STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	**50 CONCORDIA LANE OROVILLE, CA 95966**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report changes of condition to the physician for five of 10 residents when: 1. Resident 1 had a fall which resulted in increased pain and was not reported to physician timely and an X-ray (medical screening tool that takes pictures of bones) was not done until two days post fall. This resulted in a delay of [DIAGNOSES REDACTED]. Resident 2 had multiple episodes of hallucinations (an experience involving the apparent perception of something not present) and this was not reported to physician timely to address potential medication side effects and prevent falls. This resulted in an avoidable fall which required surgery to repair her left knee and increased pain. 3. The physician was not notified when three residents started smoking. (Residents 3, 4, and 5) This resulted in residents' to smoke in a non-designated smoking area, which put all residents at risk for smoking related accidents and hazards. Refer to F 689 Findings: 1. A review of Resident 1's admission record indicated she was admitted on [DATE], with [DIAGNOSES REDACTED]. Resident 1 was able to make her own health care decisions. A review of a nurses note dated 1/25/20 at 3 pm, indicated Licensed Nurse (LN) A documented Resident 1 had an unwitnessed fall, and was found by Occupational Therapist (OT) sitting on her low garden bench. Resident 1 informed OT she had fallen from the bench and into the wooden fence behind her. Resident 1 stated she lost her balance when sitting on the bench and twisted her right ankle trying to get up. Resident 1 stated to have complained of mild discomfort to her right ankle. LN A and OT walked Resident 1 from the garden area back to her room and applied ice. Resident 1 denied she was light headed prior to fall. A review of an OT treatment note dated 1/25/20 no time noted , OT indicated she found Resident 1 in the backyard (garden area) and she had swelling and bruising on the outside of the right ankle. Resident 1 reported mild pain in her right ankle with weight bearing and while at rest. A review of a licensed nurses' daily skilled charting dated 1/25/2020 on evening shift, indicated Resident 1 complained of severe pain to right ankle, ace wrap applied. A review of a licensed nurses' daily skilled charting dated 1/26/20 on day shift, indicated Resident 1 required assistance with set up of activities of daily living, one day post fall. A review of nurses note dated 1/26/2020, evening shift, indicated Resident 1 complained of severe pain to her right ankle. During an interview on 2/12/2020 at 9:24 am, CNA P stated Resident 1 called her into her room on 1/26/2020, between 2-4 am, and informed her I need to get an x-ray, my ankle is broken. CNA P stated she notified LN Q expeditiously. During an interview on 2/12/2020 at 10:10 am, Certified Nursing Assistant (CNA) O stated Resident 1 has been more dependent since the fall, and could normally performed activities of daily living (ADLs) independently. CNA O stated Resident 1 doesn't make good decisions a lot due to confusion. CNA O stated she definitely helped Resident 1 more on the day shift of 1/26/20, one day following her fall. CNA O stated Resident 1 stayed in her room with her leg elevated and required more assistance, and explained she had more complaints about pain regarding her foot. CNA O stated that due to Resident 1's unstable blood sugars that it affected her ability to think good decisions. During an interview on 2/12/2020 at 3:50 pm, the Director of Nursing (DON) stated Resident 1 was different when she was readmitted , significant mental change. DON expected nursing staff to notify the physician for changes in condition related to pain and a recent fall to determine if she had an injury. During an interview on 2/28/2020 8:55 am, LN Q informed Resident 1 the x-ray was to occur the next day on 1/27/2020, two days post fall, as scheduled. The physician was not notified of the increased pain. A review of a portable x-ray report done at the facility dated 1/27/2020 at 9:59 am, indicated Resident 1 had a broken ankle. 2. A review of Resident 2's admission records indicated she was admitted on [DATE], with [DIAGNOSES REDACTED]. Resident 2 was able to make her own health care decisions. Resident 2 was admitted to room [ROOM NUMBER] which did not have a working call light and a bell was provided for Resident 2. A review of a fall risk assessment dated [DATE], indicated Resident 2 at a high risk for falls. A review of a physician's orders [REDACTED]. A review of a nurses note dated 1/23/2020 in am (morning shift), indicated Resident 2 was screaming for assist. Resident 2 was self transferring independently and was sitting on edge of bed complained of loss of balance. Resident 2 reported having hallucinations and does this a lot. A review of a physical therapy (PT) note dated 1/23/2020, indicated Resident 2 had decreased alertness and reported fall earlier attempting to transfer from wheelchair to bed. A review of an Interdisciplinary Team (IDT- group of different health care disciplines who discuss resident's needs) progress note dated 1/23/2020, indicated Resident 2 upon admission after surgeries she has episodes of [MEDICAL CONDITION] (disorganized though process). It took Resident 2 one-two weeks post surgery to recover from general anesthesia. Resident 2 hallucinated when pain medications (opioids narcotics) were administered two tablets instead of one. Social Services (SS) indicated nursing to notify physician with pain medication management. A review of licensed nurse's daily skilled charting indicated on 1/24/2020 in the am, indicated Resident 2 continued to hallucinate and had confusing dreams which started last night. A review of Resident 2's IDT notes, nursing notes, physician notes and orders, there was no notification to the physician of Resident 2's ongoing hallucinations, her fall on 1/23/2020 and there were no changes in pain medication orders. There were no new fall interventions put in place to prevent further falls in her care plans. A review of a occupational therapy (OT) note dated 1/28/2020, indicated Resident 2 required verbal cues for safety and direction, she continued to complain of pain at left knee and declined any further therapy today. A note dated 1/29/2020, indicated OT and Resident 2 were present at the care conference, she had decreased alertness and fell earlier attempting to transfer from wheelchair to bed without putting the breaks on. Resident 2 reported having [MEDICAL CONDITION] and nursing reviewed medications for changing [MEDICATION NAME] to another medication to give her better pain relief. A review of an admission assessment dated [DATE], indicated the reason for Resident 2's readmission was a failed discharge on 1/29/2020 with multiple falls at home. A review of a PT note dated 1/31/2020, indicated Resident 2 had severe pain when weight bearing from left hip and leg, instructed CNAs to have resident non weight bearing until seen by orthopedic surgeon, and recommended nursing to X-ray lower leg leg hip due to having three falls at home before coming back to facility. Resident 2 continued to have hallucinations and nursing aware due to [MEDICATION NAME]. Portable X-ray done at facility, negative for acute fracture. A review of licensed nurse's daily skilled charting indicated on 1/31/2020 in the pm (evening shift), Resident 2 received one tablet of [MEDICATION NAME] and her scheduled extended release [MEDICATION NAME]. She became more confused in the night and thought there was a man in her room and needed to get out of there. A review of licensed nurse's daily skilled charting indicated on 2/1/2020, in the pm, Family Member (FM) 1 stated Resident 2 called her crying due to have a lot of pain and wanted her daughter to take her to the hospital. LN informed FM 1 if Resident 2 went to the hospital they would have to readmit her. FM 1 did not want that and requested pain medication to be given. LN gave Resident 2 two tablets of [MEDICATION NAME] 5 mg and later in the night she had a fall at 2:14 am. A review of an IDT resident safety investigation and intervention note dated 2/3/2020, indicated Resident 2 had an unwitnessed fall in her room on 2/1/2020 at 9:40 pm. Resident 2 fell on to the ground next to her bed while trying to turn off her bedside lamp. Resident 2 reported seeing things that were not there, this may be due to the

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	**50 CONCORDIA LANE OROVILLE, CA 95966**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) use of [MEDICATION NAME] and now changed to [MEDICATION NAME] long acting pain medication. Speech therapy (ST) to review for cognition and continue PT and OT. A record review of nurses' notes, physician orders, and IDT notes, there was no documentation found that the physician was notified of the ongoing hallucinations and psychotic episodes. There were no medication changes other than increasing the [MEDICATION NAME] to extended release on a regular schedule. A review of a history of physical from orthopedic surgeon dated 2/3/2020, indicated Resident 2 fell and injured her left knee over the weekend. She had fallen a number of times although her last fall was so severe that she wasn't able to weight bear any longer. Resident 2 reported falling four times since seen last, which resulted in constant severe pain when moving left leg. Resident 2 required surgery on 2/4/2020, due to a new left tibial (lower leg) fracture and required a total knee revision. During an interview on 2/11/2020 at 10 am, Resident 2's FM 1 stated she was in constant pain and hallucinations. FM 1 stated Resident 2 did not have a call light nor did her room mate, they were in room [ROOM NUMBER]. Resident 2 had a bell and the room mate had a squeaky toy. FM 1 stated Resident 2 had reactions to anesthesia which included hallucinations. FM 1 was upset with care at facility and wanted to discharge her. FM 1 took Resident 2 to her post surgical appointment on 1/29/2020. FM 1 stated surgeon was agreeable to discharge Resident 2. Upon return to facility, FM 1 informed nursing she wanted to take Resident 2 home to take care of her. FM 1 explained facility staff did not attempt to keep them from leaving nor did they explain the risks of taking Resident 2 home before her therapy and care goals were met to ensure a safe discharge. During an interview 2/12/2020 at 3:50 pm, the DON stated Resident 2 did have hallucinations and decreased the pain medication herself. The DON stated IDT did not request for a pharmacy review or notify physician related to her medications causing hallucinations. 3. A review of a facility policy titled, Smoke Free Campus Policy, revised 3/18/2016, indicated smoking is dangerous, poses serious risks to residents' health and safety. The facility is a 17 acre smoke free environment. A review of a facility policy titled, Smoking, revised August 2017, indicated the physician will be notified of any unsafe smoking behavior occurs. A review of a hospital discharge progress note dated 1/9/2020 at 10:57 am, the [DIAGNOSES REDACTED]. This was sent via fax to the facility on [DATE] at 11:02 am. A review of a nurses note dated 2/5/2020,with no time, indicated Resident 5 was found in his bathroom smoking a cigarette. Resident 5 was educated and will continue to monitor. A review of the of the nursing notes, social service, IDT notes, and physician progress notes [REDACTED]. During a concurrent observation and interview on 2/28/2020 at 2:15 pm, Resident 3 and Resident 3 were smoking in an area outside the facility, at the edge of the parking lot near the fire lane. Resident 3 and Resident 4 both required wheelchairs for mobility. Resident 4 stated it was very difficult to get to the area to smoke, the staff are not willing to assist me due to being a non smoking facility although they knew I smoked before I was admitted . Resident 4 stated there was no outside lights and difficult to see in the dark. During an interview on 3/11/2020 at 11:45 am, SS and DON confirmed the smoking policy was unclear, there were two policies. SS and DON stated when residents are interviewed upon admission, if they answer yes to smoking, they offer a nicotine patch. SS and DON stated they do not ask if they plan to smoke, how long they have smoked, when was the last time they smoked or if they have any smoking supplies with them. DON stated the area where all three residents (Resident 3,4,5) smoke was not safe. SS and DON confirmed once they were aware the residents were smoking, that none of the care conferences or IDT meetings discussed the issue of three smokers at the facility. The IDT did not follow the smoking policy when they did not notify the physician when residents were smoking at a non smoking facility.
