STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. BUILDING _____ B. WING _____	**03/12/2020**

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

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

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation and interview the facility failed to maintain clean and sanitary conditions when: 1. Two clean utility room under-sink cabinets were observed to be soiled. 2. Two room fans were observed to have lint on the fan blades and wire cage of the fan. These failures created the potential for environmental contamination with bacteria, viruses and allergens, not facilitating a homelike environment that could lead to negative clinical outcomes. Findings: 1. During an initial tour of the Cherry wing and concurrent interview on 3/9/20 at 9:37 AM, the clean utility room was observed with Certified Nursing Assistant (CNA) 2. CNA 2 confirmed the area under the sink was soiled with a blackish brown substance and trash bags in a corrugated cardboard box were being stored. CNA 2 stated items should not be stored under the sink. During an observation and concurrent interview on 3/9/20 at 9:47 AM, CNA 2 returned to the clean utility room and removed the box of trash can liners that were being stored under the sink and stated she would notify housekeeping to clean under the sink. During an observation on 3/11/20 at 10:30 AM, the Peach wing clean utility room was observed. The under-sink cabinet, where items were being stored, was soiled with a blackish brown substance. 2. On 3/10/20 @ 10:30 AM during an observation of the facility utility rooms and physical therapy gym, two wall mounted room fans were observed to have dust accumulation on the fan blades and wire blade cover. The fan in the physical therapy room had a strand of dust, approximately 2 inches long hanging from a fan blade. On 3/10/20 @ 10:40 AM CNA 3 was asked about the condition of the fan and stated, It looks kind of gross. Lint, yes. It needs to be cleaned. I will get housekeeping; they should have cleaned it. Shortly after, Housekeeper 2 entered the utility room and viewed the fan. I will take care of it right now was her response when viewing the condition of the fan. On 3/10/20 at 10:45 AM the fan in the physical therapy gym was called to the attention of staff. Physical Rehabilitation Aid acknowledged lint present on the fan. Housekeeping staff were summoned to clean the fan.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise the care plan and include interventions to prevent a skin tear for one of 24 sampled residents (Resident 7). This caused or contributed to an additional skin tear. Findings: A review of Resident 7's record indicated she was readmitted on [DATE], with [DIAGNOSES REDACTED].). During a concurrent observation and interview on 3/9/20 at 3:37 pm, Resident 7's responsible party said there was a new skin tear on Resident 7's right elbow arm area. She pulled up the resident's sleeve and there was a bruise with a horseshoe shaped skin tear with four steri-strips. The shirt sleeve had a reddish-brown stain. She said Resident 7 has had other prior skin tears and staff were supposed to use sleeve covers during transfers to prevent skin tears. The notes for skin tears which had happened since readmission and care plan revisions were reviewed. On 11/5/19 a skin tear occurred during a Hoyer (assistive device that allows patients to be transferred between bed and chair) transfer. The care plan was not revised. On 12/11/19, another skin tear occurred and the reason was not clear but the care plan was revised to include sleeve covers during Hoyer transfers. No skin tears during Hoyer transfers occurred after this intervention was started. Another skin tear occurred on 3/9/20 while dressing Resident 7 with a tight long sleeve shirt and the care plan was revised to use only loose long sleeves. During an interview on 3/12/20 at 8:20 am, the Director of Nurses (DON) confirmed Resident 7's care plan was updated to include additional interventions after the skin tear on 12/11/19 and 3/9/20, but the care plan had not been revised after the initial skin tear on 11/5/19.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide restorative nursing aide (RNA) therapy (services to ensure a resident's range of motion (ROM) did not decrease) to one of two residents (Resident 7), as often as ordered by the physician. This had the potential to result in a decrease in Resident 7's range of motion and optimum level of functioning. Findings: A review of Resident 7's record indicated she was readmitted on [DATE], with [DIAGNOSES REDACTED].). The physician's orders [REDACTED]. During an interview on 3/9/20 at 3:53 pm, Resident 7's responsible party (RP) said she was unsure how often ROM exercises were being done with Resident 7. A review of the RNA weekly notes since 1/1/20 indicated for nine of eleven weeks, Resident 7 received RNA therapy from three to four times per week, instead of five times per week, as ordered by the physician. During a concurrent interview and record review on 3/12/20 at 1 pm, the Director of Nursing (DON) confirmed there were two weeks, during the period from 1/1/20 to present, when Resident 7 had RNA therapy five times per week. DON stated they have been short staffed due to illness and some staff being on a leave of absence. She said she will have Resident 7 rescreened by Physical Therapy.