per their policy. This had the potential to negatively impact Patient 1 ability to have hydration needs assessed and met. Findings: Patient 1 was a 93 year old female admitted to the facility on 7/18/11. The Minimum Data Set (MDS), an assessment tool, dated 7/25/11, indicated that the patient had no memory loss, and was able to understand and make her own decisions. Diagnoses included fracture of the ulnar and neck of femur, pneumonia, and congestive heart failure. On 11/2/11, Patient 1's care plans titled, "At Risk for deficient Fluid Volume" and "At Risk for Constipation," dated 7/18/11, listed an approach as "Encouraging 1800 cc/day." On 7/27/11, a "Nutritional Observation" had been completed by the registered dietician, which indicated that Patient 1 was consuming less then 1000 cc a day. The review of Patient 1's record indicated that a "Intake and Output Record" (I&O) had been completed for 16 days. The I&O record from 7/18-8/2/11 reflected that Patient 1's intake	A 822		

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A 822	Continued From page 3 ranged between 200 and 2750 ml. The I&O readings were discontinued on 8/2/11. Review of Patient 1's Vital Report indicated that Patient 1 had consumed the following: amount of fluids: (reference value: an 8 ounce glass of water is 240 cc) On 8/2/11, 780 cc On 8/3/11, 920 cc On 8/4/11, 950 cc On 8/5/11, 980 cc On 8/6/11, 380 cc On 8/7/11, 590 cc On 8/8/11, 720 cc On 8/9/11, 660 cc On 8/10/11, 650 cc On 8/11/11, 250 cc On 8/12/11, 360 cc On 11/2/11 at 9:40 am, during an interview and a concurrent record review of the facility's undated guideline, "Intake and Output Measuring and Recording," Administrative Staff A confirmed the policy indicated that intake and output monitoring would be completed for patient with inadequate fluid intake and new admits for at least 30 days. Administrative Staff A confirm that Patient 1 met the criteria of their guidelines and should have remained on I&O monitoring for 30 days.	A 822		