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a safe discharge for one of 10 residents (Resident 2) when they did not evaluate if her therapy goals were met, pain control was met, and hallucinations were resolved and did not arrange for post discharge care. This resulted in Resident 2 to fall at home three times, return to the facility in less that 24 hours post discharge, and fell again broke left knee which required urgent surgery. Refer to F 689 F 580 and F 745. Findings: A review of a facility policy titled Social Services Assessment revised 11/22/16, indicated the purpose was to identify information to help staff develop a personalized plan of care that utilizes the individual's existing needs, strengths, functional deficits, and optimizes function and quality of life and meets individual's goal and preferences. When a resident is admitted a discharge plan is discussed, documented in the social services assessment, and updated in the record to reflect changes to the initial discharge plan. A review of Resident 2's admission records indicated she was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of admission records, indicated Resident 2 was originally admitted [DATE], discharged [DATE] to home, readmitted less than 24 hours later on 1/30/2020, then discharged to hospital for urgent surgery on 2/3/2020. A review of Resident 2's discharge care plan dated 1/31/2020, indicated the goals were to discharge to home to a lower level of care once rehabilitation goals are met. The goals were to coordinate discharge with therapies, local contact agencies, have a family conference to establish discharge plan, review plan with caregiver and resident, schedule appointments, arrange services as needed, and ensure understanding of resident and caregiver. A review of a nursing note dated 1/29/2020 at 5:30 pm, indicated Resident 2 and Family Member (FM) 1 arrived back at facility after orthopedic appointment, discharge initiated. A review of a post discharge plan of care dated 1/29/2020, indicated orthopedic associates to arrange for home health and wheelchair. A review of a care conference note dated 1/29/2020, with Resident 2, Social Services (SS) and Social Services Assistant, met to discuss discharge. Resident 2 stated she wanted to go home and the orthopedic surgeon gave her an order to go home today. The orthopedic group was going to order a wheelchair and call home health services. There was no documentation that indicated nursing and therapy were present to evaluate her ability to return home safely. There was no orthopedic documentation found in the record to support Resident 2 was ready to go home. A review of a nursing note dated 2/1/2020 at 10 am, the Director of Nursing (DON) documented FM 1 called the facility on 1/30/2020 in the morning, less then 24 hours of Resident 2 being discharged to home, and reported Resident 2 fell three times last night. FM 1 requested to have Resident 2 return to the facility. Three facility staff members, took their van and went to Resident 2's home, she was on the floor, on her back between the bed and wall. Resident 2 stated she twisted her knee during the last fall, knee was swollen. Resident 2 refused to go to hospital and was taken back to the facility to room [ROOM NUMBER] B. Resident 2 complained of pain, X-ray done at facility and results were negative for injury. A review of a physical therapy note dated 1/31/2020, indicated Resident 2 had severe pain when weight bearing from left hip and leg, instructed CNAs to have resident non weight bearing until see by orthopedic, and recommended nursing to X-ray lower leg leg hip due to having three falls at home before coming back to facility. Resident 2 continued to have hallucinations and nursing aware due to [MEDICATION NAME] (strong narcotic pain med). x-ray negative acute fracture. A review of an portable x-ray report done at the facility on 1/31/2020 at 9:24 am, Resident 2 had an x-ray of the knee with no evidence of a fracture. A review of an Interdisciplinary team (IDT-group of healthcare disciplines who discuss resident care needs) resident safety investigation and intervention note dated 2/3/2020, indicated Resident 2 had an unwitnessed fall in her room on 2/1/2020 at 9:40 pm. Resident 2 fell on to the ground next to her bed while trying to turn off her bedside lamp, Resident 2 reported seeing things that were not there, this may be due to the use of [MEDICATION NAME] and now changed to [MEDICATION NAME] long acting pain medication. Speech therapy to review for cognition and continue physical and occupational therapy. A review of a history of physical from orthopedic surgeon dated 2/3/2020, indicated Resident 2 fell and injured her left knee over the weekend. She had fallen a number of times although her last fall was so severe that she wasn't unable to weight bear any longer. Resident 2 reported falling four times since seen last, which resulted in constant severe pain when moving left leg. Resident 2 required surgery on 2/4/2020 due to a new left tibial (lower leg) fracture and required a total knee revision. During an interview on 2/11/2020 at 10 am, Resident 2's FM 1 stated she was in constant pain and hallucinations. FM 1 stated Resident 2 did not have a call light nor did her room mate, they were in room [ROOM NUMBER]. Resident 2 had a bell and the room mate had a squeaky toy. FM 1 stated Resident 2 had reactions to anesthesia which included hallucinations. FM 1 was upset with care at facility and wanted to discharge her. FM 1 took Resident 2 to her post surgical appointment on 1/29/2020. FM 1 stated surgeon was agreeable to discharge Resident 2. Upon return to facility, FM 1 informed nursing she wanted to take Resident 2 home to take care of her. FM 1 explained facility staff did not attempt to keep them from leaving nor did they explain the risks of taking Resident 2 home before her therapy and care goals were met to ensure a safe discharge. During a concurrent interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	05/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	50 CONCORDIA LANE OROVILLE, CA 95966

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) and record review on 3/11/2020 at 3:30 pm, Occupational Therapist (OT, therapy director) stated Resident 2 was not ready to go home due to cognitive issues related to safety and judgement, plus multiple falls. OT informed nursing that Resident 2 was not progressing in her therapy. A review of a physical therapy note dated 1/27/2020, indicated Resident 2 complained of a lot of pain and increased with weight bearing. On 1/28/2020, Resident 2 indicated continued pain that was not controlled by medication. On 1/29/2020, a physical therapy assistant noted Resident 2 saw orthopedic surgeon today and per resident going home, educated provided for safe transfers. During a concurrent record review and interview on 3/11/2020 at 3:30 pm, the Business Office (BO) who assisted with resident discharges stated on 1/29/2020, SS informed her that Resident 2 wanted to go home. BO filled out the top portion of the post discharge plan of care, which indicated the orthopedic surgeons office was arranging home health and equipment. BO confirmed the facility/IDT was responsible for a discharge care conference normally, and this did not happen. BO did not confirm the orthopedic associates discharged her or if they were arranging home health. There was no documentation found in the record from the orthopedic associates which indicated she was good to go home and they were arranging all the necessary services needed for Resident 2. BO stated the facility was responsible for arranging and facilitating all home health services and or equipment needed for resident discharges.