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 one of six residents (Resident 74) who smoked received adequate supervision. This had the potential to result in an accident related to smoking including burns. Findings: A review of Resident 74's record indicated he was admitted on [DATE], with [DIAGNOSES REDACTED]. A review of the smoking assessment and interdisciplinary team note, indicated Resident 74 was safe to smoke and agreed to smoke only with a designated smoking aide or family member present. On 3/9/20 at 4:06 pm, Resident 74 was observed out in the smoking area with another resident. Resident 74 was smoking and ash fell from his cigarette onto the ground. He stopped smoking as soon as the surveyor arrived at the smoking area. No staff were present. A very short time later (approximately one minute), two other residents came out as well as the designated smoking aide (AA 1) who offered Resident 74 a smoking apron. Resident 74 accepted the smoking apron and put it on prior to starting to smoke again. The above observation was

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) discussed with the Director of Nurses (DON) on 3/10/20 at 8:59 am. The DON said staff from various departments are assigned to be with residents at designated smoking times. She said according to their policy, staff should be present when residents are smoking, although their policy does allow a visitor to be present at times. She said they try to get residents to wear smoking aprons and Resident 74 was willing to wear one. The DON said Resident 74 had a visitor yesterday and she would see if he left cigarettes for this resident, but otherwise the cigarettes were kept locked up in a box in the medication room. The facility's Smoking Policy - Residents, revised 9/2017, was reviewed. It indicated, all residents with smoking privileges shall have the direct supervision of a staff member, resident representative, family member, volunteer worker, or other person deemed safe by the facility at all times while smoking.
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 observation, interview and record review, the facility failed to consistently follow a medication order and did not follow medication administration policy when they did not notify the doctor or pharmacist of a pattern of refusal for [MEDICATION NAME] ointment (Nonsteroidal anti-[MEDICAL CONDITION] drug) for one of 24 sampled residents (Resident 42). This failure delayed the doctor from assessing and adjusting an individualized medication regimen that met the wishes and needs of Resident 42. Findings: A review of the medical record for Resident 42 indicated he was last admitted on [DATE] from the hospital with heart and lung problems, back pain, swollen legs, [MEDICAL CONDITION] (nerve pain in the hands and fingers). Resident 42 was his own responsible party. A review of a facility policy, titled, Administering Medications, revised 4/2019, indicated that medications should be administered in accordance with prescriber orders. Identified concerns should be communicated to the prescribing doctor. A review of a facility policy, titled, Medication Regimen Reviews, Revised 7/2018, indicated the Pharmacist will identify any irregularities and provide timely communication to the attending physician, the facility's Medical Director and to the Director of Nursing (DON). A review of the physician orders [REDACTED]. During observation of a medication administration on the Plum Wing, on 3/11/20 at 9:18 AM, Licensed Nurse (LN) A stated she was going to ask Resident 42 if he wanted to refuse the [MEDICATION NAME] gel that the doctor had ordered. During an interview with LN A, on 3/11/20 at 9:35 AM, she stated she did not give this ointment to him daily as he usually did not want it. During an observation of LN A interacting with Resident 42, on 3/11/20 at 9:40 AM, she instructed Resident 42 that he should let her give him the [MEDICATION NAME] ointment since surveyors wanted to watch her conduct a medication administration. Resident 42 agreed to let her apply the ointment but stated that he did not need it. LN A applied the [MEDICATION NAME] gel to Resident 42's left thumb. During an interview with Resident 42, on 3/11/20 at 09:48 AM, he stated he did not want to rely on pain medications, so he refused them often. Resident 42 stated he would rather just ask for the ointment when he felt he needed it. He stated the nurses and doctors had never discussed changing the medication from routine to as needed. During an interview with LN A, on 3/11/20 at 9:55 AM, she stated she had not spoken to the doctor about how often Resident 42 refused the medication. She stated she usually did not get the medication ready to offer as Resident 42 as he usually refused it. When asked if he would be more likely to accept the ointment if it were ready to apply, LN A said possibly but it would still get thrown away most of the time. During a concurrent interview and review of Resident 42's orders, medication administration records (MAR) and progress notes with the DON, on 3/11/20 at 3:00 PM, the MAR indicated several stretches