

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Cottonwood Canyon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1391 Madison Avenue El Cajon, CA 92021	

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)
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471</p> <p>Based on observation, interview, and record review, the facility failed to:(1) document a change in the resident's condition's or status for one of three sampled residents (Resident 1) before starting Lorazepam (a medication that affects mood, emotions, and behaviors), and (2) ensure the licensed nurse (LN) correctly transcribed the physician's order for one of three sampled residents (Resident 1).</p> <p>As a result, Resident 1 had the potential to receive unnecessary medication without proper monitoring of the behavior.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), per the Admission Record.</p> <p>A review of Resident 1's medical record was conducted. Per the Order Summary Report, dated 4/16/24, Resident 1 was to receive Lorazepam 1 mg (milligram) two times a day [routinely].</p> <p>There was no change of condition or documentation in the medical record regarding Resident 1's behavioral symptoms or which approaches were attempted from the morning or afternoon shift of 4/16/24, prior to the practitioner ordering the Lorazepam.</p> <p>Per the Progress Notes, dated 4/16/24 at 5:30 P.M., Licensed Nurse (LN) 1 documented, Resident noted increase irritability and agitation, unable to redirected, no c/o [complain of] pain. Called placed to NP [Nurse Practitioner] with order: Ativan [Lorazepam] 1 mg bid (twice a day) for anxiety aeb [as evidence by irritability and agitation], noted and carried out. Resident aware. There was no documentation from the LN about how Resident 1 behaved and what interventions were implemented before starting the Lorazepam.</p> <p>Per the Medication Administration Record for April 2024, Resident 1 received Lorazepam twice a day from 4/20/24 through 4/29/24.</p> <p>On 4/30/24 at 2 P.M., Resident 1 was observed in bed with the head of the bed in the up position. Resident 1 stated he could not say what medications he was taking or recall what he had for lunch.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/30/23 at 4:30 P.M., an interview was conducted with LN 1. LN 1 stated LN 2 spoke to the NP and received the order for the Lorazepam. LN 1 further stated LN 2 had verbally told her about the new order for Resident 1's Lorazepam, and she (LN 1) transcribed the order for LN 2. LN 1 stated she expected LN 2 to document the event [change of condition], which included the description of the event in Resident 1 ' s medical record.</p> <p>On 5/22/23 at 3:14 P.M., a joint interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated LN 2 should have documented the change of condition in Resident 1's medical record, but there was no documentation of Resident 1's change in condition.</p> <p>On 5/29/23 at 3:54 P.M., a joint interview and record review was conducted. LN 2 stated it was the beginning of her shift, and she was asked to report to the physician that Resident 1 had been agitated all day. Resident 1 was trying to get out of bed, and they were worried he might fall. LN 2 further stated she received an order for Lorazepam 1 mg twice a day, as needed, for 14 days. LN 2 further stated she did not document the event and should have. LN 2 also said LN 1 transcribed the order for her, and it was incorrect.</p> <p>The NP was not available to interview.</p> <p>On 5/30/24 at 1:48 P.M., an interview was conducted with the ADON. The ADON stated she confirmed the order for the Lorazepam and it was as needed not routinely to be given and that LN 1 transcribed the Lorazepam order incorrectly.</p> <p>Per the facility's policy and procedure, dated 3/18, titled Psychotropic Medication Use, .Residents will only receive Psychotropic medications when necessary to treat a specific condition, diagnosed , and documented in the medical record .</p> <p>Per the facility's policy and procedure, dated titled Change in Resident's Condition or Status, .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .</p>		