F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safe smoking for 3 of 3 sampled residents, prevent avoidable harmful falls with injuries for two of two sampled residents, and did not provide a fully functioning essential call light system when: 1. Smoking residents (Resident 3, 4, and 5) were smoking on the facility grounds, without smoking assessments, supervision, and necessary safety equipment. This had the potential for fire related injuries and hazards for all residents. 2.a Resident 1 had a significant change in condition that contributed to an avoidable unwitnessed fall while gardening without supervision. This resulted in a right broken ankle and pain. b. Resident 2 had a significant change in condition that contributed to two unwitnessed avoidable falls. This resulted in an injury to her left knee that required emergent surgery to repair. 3. An essential communication call light system did not function for all residents since July 2019. This had the potential to put all residents at risk for accidents and hazards and neglect. An Immediate Jeopardy (IJ) that was declared on 3/6/2020 at 2 pm, for failure to provide a system to prevent smoking hazards, prevent falls, and ensure a working call light system. An immediate corrective action plan to address unsafe smoking, prevent falls and interventions to ensure residents were able to call for assistance until call lights system functioning was provided by the facility's administrator on 3/6/2020 at 6:03 pm. The IJ was abated on 3/12/2020 at 11:50 am, after verification systems were in place to ensure residents were free from accidents and hazards. Refer to F 580, F 622 and F 919. Findings: 1. A review of a facility policy titled, Smoke Free Campus Policy, revised 3/18/2016, indicated smoking is dangerous, poses serious risks to residents' health and safety. The facility is a 17 acre smoke free environment. Skilled nursing residents' and visitors are to remain smoke free during their stay on our campus. Smoking by residents is permissible only through authorized leaves of absence off the 17 acre campus. A resident or visitor shall not cause or aid another resident to violate any of the terms of the smoke free campus policy. A review of a facility policy titled, Smoking, revised August 2017, indicated ashtrays of safe design shall be provided in areas where smoking is permitted. Residents who smoke will be assessed initially when they voice their interest to smoke, then quarterly and when there is a significant change. Residents will not be permitted to keep smoking materials in their possession unless interdisciplinary team (IDT- group of different health care disciplines who discuss resident care needs) determines they can manage them, if resident keeps smoking materials they must be locked in a box or drawer. A resident who poses a risk to themselves or others as a result of their non compliant smoking behavior will be given a thirty day notice of transfer or discharge. The assessment will be documented on the interdisciplinary team Smoking Assessment. The resident physician will be notified and an order will be obtained. Resident will have a smoking care plan which includes restrictions, special equipment, and instructions. Smoking safety aprons, ashtrays, fire blanket, fire extinguisher will be available in the designated smoking area. The physician will be notified of any unsafe smoking behavior occurs. This will be documented in the medical record. A thirty day notice or transfer or discharge will be issued if the unsafe practice or behavior cannot be resolved. 1. a. Resident 5's admission record indicated he was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 5 was unable to make his own health care decisions. A review of a hospital discharge progress note dated 1/9/2020 at 10:57 am, the [DIAGNOSES REDACTED]. This was sent via fax to the facility on [DATE] at 11:02 am. A review of a comprehensive resident admission assessment dated [DATE], indicated there was no response marked under the section that addressed resident smoked, it was blank. The assessment indicated Resident 5 was forgetful and confused. A review of a baseline care plan dated 1/9/2020, indicated no documentation in the section for smoking concerns. A review of a smoking assessment undated, indicated Resident did not smoke. A review of a facility smoking policy in Resident 5's record, indicated facility was a smoke free environment, physician can order a nicotine patch, resident given choice to transfer to another facility to smoke, and violation of this policy would result in a discharge or they will no longer be allowed to smoke. This form had a line drawn through the information, no signature or dates. A review of a Smoke Free Campus Consent form dated 1/12/2020, three days after admission, indicated it was signed by a Family Member (FM) 1. The consent form indicated facility was a smoke free facility, if violated they may take corrective action up to immediate eviction. A review of social services notes dated, 1/15/2020 and 1/21/2020, indicated family members wanted hospice and the question does resident smoke, Social Services (SS) documented no. A review of a care plan conference summary note dated 1/15/2020, with family members, and facility staff which included social services, activities, nursing, and therapy. The note discussed need for ongoing hospice and no mention of smoking. A review of the IDT notes from 1/9/2020 through 2/26/2020, indicated Resident 5 had fallen on 2/11/2020, going to the bathroom. There were no IDT notes found in the record that documented Resident 5 was smoking and this may be a reason for getting up without assistance. A review of a nurses note dated 2/5/2020,with no time, indicated Resident 5 was found in his bathroom smoking a cigarette. Resident 5 was educated and will continue to monitor. A review of the nursing notes, social service, IDT notes, and physician progress notes [REDACTED]. During an interview on 3/6/2020 at 9 am, FM 2 stated when Resident 5 wanted to smoke, she asked the charge nurse at the time and was informed he could smoke off property. FM 2 stated she was not sure where this was and took Resident 5 where she had seen other people smoke. During an interview on 3/12/2020 at 11 am, Certified Nursing Assistant (CNA) L stated Resident 5 smoked in his bathroom and had his smoking supplies at times. 1.b. A review of Resident 4's admission record indicated she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 4 was her own health care decision maker. A review of a comprehensive resident admission assessment dated [DATE], indicated Resident 4 smoked. A review of a smoking assessment undated and unsigned, indicated Resident 4 did not smoke. A review of a social service admission assessment dated [DATE], indicated Resident 4 did not smoke. A review of a psychiatric progress note dated 1/13/2020, faxed to the facility same day at 10:23 am, indicated Resident 4 smoked a half a pack of cigarettes a day. A review of a licensed nurses daily skilled charting dated 2/7/2020, indicated Resident 4 was seen right outside the facility with Resident 3, reminded residents it was a non smoking facility. A review of a licensed nurses daily skilled charting dated 2/18/2020, indicated Administrator was aware of Resident 4 going out to smoke and needed to sign out of the facility when doing so. A review of a licensed nurses daily skilled charting dated 2/23/2020, indicated Resident 4 continued to smoke outside and very mobile around the facility. A review of a social service note dated 2/24/2020, indicated Resident 4 tried to quit smoking and did not. A review of a smoking care plan dated 2/25/2020, indicated Resident 4 signed herself out of the facility to smoke and frequently forgot to sign out. The care plan indicated the facility smoking policy was explained to Resident 4. A review of a social service note dated 2/26/2020, indicated Resident 4 was aware facility was a non smoking and if she continued to smoke she needed to sign herself out and go off facility grounds. During a concurrent observation and interview on 2/28/2020 at 2:15 pm, Resident 4 and Resident 3 were smoking in an area outside the facility, at the edge of the parking lot near the fire lane. Resident 4 and Resident 3 both required wheelchairs for mobility. Resident 4 stated it was very difficult to get to the area to smoke, the staff were not willing to assist her due to being a non smoking facility. Resdident 4 stated although they knew she smoked before she was admitted . Resident 4 stated there was no outside lights and difficult to see in the dark. During a concurrent observation and interview on 3/5/2020 at 12:46 pm, Resident 4 smoked just outside the facility parking lot in the fire lane, near an open area with dry grass, oak leaves and many oak trees. Resident 4 confirmed there were a lot of cigarette butts all over the dry ground and had witnessed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	05/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	50 CONCORDIA LANE OROVILLE, CA 95966