of refusals that started in 1/2020 and continued through 3/2020. When asked if a care conference should recognize and address patterns of medication refusal, DON stated they should have reviewed current medications and discussed with Resident 42 if any medications should be changed or discontinued. There should have been a referral to the doctor to change the [MEDICATION NAME] gel to PRN (as needed) and then Resident 42 would have to ask for it. DON confirmed there had been a pattern of refusal. She stated they should have identified the root cause for the refusals, but that the pattern had not been captured in the progress notes. Nurses would not know about the pattern of refusal unless they printed out the MAR and did an intentional review. It should have been the responsibility of the nurse to notify the doctor of three or more days in a row of refusal to accept the ointment. A review of the 2020 Medication Administration History for Resident 42 indicated the following refusals for the [MEDICATION NAME] sodium gel: January 10, 17-19, 24-26 February 1, 2, 7-9, 14-16, 21-23, 28-29 March 1, 2, 4, 6-8 A review of the Pharmacy Consultant's Medication Regimen Review indicated, for 1/2020 and 2/2020, she did not address the pattern of refusal by Resident 42 for the [MEDICATION NAME] gel. During an interview with the Pharmacy Consultant (PC), on 3/12/20 at 8:36 AM, she stated that the nurses were responsible to alert the doctors and pharmacist if a chronic medication had a pattern of refusal. PC stated the pharmacists checked PRN medications (ordered as needed) for patterns of refusal, but did not check routine medications for patterns of refusal.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the standard of practice and manufacturer's recommendations for identifying expiration dates when it did not label blood sugar testing strips and solutions with the date they were opened, and when an expired bottle of [MEDICATION NAME] (a solution used to kill germs on skin) was not labeled with the date it was opened and was still in use. This failure had the potential to cause inaccurate blood sugar test results and insulin medication errors, and to ineffectively kill germs during wound care treatments, increasing the risk of infection. Findings: A review of a facility policy, titled, Storage of Medications, revised ,[DATE], indicated that all drugs and biologicals would be stored in a safe, secure and orderly manner. Nursing staff was responsible for maintaining medication storage in a clean, safe and sanitary manner. Outdated drugs or biologicals would be destroyed. Antiseptics, disinfectants and germicides used in any aspect of resident care must be clearly labeled with directions for use. During an observation of a Treatment Nurse's (TN) treatment cart, on [DATE] at 3:45 PM, a bottle of [MEDICATION NAME] solution had an expiration date of ,[DATE]. During an interview with TN, on [DATE] at 3:50 PM, she confirmed that the bottle did not have a date written on it for when it was first opened and that the expiration date from the manufacturer had expired. TN stated that staff routinely refill the expired bottle with solution from a larger bottle. She discarded the expired bottle and stated they would change their process to avoid potential infection control issues. During an observation of a medication cart on Cherry Wing, on [DATE] at 11:35 AM, the blood sugar device testing strips and control solution bottles (used to determine if the device is working accurately) were not labeled with the date when they were opened. The strips and solutions were in containers that identified the manufacturer. During an interview with a Licensed Nurse (LN) C, on [DATE] at 11:40 AM, she confirmed the bottles of test strips and control solutions were not labeled with the date they were opened. She stated that staff would use the expiration dates stamped on the bottles by the manufacturer to stop using those bottles. LN C was not aware of any other time frame after they were opened where they should be considered expired. During an interview with the Assistant Director of Nurses (ADON), on [DATE] 11:49 AM, she stated that staff go by the expiration date for test strips and solutions. A review of the manufacturer's recommendation for the blood sugar device test strips and control solution, on [DATE] at 11:58 AM, indicated they were good for 3 months after opening. During an observation of a medication cart in front of Apple Wing, on [DATE] at 12:25 PM, the blood sugar device testing strips and control solution bottles were not labeled with the date when they were opened. During an interview with LN D and ADON, on [DATE] at 12:16 PM, they stated they do not label the test strips or control solutions with the date they are first opened. When advised of the manufacturer's recommendations to stop using them within three months of being opened, they stated all the bottles would need to be labeled for staff to identify when three months had passed. During an interview with the Pharmacy Consultant, on [DATE] at 8:36 AM, she stated all medications used in patient care should be labeled with the date they are opened, including glucometer control solutions (used to verify accuracy of blood sugar testing devices).