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) Resident 3 threw some on the ground. There were no cigarette trash receptacles in the area nor any safety equipment available. Resident 4 stated she had been smoking at the facility within one week of admission, over two months ago. Resident 4 stated she smoked on a patio behind her room at times and facility staff were aware of her smoking. Resident 4 had possession of all of her smoking supplies. Resident 4 further explained she did not feel safe in this area. Resident 4 stated the residents who smoke out in this area were Resident 3 and Resident 5 with his family, and staff from the facility across the parking lot. Resident 4 stated CNA M who worked night shift was aware she was smoking on the back patio near her room, unsupervised. During an interview on 3/5/2020 at 1:30 pm, CNA L stated she was aware that Resident 4 was smoking, she could see her when she drove through the parking lot. CNA L stated Resident 4 was smoking since she had been admitted to the facility. CNA L stated she did not inform anyone that Resident 4 was smoking. During an interview on 3/5/2020 at 1:25 pm, CNA N stated Resident 4 had been smoking at the facility for a couple of months and she never told anyone about it. CNA N stated she saw Resident 4 in the parking lot in an area that was not safe. 1.c. A review of Resident 3's admission record indicated he was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 3 was able to make his own health care decisions. A review of a history and physical hospital note dated 1/17/2020, and faxed to the admitting facility on same day at 11:47 am, indicated Resident 3 was dependent on tobacco. A review of a comprehensive resident admission assessment dated [DATE], indicated Resident 3 smoked. A review of a smoking policy undated, indicated Resident 3 signed and reviewed the rules of the facility was a smoke free environment, physician can order a nicotine patch, resident given choice to transfer to another facility to smoke, and violation of this policy would result in a discharge or they will no longer be allowed to smoke. This form had a line drawn through the information, no signature or dates. A review of a social service assessment dated [DATE], SS documented that Resident 5 smoked and next to the question was there a smoking safety plan in place SS marked not applicable, nicotine patch. A review of a smoke free campus policy and consent form dated and signed by Resident 3 on 1/26/2020, indicated the facility was a smoke free facility, if violated they may take corrective action up to immediate eviction. A third smoking assessment not signed and undated, indicated Resident 3 could not walk independently, not free of sedative medications, had decline in the last three months of the ability to perform activities of daily living, could not move fast to obtain help if needed and had smoked successfully in the past without prior incident, the rest of the form was incomplete. There was no decision made based on the smoking assessment if Resident 3 could smoke independently. A review of a licensed nurse progress note dated 2/14/2020, with no time, indicated Resident 3 smoked. A review of a smoking care plan dated 2/15/2020, indicated Resident 3 required frequent reminder to sign out to smoke and been counseled many times. A licensed nurse daily skilled note dated 2/18/2020 at 3 pm, indicated Administratorwas aware of Resident 3 smoking, he needed constant reminders to sign out before going on smoke break. A review of a nurses note dated 2/24/2020 at 4:30 pm, Licensed Nurse (LN) informed Resident 3 because he drank caffeine and smoked often that this can made his blood pressure run high. A review of an IDT progress note dated 2/24/2020 at 2 pm, indicated Resident 3 checked out of the facility frequently to go off campus and smoked. The IDT members present were the DON, SS, AD, and TD. A review of a smoking care plan dated 2/25/2020, indicated Resident 3 will sign himself out of the facility and smoke off campus. A note indicated Resident 3 was advised the facility was a no smoking policy. A licensed nurse daily skilled note dated 2/25/2020 at 3 pm, indicated staff had to constantly remind Resident 3 to sign out to go out smoking. A review of a social service progress note dated 2/27/2020, indicated Resident 3 was seen outside smoking with Resident 4. During an interview on 3/5/2020 at 1:25 pm, the Director of Staff Development (DSD) stated the facility was a non smoking and was unsure which smoking policy the facility was using, there were two different ones provided, one which allowed smoking and one that did not. DSD stated nursing staff did not have access to the policies. DSD was aware that Resident 4 was smoking due to catching her once. DSD further explained residents who smoked must sign out and go off campus to smoke, and could not describe what off campus meant or where it was located. DSD stated the area where Resident 4 was smoking was not safe. DSD was aware Resident 3 was signing out to smoke and he kept his smoking supplies in his pocket. DSD stated the facility was not enforcing the no smoking policy. During an interview on 3/6/2020 at 1 pm, Admissions Assistant (AA) stated we are a smoke free facility and when we admit someone who smokes, we offer a nicotine patch. AA stated residents needed to sign the policy upon admission. AA was unsure which policy was currently being used. AA stated they admit smoking residents and was not instructed not to admit smoking residents. During an interview on 3/11/2020 at 11:45 am, SS and Director of Nursing (DON) confirmed the smoking policy was unclear, there were two policies. SS and DON stated when residents are interviewed upon admission, if they answer yes to smoking, they offered a nicotine patch. SS and DON stated they did not ask if they plan to smoke, how long they have smoked, when was the last time they smoked or if they have any smoking supplies with them. DON stated the area where all three residents (Resident 3,4,5) smoked was not safe. SS and DON confirmed once they were aware the residents were smoking, that none of the care conferences or IDT meetings discussed the issue of three smokers at the facility. The IDT did not follow the smoking policy when they did not offer or coordinate a transfer/discharge to another facility that allowed smoking when residents did not follow the rules. During an interview on 3/6/2020 at 1:30 pm, the Adminstrator (Admin) stated the facility was non-smoking. Admin stated the admission staff are not to admit any smokers and this should be assessed with [REDACTED]. Admin explained off campus was just past the front entry of the facility. Admin was unable to define the smoking policy statement of 17 acres and where the facility boundaries were which defined off campus. Admin was unaware that employees from the other facility across the parking lot were smoking in the parking lot near the fire lane and that there were many cigarette butts on the dirt and brush. Admin was unaware that the smoking trash receptacles had been moved to the staff smoking area in back of the facility. Admin was aware there were three smokers currently at the facility and explained they were instructed to sign themselves out and smoke off campus. Admin confirmed there were two policies, and was unaware which policy the facility staff were using. Admin confirmed no safety equipment in the areas residents were smoking, such as trash receptacle, fire extinguisher, fire blankets and smoking aprons due to being a non smoking facility. Admin confirmed that discharges/transfers were not offered or other facilities contacted to better accommodate smoking residents. 2. a. A review of Resident 1's admission record indicated she was admitted [DATE], with [DIAGNOSES REDACTED]. Resident 1 was able to make her own health care decisions. A review of a Minimum Data Set (MDS, an assessment tool) dated 1/13/2020, indicated Resident 1 required limited assistance, and nursing staff to provide assistance for walking on and off and around the unit. A review of a nurses note dated 1/13/2020 at 3:30 pm, Resident 1's blood sugar was too high for blood sugar machine to give a reading at 11:30 am. LN A rechecked still too high. LN A notified Medical Director (MD) who ordered [MEDICATION NAME] 100 units per milliliter (u/ml) one time for blood sugar machine reading HI, recheck in two hours. At 3:30 pm, machine still read HI, MD notified Resident 1 received another 15u/ml of [MEDICATION NAME]. A review of Resident 1's record indicated she was in the hospital for high blood sugars from 1/13/2020 to 1/19/2020. A review of a care plan dated 1/20/2020, noted that Resident 1 had poor balance, lack of awareness, intermittent confusion, impulsive behavior, and loves to work in garden which has uneven surfaces. A review of Resident 1's second hospital admission, an emergency room note dated 1/20/20 5:45 pm, indicated Resident 1 presented with confusion, nausea and vomiting, abdominal pain, and extremely high blood sugar of 995. Resident 1 presented with confusion, nausea and abdominal pain (symptoms of high blood sugar). Resident 1 was diagnosed with [REDACTED]. A safety assessment on,1/20/20 at 5:45 pm, identified Resident 1 as a fall risk and implemented interventions, including being placed close to the nurses' station for close monitoring, and frequent reorientation for confusion with standby assist with ambulation (walking). A review a hospitalist progress note dated 1/21/2020 at 1:16 pm, the physician indicated Resident 1 was a brittle diabetic (hard to control blood sugar very low to very high). A review of a admission assessment dated [DATE], indicated Resident 1 was confused. A review of a fall risk assessment dated [DATE], 1/23/2020, and 1/27/2020 indicated Resident 1 was a high fall risk. A review of Resident 1's fall care plan dated 1/23/2020, indicated Resident 1 had an actual fall 3 months ago in the garden. Physical therapy (PT) and Occupational Therapy (OT) were ordered to work with Resident 1 on goals. A review of Resident 1's activity progress note dated 1/24 /2020, indicated she liked to garden daily. A review of PT and OT progress notes for Resident 1, there were no activities related to gardening. A review of the CNA Activity Daily Living (ADL) Tracking Form ranging in dates 1/01/2020 to 1/31/2020 for morning, evening and night (NOC) shifts, indicated Resident 1 required one person assistance for walking and moving about the facility during every shift. A review of a nurses note dated 1/25/2020 at 3:00 pm, LN A documented Resident 1 had an unwitnessed fall, and was found by OT sitting on her low garden bench. Resident 1 informed OT she had fallen from the bench and into the wooden fence behind her. Resident 1 stated she lost her balance when sitting on the bench and twisted her right ankle trying to get up. Resident stated to have complained of mild discomfort to her right ankle. LN A and OT walked Resident 1 from the garden area back to her room and applied ice. A review of a OT treatment note 1/25/20 no time noted, OT indicated she found Resident 1 in the back yard (garden area) and she had swelling and bruising on the outside of the right ankle. Resident 1 reported mild pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	05/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	50 CONCORDIA LANE OROVILLE, CA 95966

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) in her right ankle with weight bearing and while at rest. A review of a nurses note dated 1/25/2020 at 3 pm, LN A documented Resident 1 presented with a finger stick blood sugar of 508 at 7:30 am, (blood sugar target 80 - 130, high level of 508 requires notification of physician), 15 u/ml was given as per physician orders, blood sugar checked again 11:30 am, it was 250. A review of a care plan dated 1/25/2020, noted that Resident 1 had increased weakness, with with delayed thoughts and word finding after recent hospitalization for unstable blood sugars. Resident 1 now restricted from garden area following her discharge until cleared by therapy. A review of an x-ray report dated 1/27/2020, indicated Resident 1 had a right broken ankle. During an interview on 2/10/2020, at 12:45 pm, the Admin stated Resident 1 was informed that she was not to go outside to the garden area without assistance, due to being more confused lately, and often did not follow instructions. During an interview on 2/10/2020, at 2:15 pm, LN A stated when she assessed Resident 1 post fall, she stated initially she was not making sense. LN A stated Resident 1's fall was related to the elevated blood sugars that day prior to the fall. LN A did not recheck blood sugar after the fall. The Medical Doctor (MD) was notified and ordered staff to monitor the resident. Resident 1 was known to spend time gardening in the garden areas, and though restricted per care plan, was allowed to continue gardening without assistance. LN A stated she worried about Resident 1's DM and labile (unstable up and down) blood sugars along with her confusion and weakness but allowed Resident 1 to go to the garden because it is what she loves to do. LN A stated she told Resident 1 that she could go to the garden that day but needed to check in with her on occasion. During an interview on 2/10/2020, at 2:40 pm, OT stated she found Resident 1 in the garden sitting on a low gardening bench. OT stated Resident 1 was not assessed to determine Resident 1's ability to utilize the extremely low gardening bench prior to its use. OT stated Resident 1 informed her that she had fallen off her gardening bench backwards into the fence. Resident 1 stated she twisted her ankle trying to get up as she slipped in the wet grass. OT and LN A walked Resident 1 back to her room which was on another wing of the facility. During a interview on 2/12/2020 at 3 pm, the Activity Director confirmed Resident 1 loved to garden, and this supervised activity had not been provided. During an interview 2/12/2020 at 3:50 pm, the DON stated Resident 1 was different when she was readmitted , significant mental change. DON expected nursing staff to notify physician for changes in condition related to pain. 2.b. A review of Resident 2's admission records indicated she was admitted on [DATE], with [DIAGNOSES REDACTED]. Resident 2 was able to make her own health care decisions. Resident 2 was admitted to room [ROOM NUMBER] which did not have a working call light and a bell was provided Resident 2. A review of a record of admissions, indicated Resident 2 was originally admitted [DATE], discharged [DATE] to home, readmitted [DATE], then discharged [DATE]. A review of a fall risk assessment dated [DATE], indicated Resident 2 at a high risk for falls. A review of a physician's orders [REDACTED]. A review of a nurses note dated 1/23/2020 in am, indicated Resident 2 was screaming for assist. Resident 2 was self transferring independently and was sitting on edge of bed complained of loss of balance. Resident 2 reported having hallucinations and does this a lot. A review of a PT note dated 1/23/2020, indicated Resident 2 had decreased alertness and reported fell earlier attempting to transfer from wheelchair to bed. A review of a IDT progress note dated 1/23/2020, indicated Resident 2 upon admission after surgeries she has episodes of [MEDICAL CONDITION] it takes her one-two weeks post surgery to recover from general anesthesia. Resident 2 hallucinated when pain medications (opioids narcotics) were administered two tablets instead of one. SS indicated nursing to notify physician with pain medication management. A review of licensed nurse's daily skilled charting indicated on 1/24/2020 in the am, Resident 2 continued to hallucinate and had confusing dreams which started last night. A review of Resident 2's IDT notes, nursing notes, physician notes and orders, there was no notification to the physician of Resident 2's ongoing hallucinations, her fall on 1/23/2020 and there were no changes in pain medication orders. There were no new fall interventions put in place to prevent further falls in her care plans. A review of a OT note dated 1/28/2020, indicated Resident 2 required verbal cues for safety and direction, she continued to complain of pain at left knee and declined any further therapy today. A note dated 1/29/2020, indicated OT and Resident 2 were present at the care conference, she had decreased alertness and fell earlier attempting to transfer from wheelchair to bed without putting the breaks on. Resident 2 reported having [MEDICAL CONDITION] and nursing reviewed medications for changing [MEDICATION NAME] to another medication to give her better pain relief. A review of a PT analysis note dated 1/29/2020, indicated Resident 2 was progressing toward goals but unfortunately went home with daughter with understanding physician did not want her putting pressure on her left leg. Resident 2 had the inability to move or weightbear without severe left lower extremity pain, standing balance, cognitive deficits, weakness and poor functional activity tolerance. Resident 2 stated her knee surgeon explained she was to limit pressure as much as possible on her surgical knee due to inflammation and severe pain. A review of an email dated 1/29/2020 at 4:05 pm, authored by the Admin to a chief marketing officer, indicated a yelp review (online rating system) written by a resident and her family member, complained staff was not being responsive to her needs and it had to do with her being admitted into a room without an operational call light. The staff gave her a hand held bell and it could not be heard when she needed assistance or medication for pain. The call light issue has not been resolved and have had several complaints regarding the staff not responding to the hand bells, they are difficult to hear away from the room. A review of a nursing note dated 1/29/2020 at 5:30 pm, indicated Resident 2 and FM 1 arrived back at facility after orthopedic appointment, discharge to home initiated. A review of an admission assessment dated [DATE], indicated the reason for Resident 2's readmission was a failed discharge on 1/29/2020 with multiple falls at home. A review of a nursing note dated 2/1/2020 at 10 am, the DON documented FM 1 called the facility on 1/30/2020 in the morning, less then 24 hours of Resident 2 being discharged to home, and reported Resident 2 fell three times last night. FM 1 requested to have Resident 2 return to the facility. Three facility staff members, took their van and went to Resident 2's home, she was on the floor, on her back between the bed and wall. Resident 2 stated she twisted her knee during the last fall, knee was swollen. Resident 2 refused to go to hospital and was taken back to the facility to room [ROOM NUMBER] B. Resident 2 complained of pain, x-ray done at facility and results were negative for injury. A review of a PT note dated 1/31/2020, indicated Resident 2 had severe pain when weight bearing from left hip and leg, instructed CNAs to have resident non weight bearing until seen by orthopedic surgeon, and recommended nursing to x-ray lower leg leg hip due to having three falls at home before coming back to facility. Resident 2 continued to have hallucinations and nursing aware due to [MEDICATION NAME]. Portable x-ray done at facility, negative for acute fracture. A review of an portable X-ray report done at the facility on 1/31/2020 at 9:24 am, Resident 2 had an X-ray of the knee with no evidence of a fracture. A review of licensed nurse's daily skilled charting indicated on 1/31/2020, in the pm, Resident 2 received one tablet of [MEDICATION NAME] and her scheduled extended release [MEDICATION NAME]. She became more confused in the night and thought there was a man in her room and needed to get out of there. A review of licensed nurse's daily skilled charting indicated on 2/1/2020, in the pm, FM 1 stated Resident 2 called her crying due to have a lot of pain and wanted her daughter to take her to the hospital. LN informed FM 1 if Resident 2 went to the hospital they would have to readmit her. FM 1 did not want that and requested pain medication to be given. LN gave Resident 2 two tablets of [MEDICATION NAME] 5 mg and later in the night she had a fall at 2:14 am. A review of a nursing note dated 2/1/2020 at 10 am, the DON documented FM 1 called the facility on 1/30/2020 in the morning, less then 24 hours of Resident 2 being discharged to home, and reported Resident 2 fell three times last night. FM 1 requested to have Resident 2 return to the facility. Three facility staff members, took their van and went to Resident 2's home, she was on the floor, on her back between the bed and wall. Resident 2 stated she twisted her knee during the last fall, knee was swollen. Resident 2 refused to go to hospital and was taken back to the facility to room [ROOM NUMBER] B. Resident 2 complained of pain, X-ray done at facility and results were negative for injury. A review of an IDT resident safety investigation and intervention note dated 2/3/2020, indicated Resident 2 had an unwitnessed fall in her room on 2/1/2020 at 9:40 pm. Resident 2 fell on to the ground next to her bed while trying to turn off her bedside lamp. Resident 2 reported seeing things that were not there, this may be due to the use of [MEDICATION NAME] and now changed to [MEDICATION NAME] long acting pain medication. Speech therapy to review for cognition and continue PT and OT. A review of a history of physical from orthopedic surgeon dated 2/3/2020, indicated Resident 2 fell and injured her left knee over the weekend. She had fallen a number of times although her last fall was so severe that she wasn ' t ' unable to weight bear any longer. Resident 2 reported falling four times since seen last, which resulted in constant severe pain when moving left leg. Resident 2 required surgery on 2/4/2020, due to a new left tibial (lower leg) fracture and required a total knee revision. During an interview on 2/11/2020, Resident 2's FM 1 stated she was in constant pain and hallucinations. FM 1 stated Resident 2 did not have a call light nor did her room mate, they were in room [ROOM NUMBER]. Resident 2 had a bell and the room mate had a squeaky toy. FM 1 stated Resident 2 had reactions to anesthesia which included hallucinations. FM 1 was upset with care at facility and wanted to discharge her. FM 1 took Resident 2 to her post surgical appointment on 1/29/2020. FM 1 stated surgeon was agreeable to discharge Resident 2. Upon return to facility, FM 1 informed nursing she wanted to take Resident 2 home to take care of her. FM 1 explained facility staff did not attempt to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	05/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	50 CONCORDIA LANE OROVILLE, CA 95966