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Based on observation, interview, and document review, the facility failed to ensure it maintained an infection control and prevention program to provide a safe and sanitary environment when: 1. RNA (restorative nursing aide) 1 wore a wrist splint while providing care to residents; and 2. The portable vital signs machine had not been properly cleaned between residents. This had the potential to spread infection and communicable diseases between residents. Findings: 1. On 3/9/20 at 12:18 pm, RNA 1 was seen in the Assisted Dining Room wearing a wrist brace on her right hand, wrist, and forearm while feeding Resident 7. On 3/9/20 at 2:11 pm, RNA 1 was observed entering room [ROOM NUMBER] and closing the door. RNA 1 had used hand sanitizer to hands and brace before entering the room. During an interview on 3/10/20 at 9:58 am, RNA 1 said she works as an RNA not Certified Nursing Assistant. She said she can put her wrist splint in the washer and does so frequently. She also said she can take it off to wash her hands and it can be wiped down with alcohol. She said she does not change residents or shower them but only does RNA services like taking residents down to therapy room and helping them onto the bicycle. During an interview on 3/10/20 at 11:09 am, the infection control nurse (ICN) said portable equipment that is used for multiple residents, such as a vital sign machine, was cleaned between residents with bleach germicidal wipes. RNA 1's splint was discussed with ICN since RNA 1 was providing RNA services to more than one resident. ICN said she would expect RNA 1 to clean her splint between residents with a bleach germicidal wipe and would give her packets to keep in her pocket. 2. A review of a facility policy, titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 10/2018, indicated that reusable items were to be cleaned and disinfected between residents. Reusable resident care equipment would be decontaminated between residents according to manufacturer's recommendations. During observation of the Plum Wing hallway, on 3/11/20 at 9:20 AM, a vital signs machine plugged into the wall by the medication cart was observed to have yellow-brown fluid, partially dried, and splattered around the base of the machine. During an observation of medication administration on Plum Wing, on 3/11/20 at 10:09 AM, a Licensed Nurse (LN A) did not wipe down the vital signs machine before or after she used it on Resident 19 and placed it in the hallway. During an interview with LN A, on 3/11/20 at 10:15 AM, she stated that each resident has their own blood pressure cuff that did not need to be wiped down between uses. LN A stated the vital signs machine should be wiped down between patients if soiled or if it contacts a resident. She stated she did not need to wipe down the entire machine at that time. During an interview on 3/11/20 at 3:22 PM, the Infection Control Nurse said the portable vital sign machine should be cleaned with a bleach wipe between residents. During concurrent observation and interview with the Director of Nurses (DON), on 3/11/20 at 3:24 PM, she confirmed that the vital signs machine on the Plum Wing was visibly dirty around the base and should have been cleaned. DON stated that the nurses and aides were responsible to clean the devices between patients. During an interview with LN B, 03/12/20 10:05 AM, she sated the vital sings machine should be cleaned between patients. She would wipe down any parts that were touched. LN B stated that if visibly soiled, she would clean the machine down to its base.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide a safe and sanitary environment when: 1. Two sit-to-stand patient lifts were observed with visibly dirty foot sections. 2. The bathroom toilet shared by Residents 104 & 109, was visibly soiled with a brown substance. 3. A partially filled corrugated box of isolation gowns was stored on top of a clean linen cart, within approximately eight inches of the ceiling, in a clean utility room. These failures had the potential for cross-contamination of bacteria [MEDICAL CONDITION] between residents and to impede the function of the fire suspension sprinklers in the event of a fire. Findings: 1. Review of the facility's policy and procedure titled Cleaning and Disinfection of Resident-Care Items and Equipment, dated 10/1/18, indicated reusable items are cleaned and disinfected or sterilized between residents. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions. Manufacturer instructions provided by the facility for the sit-to-stand lifts, titled Disinfection, Cleaning and Maintenance, not dated, indicated Unless otherwise stated, before each and every use follow the cleaning, care and inspection procedures . The lift should be cleaned before it is used by another patient. ULINE Anti-Slip Tape application instructions, provided by the facility, not dated, indicated to keep tape surface clean. Use mild floor cleaners as directed. During an initial tour of the facility on 3/9/20 at 8:51 AM, a sit-to-stand patient lift was observed in the exit hallway on the Cherry wing with a visibly soiled foot section, with what looked like skin flakes. During an observation and concurrent interview on 3/09/20 at 9:34 AM with Certified Nursing Assistant (CNA) 1, a sit-to-stand lift was observed in the hallway, across from the nurse's station on the Cherry wing. CNA 1 confirmed the foot section of the lift was dirty. She stated the lifts were wiped down with bleach wipes between use and deep cleaned by housekeeping. CNA 1 stated the lift had been deep cleaned last week. She agreed the dirty foot section of the lift was an infection control issue and that she would deep clean the lift. CNA 1 stated it was difficult to clean the foot sections of the lifts, due to the anti-slip surface. During an observation and concurrent interview on 3/09/20 at 10:37 AM with Housekeeper (HSK) 1, a sit-to-stand lift was observed outside of room [ROOM NUMBER]. HSK 1 confirmed the foot section of the lift was dirty. She stated she was not sure if housekeeping cleaned the lifts and would need to check with her supervisor. During an observation and concurrent interview on 3/09/20 at 11:28 AM with Administrator (Admin), he confirmed the lift in the hallway outside of resident room [ROOM NUMBER] was dirty. During an interview on 3/12/20 at 8:20 AM with Assistant Director of Nursing (ADON) at the nurse's station on the Cherry wing, she stated staff were expected to clean the patient lifts between each use, using bleach wipes. ADON stated that maintenance staff were responsible for deep cleaning the lifts weekly and kept a cleaning log. Review of the facility's Resident Council Minutes, dated 4/9/19, indicated Hoyer & sit-to-stand wheels need to be cleaned clogged with excess hair. 2. Review of the facility's policy and procedure titled Cleaning and Disinfecting Residents' Rooms, dated 8/1/13, indicated environmental surfaces will be disinfected (or cleaned) on a regular basis .and when surfaces are visibly soiled. During an observation and concurrent interview on 3/09/20 at 10:33 AM, the bathroom in room [ROOM NUMBER], shared by Residents 104 and 109 was observed. The toilet and elevated toilet were not clean. A brown substance was smeared on the toilet seat and the toilet bowl was splattered with what appeared to be fecal material. There was no liner in trash can. HSK 1 confirmed the toilet and elevated seat were not clean. She stated the toilet had been used since she cleaned it earlier and confirmed the trash can should have had a liner. During an observation on 3/11/20 at 7:34 AM the bathroom in resident room [ROOM NUMBER] was observed. The sides of the toilet bowl were splattered with a brown substance that appeared to be fecal material. 3. Review of the facility's policy and procedure titled Receipt and Storage of Supplies and Equipment, dated 11/1/09, indicated .must be properly stored and labeled in accordance with current regulations. During an observation and concurrent interview on 3/09/20 at 9:37 AM the Cherry wing clean utility room was observed. A corrugated cardboard box with isolation gowns was observed on top of the clean linen cart, within approximately eight inches of the ceiling and a fire suppression sprinkler head. Certified Nursing Assistant (CNA) 2 confirmed the box was stored too close in proximity to the sprinkler head. She did not know the specific distance standard for storage of supplies in proximity to a sprinkler and stated she would need to ask someone. During an observation and concurrent interview on 3/09/20 at 9:47 AM, the Cherry wing clean utility room was observed. CNA 2 returned to the room and stated storage was supposed to be 18 from the ceiling. She removed the box of isolation gowns stored on top of the linen cart. Review of the National Fire Protection Agency (NFPA) Standard 13 for the installation of Sprinkler Systems 2019 indicated there needs to be a minimum clearance to storage of 18 inches between the top of storage and ceiling sprinkler.