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) keep them from leaving nor did they explai
F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure social services met the needs for four of 10 residents when: 1. A failed discharge resulted in repeat injury of broken knee for Resident 2. 2. Assist Resident 3 to access housing resources and benefits prior to discharge. 3. Did not facilitate discharge/transfers for residents (Resident 3, 4, and 5) to a smoking facility. These failures resulted in a unsafe failed discharge (Resident 2) and had potential for all residents to be at risk for discharge goals not to be met. Refer F 689 and F 622. Findings: A review of a facility policy titled, Social Services Assessment, revised 11/22/16, indicated the purpose was to identify information to help staff develop a personalized plan of care that utilizes the individual's existing needs, strengths, functional deficits, and optimizes function and quality of life and meets individual's goal and preferences. When a resident is admitted a discharge plan is discussed, documented in the social services assessment, and updated in the record to reflect changes to the initial discharge plan. A review of a facility job description for Social Service Designee undated, indicated the primary purpose of the job position is to assist in planning, developing, organizing, implementing, evaluating, and directing social service program in accordance with existing federal, state, and local standard and our policies and procedures to assure the medically related emotional and social needs of residents are maintained/met on an individual basis. Provide information about social service agencies when facility does not provide the services or needs of the resident and other financial assistance programs available through the community. Assist in providing practical solutions for environmental problems, including financial, discharge planning and referrals to specialized assistance in the community. Report all unsafe/hazards condition immediately. Meet with administration, nursing and medical staff and other related departments in planning social services. Assist in developing and implementing policies and procedures for identifying medical and social needs of residents. Participate in discharge planning, care plans and resident assessments. 1. A review of Resident 2's admission records indicated she was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of a nursing note dated 1/29/2020 at 5:30 pm, indicated Resident 2 and Family Member (FM) 1 arrived back at facility after orthopedic appointment, discharge initiated. During a concurrent interview and record review on 3/11/2020 at 3:30 pm, Occupational Therapist (OT, Therapy Director) stated Resident 2 was not ready to go home due to cognitive issues related to safety and judgement, plus multiple falls. OT informed nursing that Resident 2 was not progressing in her therapy. A review of a physical therapy (PT) note dated 1/27/2020, indicated Resident 2 complained of a lot of pain and increased with weight bearing. On 1/28/2020, Resident 2 indicated continued pain that was not controlled by medication. On 1/29/2020, a physical therapy assistant noted Resident 2 saw orthopedic surgeon today and per resident going home, educated provided for safe transfers. A review of an admission assessment dated [DATE], indicated the reason for Resident 2's readmission was a failed discharge on 1/29/2020 with mulitple falls at home. A review of a nursing note dated 2/1/2020 at 10 am, the DON documented FM 1 called the facility on 1/30/2020 in the morning, less then 24 hours of Resident 2 being discharged to home, and reported Resident 2 fell three times last night. FM 1 requested to have Resident 2 return to the facility. Three facility staff members, took their van and went to Resident 2's home, she was on the floor, on her back between the bed and wall. Resident 2 stated she twisted her knee during the last fall, knee was swollen. Resident 2 refused to go to hospital and was taken back to the facility to room [ROOM NUMBER] B. Resident 2 complained of pain, xray done at facility and results were negative for injury. A review of a care conference note dated 1/29/2020, with Resident 2, SS and Social Services Assistant, met to discuss discharge. Resident 2 stated she wanted to go home and the orthopedic surgeon gave her an order to go home today. The orthopedic group was going to order a wheelchair and call home health services. There was no documentation that indicated nursing and therapy were present to evaluate her ability return home safely. There was no orthopedic documentation found in the record to support Resident 2 was ready to go home. During a concurrent record review and interview on 3/11/2020 at 3:30 pm, the Business Office (BO) who assisted with resident discharges stated on 1/29/2020, SS informed her that Resident wanted to go home. BO filled out the top portion of the post discharge plan of care, which indicated the orthopedic surgeons office was arranging home health and equipment. BO confirmed the facility/IDT (Interdisciplinary team- group of health care disciplines who discuss resident care needs) was responsible for a discharge care conference normally, and this did not happen. BO did not confirm the orthopedic associates discharged her or if they were arranging home health. There was no documentation found in the record from the orthopedic associates which indicated she was good to go home and they were arranging all the necessary services needed for Resident 2. BO stated the facility was responsible for arranging and facilitating all home health services and or equipment needed for resident discharges. 2. A review of Resident 3's admission record indicated he was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 3 was able to make his own health care decisions. A review of an interdisciplinary (IDT) progress note dated 2/17/2020, a care conference was held for Resident 3, and discharge plans were discussed. Resident 3 arranged for an apartment that fell through, and he independently continued to look for affordable housing. The IDT note was signed by SS. During a concurrent observation and interview on 2/25/2020 at 11:30 am, Resident 3 stated the SS was not assisting him with his discharge, he explained at the other skilled facility they were helping him with his discharge plans (accessing county resources). Resident 3 stated he survived the fire, lost home and had several [MEDICAL CONDITION] since then. Resident 3 stated he may be eligible for benefits for housing due to the fire and the SS has not made phone calls to inquire about it for him. Resident 3 stated there was no assistance with available resources. During an interview on 3/12/2020 at 3:15 pm, SS confirmed she did not assist Resident 3 in accessing resources for housing which he may have been eligible for due to the fire. SS was aware that Resident 3 was looking for housing and sometimes it would fall through. 3. A review of a hospital discharge progress note dated 1/9/2020 at 10:57 am, the [DIAGNOSES REDACTED]. This was sent via fax to the facility on [DATE] at 11:02 am. A review of social services notes dated, 1/15/2020 and 1/21/2020, indicated family members of Resident 5 wanted hospice and the question does resident smoke SS documented no. A review of a nurses note dated 2/5/2020,with no time, indicated Resident 5 was found in his bathroom smoking a cigarette. Resident 5 was educated and will continue to monitor. A review of a social service assessment dated [DATE], SS documented that Resident 3 smoked and next to the question was there a smoking safety plan in place SS marked not applicable, nicotine patch. A review of a social service progress note dated 2/27/2020, indicated Resident 3 was seen outside smoking with Resident 4. A review of a social service admission assessment dated [DATE], indicated Resident 4 did not smoke. During an interview on 3/11/2020 at 11:45 am, SS and DON confirmed the smoking policy was unclear, there were two policies. SS and DON stated when residents are interviewed upon admission, if they answer yes to smoking, they offer a nicotine patch. SS and DON stated they do not ask if they plan to smoke, how long they have smoked, when was the last time they smoked or if they have any smoking supplies with them. DON stated the area where all three residents (Resident 3,4,5) was not safe. SS and DON confirmed once they were aware the residents were smoking, that none of the care conferences or IDT meetings discussed the issue of three smokers at the facility. The IDT did not follow the smoking policy when they did not offer or coordinate a transfer/discharge to another facility that allowed smoking when residents did not follow the rules. SS confirmed no other facilities were contacted about admitting a smoker and this was not offered to all the residents who smoked at the facility.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered per a physician's order when Resident 4 was given 20 milligrams (mg) extra of [MEDICATION NAME] (sedative medication, given for muscle spasms) in error. This resulted in Resident 4 to feel overly sedated. Findings: A review of Resident 4 admission record indicated she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 4 was her own health care decision maker. A review of Resident 4's physician order dated 12/21/19, indicated [MEDICATION NAME] 10 mg one tablet by mouth every eight hours for muscle spasms. A review of Resident 4's controlled drug record for [MEDICATION NAME] ([MEDICATION NAME]) dated 2/14-3/6/2020, indicated Director of Nursing (DON) on 3/3/2020, removed and administered 30 mg (three 10 mg tablets) of [MEDICATION NAME] to Resident 4 at 8 pm. The DON wrote error next to two of the doses. A review of a nursing note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	05/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	50 CONCORDIA LANE OROVILLE, CA 95966

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) 3/3/2020 at 11:30 pm, DON documented Resident 4 received an extra dose of [MEDICATION NAME] instead of [MEDICATION NAME] (strong narcotic) at approximately 8 pm. Physician notified and will continue to monitor. During an interview on 3/5/2020 at 1 pm, Resident 4 stated last night the DON gave her three instead of one [MEDICATION NAME] in the evening. Resident 4 stated she passed out in wheelchair and asked to be put bed. According to Lexicomp, an online drug reference, indicated [MEDICATION NAME] can cause severe drowsiness or feeling like passing out and to call the physician immediately. Also, accidental falls are commom in elderly residents who take this medication. Use caution to avoid falling or accidental injury while taking [MEDICATION NAME]. During an interview on 3/11/2020 at 3 pm, DON confirmed she administered two extra doses of [MEDICATION NAME] instead of giving her the routine [MEDICATION NAME]. DON stated she notified the physician and put Resident 4 on alert charting to monitor for adverse side effects.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide consistent administrative oversight to ensure the residents' received the care and services to meet their needs when: 1. Facility's smoking policy was not implemented to ensure resident safety in relation to smoking hazards. 2. The interdisciplinary team (IDT-group of different health care disciplines who discuss resident care needs) did not implement safe discharge planning. 3. The facility did not provide a functioning call light communication system. 4. The Quality Assurance Program Improvement (QAPI) did not implement improvements into the fall management program to reduce resident injuries from falls. These failures contributed to an Immediate Jeopardy to correct potential harm related to smoking hazards, fall prevention, safe discharges and a functioning call light system. Refer to F 622, F 689 and F 919. Findings: A review of the Administrator job description dated 2003, indicated the primary purpose of the job position is to direct the day to day function of the facility in accordance with current federal, state and local standards and regulations. Develop and maintain written policies and procedures that govern the operation of the facility. Assist department directors in the development and use, and implementation of policies and procedures with professional standards of practice. Review polices and procedures at least annually and make changes as necessary to assure continued compliance with current regulations. Ensure all employees, residents, visitors, and general public follow the facility's established policies and procedures. Ensure all personnel have training in the facility's policy and procedures. Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies. 1. During an interview on 3/6/2020 at 1:30 pm, Administrator (Admin) stated the facility was non-smoking. Admin stated the admission staff were not to admit any smokers and this should be assessed with [REDACTED]. Admin explained off campus was just past the front entry of the facility. Admin was unable to define the smoking policy statement of 17 acres and where the facility boundaries were which defined off campus. Admin was unaware that employees from the other facility across the parking lot were smoking in the parking lot near the fire lane and that there were many cigarette butts on the dirt and brush. Admin was unaware that the smoking trash receptacles had been moved to the staff smoking area in back of the facility. Admin was aware there were three smokers currently at the facility and explained they were instructed to sign themselves out and smoke off campus. Admin confirmed there were two policies, and was unaware which policy the facility staff were using. Admin confirmed no safety equipment in the areas residents were smoking, such as trash receptacle, fire extinguisher, fire blankets and smoking aprons due to being a non smoking facility. Admin confirmed that discharges/transfers were not offered or other facilities contacted to better accommodate smoking residents. 2. A review of an admission assessment dated [DATE], indicated the reason for Resident 2's readmission was a failed discharge on 1/29/2020 with multiple falls at home. Resident 2 had a significant change in condition that contributed to two unwitnessed avoidable falls. This resulted in an injury to her left knee that required emergent surgery to repair. During a concurrent record review and interview on 3/11/2020 at 3:30 pm, the Business Office (BO) who assisted with resident discharges stated on 1/29/2020, SS informed her that Resident 2 wanted to go home. BO filled out the top portion of the post discharge plan of care, which indicated the orthopedic surgeons office was arranging home health and equipment. BO confirmed the facility/IDT was responsible for a discharge care conference normally, and this did not happen. BO did not confirm the orthopedic associates discharged her or if they were arranging home health. There was no documentation found in the record from the orthopedic associates which indicated she was good to go home and they were arranging all the necessary services needed for Resident 2. BO stated the facility was responsible for arranging and facilitating all home health services and or equipment needed for resident discharges. 3. A review of the call light logs, which the Maintenance Supervisor (MS) completed weekly indicated room [ROOM NUMBER], 104, 105, 109, 111, 126, and 131 needed repair or replacement. A review of a call light vendor estimate dated 8/23/19, indicated 10 call cord patient stations, six feet call cords and 3 bathroom call cords were requested. A second invoice dated 1/21/2019, indicated 10 call cord resident stations and 5 pull cord bath station. During a concurrent interview and record review on 2/25/2020 at 11:55 am, the MS stated they requested for replacement parts last year and now has been informed the call light manufacturer was going out of business, which made it difficult or impossible to get parts. Admin stated they move call lights around based on residents cognition. Admin explained a resident was moved over the weekend due to her bell not being heard. Admin stated corporate was notified by phone, email and was brought up in a meeting last week with no resolution. Admin stated this was not in her Quality Assessment and Assurance Program as an ongoing issue. Admin confirmed the parts were ordered and the invoice was not paid, so parts were not delivered and now they are not in business any longer. 4. During a concurrent interview and record review of the Continuous Quality Improvement records on 2/25/2020 at 12:15 pm indicated: -for the months of October-December 2019, there were 52 falls with an average of 17 per month. -for the month of January 2020, there were 26 falls. -for the month of February 2020, there were 26 falls. The Admin confirmed the committee talked about implementing new fall interventions due to the increase in falls over the past few months, and did not get to it. During an interview on 3/12/2020 at 10:30 am, Admin stated they started a new fall program. Admin stated they started a Kardex (overview of each resident updated daily) for the CNAs (Certified Nursing Assistants). Admin stated before there was no way for all direct care staff to know if a resident had been falling. Admin stated she primarily managed the IDT fall meetings and should be nursing to investigate cause and implement interventions to reduce falls.
F 0837 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have an effective governing body (GB) legally responsible for establishing and implementing management and operational policies to ensure effective administration of the facility and quality of care and services to residents when it failed to: 1. Ensure administrator was implementing their smoking policy. 2. Ensure a functioning communication call light system. These failures contributed to an Immediate Jeopardy to correct potential harm related to a smoking hazards and a functioning call light system. Refer to F 689, F 835, and F 919. Findings: 1. Smoking residents (Resident 3, 4, and 5) were smoking on the facility grounds, without smoking assessments, supervision, and necessary safety equipment. 2. A review of the call light logs, which the Maintenance Supervisor (MS) completes weekly indicated room [ROOM NUMBER], 104, 105, 109, 111, 126, and 131 need repair or replacement. A review of email communication between Administrator (Admin), call light vendor and Regional Operational Leader (ROL, governing body) indicated: -On 8/23/19, vendor gave an estimate for call light repairs. -On 10/16/19, vendor requested payment to then order the necessary parts to repair. -On 10/16/19, Admin sent invoice to corporate for payment. -On 10/16/19, Admin sent high priority email to ROL (governing body), Admin wrote I'm not sure how we can get this paid, I have four residents that are currently using hand bells and need more for replacement, this is a top priority. -On 1/6/2020, Admin sent request to ROL to have call light issue taken care of. We have several call lights out of service. A review of a call light vendor estimate dated 8/23/19, indicated 10 call cord patient stations, six feet call cords and 3 bathroom call cords were requested. A second invoice dated 1/21/2019, indicated 10 call cord patient stations and 5 pull cord bath station. During a concurrent interview and record review on 2/25/2020 at 11:55 am, the MS stated they requested for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	**50 CONCORDIA LANE OROVILLE, CA 95966**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0837 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 7) replacement parts last year and now has been informed the call light manufacturer was going out of business, which made it difficult to impossible to get parts. Admin stated they move call lights around based on residents cognition. Admin explained a resident was moved over the weekend due to her bell not being heard. Admin stated corporate was notified by phone, email and was brought up in a meeting last week with no resolution. Admin stated this was not in her Quality Assessment and Assurance Program as an ongoing issue. Admin confirmed the parts were ordered and the invoice was not paid, so parts were not delivered and now they are not in business any longer. During an interview on 3/11/2020 at 1:50 pm, the ROL stated he was unaware of any smoking by residents or by other visitors (staff from neighboring facility across the parking lot) on their property, they were a non smoking facility. ROL stated he was aware of the call lights issues starting in December 2019.
F 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a plan that describes the process for conducting QAPI and QAA activities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have an effective Quality Assurance Performance Improvement (QAPI) committee when they did not identify nor correct facility issues to ensure care and services met resident needs when: 1. Call light communication system was not functioning in multiple rooms since August 2019. 2. Resident falls were increasing from January 2020 and unwitnessed harm level falls for Resident 1 and 2. This resulted in an immediate jeopardy for failure to provide a system to prevent falls and ensure a working call light system. Refer to F 689 and F 919. Findings: A review of a facility policy titled Quality Assessment and Assurance Committee revised August 2006, indicated the Administrator shall delegate actions and processes for the committee. The committee shall provide reports to the Administrator and Governing Body. The goal of the committee is to oversee facility systems and processes related to improving quality of care and services. To identify and correct problems in facility systems. To coordinate and facilitate communication regarding the delivery of quality resident care among departments, facility staff, residents and family members. The QAPI committee is to oversee the implementation of the program including identifying negative and positive outcomes of care and services, establishing quality indicators and standards of practice, meeting with the governing body or owner to review quality related items. 1. There were no QAPI records provided that included information about the call light system. A review of the call light logs, which the Maintenance Supervisor (MS) completes weekly indicated room [ROOM NUMBER], 104, 105, 109, 111, 126, and 131 need repair or replacement. A review of email communication between Administrator (Admin), call light vendor and Regional Operational Leader (ROL, governing body) indicated: -On 8/23/19, vendor gave an estimate for call light repairs. -On 10/16/19, vendor requested payment to then order the necessary parts to repair. -On 10/16/19, Admin sent invoice to corporate for payment. -On 10/16/19, Admin sent high priority email to ROL (governing body), Admin wrote I'm not sure how we can get this paid, I have four residents that are currently using hand bells and need more for replacement, this is a top priority. -On 1/6/2020, Admin sent request to ROL to have call light issue taken care of. We have several call lights out of service. A review of a call light vendor estimate dated 8/23/19, indicated 10 call cord patient stations, six feet call cords and 3 bathroom call cords were requested. A second invoice dated 1/21/2019, indicated 10 call cord patient stations and 5 pull cord bath station. During a concurrent interview and record review on 2/25/2020 at 11:55 am, the MS stated they requested for replacement parts last year and now has been informed the call light manufacturer was going out of business, which made it difficult to impossible to get parts. Admin stated they move call lights around based on residents cognition. Admin explained a resident was moved over the weekend due to her bell not being heard. Admin stated corporate was notified by phone, email and was brought up in a meeting last week with no resolution. Admin stated this was not in her Quality Assessment and Assurance Program as an ongoing issue. Admin confirmed the parts were ordered and the invoice was not paid, so parts were not delivered and now they are not in business any longer. 2. During a concurrent interview and record review of the Continuous Quality Improvement records on 2/25/2020 at 12:15 pm indicated: -for the months of October-December 2019, there were 52 falls with an average of 17 per month. -for the month of January 2020, there were 26 falls. -for the month of February 2020, there were 26 falls. The Admin confirmed the committee talked about implementing new fall interventions due to the increase in falls over the past few months, and did not get to it.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the communication call light system was working for five rooms since August of 2019. This failure had the potential for residents without a call light to be at risk for accidents and their care needs not to be met. Findings: During an observation of the facility on 2/25/2020 at 11:05 am, Licensed Nurse (LN) A stated the call light in room [ROOM NUMBER] B did not work, 102 B works although loose from the wall, room [ROOM NUMBER] call light was not working. LN A stated call lights not working make it difficult to know when residents need assistance. During a concurrent observation and interview on 2/25/2020 at 11:15 am, room [ROOM NUMBER] call light unit had been removed entirely from the wall. A Family Member (FM) 3 of one of the residents in the room stated They need more people, sometimes there is too much to do. During a concurrent observation and interview on 2/25/2020 at 11:25 am, Certified Nursing Assistant (CNA) H and CNA I explained some call lights in residents rooms have been not working for at least six months. CNA H and CNA I confirmed room [ROOM NUMBER] call light was not working and further explained we give them a courtesy bell to the functional residents. CNA H and I stated we usually do hear the bell unless we are in a different room and busy and we just do not hear it. We have to be on our toes. During a concurrent observation and interview on 2/25/2020 at 11:30 am, Resident 3 in room [ROOM NUMBER] stated his call light worked but his room mates did not and will call for assistance for him when he needed it. Resident 3 stated there were problems with staffing on the night shift. There were two bells at bedside. During an interview on 2/25/2020 at 11:40 am, CNA J stated sometimes the bell work in room [ROOM NUMBER] and sometimes not. During an interview on 2/25/2020 at 11:45 am, CNA K stated call lights not working makes it challenging. During a concurrent observation and interview on 2/25/2020 at 11:50 am, Resident 6 stated her call light did not work and she does use the bell provide by the facility although nursing staff do not always hear it, and I do not have a cell phone or regular one in my room. Resident 6 further explained the bathroom call light get staff quicker than used the bell at her bedside. During a concurrent observation and interview on 2/25/2020 at 12:15 pm, Resident 9 was in her wheelchair room [ROOM NUMBER] with Family Member (FM) 4. FM 4 stated Resident 9 preferred the call light though used the bell. FM 4 stated the bell was not effective due to not always being heard by nursing staff. The Maintenance Supervisor (MS) removed the call light and will replace with one that works. During an interview outside room [ROOM NUMBER] on 2/25/2020 at 11:50 am, CNA K stated the call light had been not working for a couple of months. CNA K stated it was a problem when contract staff work due to having to ensure they know to listen for the sound of the bells ringing. During an interview on 3/5/2020 at 2:40 pm, Resident 10 was observed to have a bell on his bedside table in room [ROOM NUMBER]. Resident 10 stated I have rung that bell 5-6 times and no one answers. Resident 10 further explained he has need to use the bathroom and required assistance to do so. Resident 10 went to the bathroom without help as not to wet himself. A review of the call light logs, which the Maintenance Supervisor (MS) completes weekly indicated: -5/24/19, 5/28/19, there were no documented call light checks. -6/3/19, room [ROOM NUMBER] broken and out of the wall, parts ordered, room [ROOM NUMBER] smashed when moving bed. -6/7/19, there were no documented call light checks. -6/13/19, there were no documented call light checks. -6/21/19, room [ROOM NUMBER] and room [ROOM NUMBER] parts on order. -7/1/19 and 7/15/19, there were no documented call light checks. -9/8/19, room [ROOM NUMBER] broken. -9/17/19 and 9/23/19, there were no documented call light checks. -10/2/19, room [ROOM NUMBER] parts on order. -11/7/19, room [ROOM NUMBER] A side of room needs replacement. -11/7/19, room [ROOM NUMBER] needs replacement. -11/7/19, room [ROOM NUMBER] needs replacement. -12/2/19, room [ROOM NUMBER],105, and 126 continue to need replacement. -1/2/19, room [ROOM NUMBER] B, 105 A, 126, and 129 A need replacement. -2/3/2020, room [ROOM NUMBER] and 126 replacment parts on order. A review of email communication between Administrator (Admin), call light vendor and Regional Operational Leader (ROL, governing body) indicated: -On 8/23/19, vendor gave an estimate for call light repairs. -On 10/16/19, vendor requested payment to then order the necessary parts to repair. -On 10/16/19, Admin sent invoice to corporate for payment. -On 10/16/19, Admin sent high priority email to ROL (governing body), Admin wrote I'm not sure how we can get this paid, I have four residents that are currently using hand bells and need more for replacement, this is a top priority. -On 1/6/2020, Admin sent request to ROL to have call light issue taken care of. We have several call lights out of service. A review of a call light vendor estimate dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555802	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY CREST POST ACUTE	**50 CONCORDIA LANE OROVILLE, CA 95966**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) 8/23/19, indicated 10 call cord patient stations, six feet call cords and 3 bathroom call cords were requested. A second invoice dated 1/21/2019, indicated 10 call cord patient stations and 5 pull cord bath station. During a concurrent interview and record review on 2/25/2020 at 11:55 am, the MS stated they requested for replacement parts last year and now has been informed the call light manufacturer was going out of business, which made it difficult to impossible to get parts. Admin stated they move call lights around based on residents cognition. Admin explained a resident was moved over the weekend due to her bell not being heard. Admin stated corporate was notified by phone, email and was brought up in a meeting last week with no resolution. Admin stated this was not in her Quality Assessment and Assurance Program as an ongoing issue. Admin confirmed the parts were ordered and the invoice was not paid, so parts were not delivered and now they are not in business any longer.