STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056098	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Healthcare Center	625 Cottonwood Street Woodland, CA 95695

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 36681 Based on interview and record review, the facility failed to ensure services were provided to meet professional standards of quality for one of eight sampled residents (Resident 1) when Resident 1's physician was not informed of a medication that was not available and not administered as prescribed. This failure had the potential to put Resident 1's health and safety at risk. Findings: A review of the admission record indicated Resident 1 was admitted with multiple diagnoses including encephalopathy (brain function is impaired), and pneumonia (an infection/inflammation in the lungs) due to pseudomonas (group of bacteria commonly found in soil and water). A review of Resident 1's Order Summary Report dated 4/15/24 indicated, Dornase Alfa [medication that thins mucus] Inhalation Solution 2.5 MG [milligram, unit of measurement]/2.5ML [milliliter] .2.5 ml inhale orally two times a day for Pneumonia . A review of Resident 1's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for April 2024 indicated Dornase Alfa was scheduled for administration at 9 a.m. and 5 p.m. The MAR indicated there were nine times (9 x) the administration was marked as 9 for this medication. The code 9 indicated other/see progress notes. The medication code 9 was marked twice on 4/16, twice on 4/17, twice on 4/19, twice on 4/20, and one time on 4/23. A review of Resident 1's administration notes for Dornase Alfa indicated the following: -on 4/16/24 at 10:31 a.m., the note indicated, med [medication] not delivered this shift; -on 4/16/24 at 17:07 (5:07 p.m.), the note indicated the name, dose and indication of use for said medication. The note did not indicate if the medication was delivered or administered; -on 4/17/24 at 8:52 a.m., the note indicated, on order; -on 4/17/24 at 18:32 (6:32 p.m.), the note indicated, N/A [not available]; (continued on next page)

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 4/19/24 at 9:43 a.m., the note indicated, ordered; -on 4/19/24 at 1700 (5 p.m.), there was no administration note; -on 4/20/24 at 8:06 a.m., the note indicated, medication not available; -on 4/20/24 at 16:23 (4:23 p.m.), the note indicated, ordered to pharmacy; -on 4/20/24 at 23:06 (11:06 p.m.), the note indicated, unavailable; and, -on 4/23/24 at 19:44 (7:44 p.m.), the note indicated, LOA [leave of absence] sent to [name of hospital] for eye exam. There was no documented evidence in Resident 1's clinical records of physician notification of the medication not available for administration. In a concurrent interview and record review on 2/20/25 at 3:10 p.m., the Director of Nursing (DON) confirmed Resident 1's Dornase was not given nine times for April. The DON further confirmed there was no documented evidence the physician was informed of Resident 1's medication not administered as ordered. The DON stated her expectation was for licensed nurses to have notified the physician right then if medication was not available for Resident 1. A review of the facility's policy & procedure (P & P) revised December 2012 and titled, Administering Medications indicated, Medications shall be administered in a safe and timely manner, and as prescribed . Medications must be administered in accordance with the orders, including any required time frame. A review of the facility's P & P effective April 2008 and titled, MEDICATION ORDERS indicated, .The prescriber is contacted for direction when the medication will not be available.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681 Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for 1 of 8 sampled residents (Resident 3) when Resident 3's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was observed on the side of the bed, uncovered and undated when not in use. This failure increased the risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another). Findings: A review of the admission record indicated Resident 3 was initially admitted [DATE] with multiple diagnoses including congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently) and diagnosed early this year with acute respiratory failure with hypoxia (lungs unable to adequately exchange oxygen, leading to low level of oxygen in the blood). A review of Resident 3's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated 1/23/25 indicated resident was cognitively intact. A review of Resident 3's physician order dated 11/25/24 indicated, Oxygen via nasal cannula at 2 Liters/minute if oxygen saturation (used to assess effectiveness of oxygen therapy) less than 90% or for shortness of breath. A concurrent observation and interview was conducted on 2/20/25 at 10:44 a.m., inside Resident 3's room. The nasal cannula attached to an oxygen tubing was in between the side rail and the mattress. Resident 3 stated he was using oxygen once in a while and he had used oxygen 2 days ago. Resident 3 stated the nasal cannula should be in a clear bag. A concurrent observation and interview was conducted on 2/20/25 at 11:03 a.m. with the Licensed Nurse (LN) inside Resident 3's room. The LN confirmed Resident 3's nasal cannula was on the side of the bed. The LN stated the nasal cannula should be in a plastic bag to prevent contamination. The LN further stated the oxygen tubing was changed every week by night shift. The LN was unable to locate the date on the tubing. In an interview on 2/20/25 at 3 p.m., the Director of Nursing (DON) stated her expectation was for the nasal cannula to be dated and placed in a plastic bag when not in use. The DON further stated this was a potential for infections. A review of the facility's policy & procedure effective 11/15/2023 and titled, Respiratory Therapy - Prevention of Infection indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment .among residents and staff .Change the oxygen cannulae and tubing every seven (7) days, or as needed .Keep the oxygen cannulae and tubing used PRN [as needed] in a plastic bag when not in use.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36681 Based on observation, interview, and record review, the facility failed to ensure a call light (a device used by a resident to signal the need for help) was accessible for 1 of 8 sampled residents (Resident 2) when Resident 2 was not physically able to use the call light provided when it was out of reach. This failure had the potential to result in unmet resident needs and delayed staff response. Findings: A review of the admission record indicated Resident 2 was admitted [DATE] with multiple diagnoses including encounter for orthopedic aftercare following surgical amputation (a procedure to remove a body part) and acquired absence of left foot (loss due to surgery). A review of Resident 2's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 9 out of 15 indicated Resident 2 had moderate cognitive impairment. Resident 2's functional abilities dated 1/7/25 indicated he required both substantial/maximal assistance (staff does more than half of the effort for mobility needs) and partial/moderate assistance (staff provides less than half of the effort for mobility needs). A review of Resident 2's care plan dated 12/25/24 indicated, Self care deficit as evidenced by requiring assistance or is dependent in lower body dressing, oral hygiene, personal hygiene. putting on/taking off footwear, shower/bathe self, toileting hygiene, and upper body dressing. During an observation on 2/20/25 at 9:43 a.m., Resident 2 was calling the attention of State surveyor by pointing with his left index finger. In a follow-up observation and interview on 2/20/25 at 9:46 a.m., Resident 2 was lying in bed and his call button was on the floor underneath his bed. Resident 2 stated when he needs help he press the call button. Resident 2 further stated, it's around here, someplace and he had been looking for it for 2-3 days. A concurrent observation and interview was conducted on 2/20/25 at 9:51 a.m. inside Resident 2's room with the Director of Nursing (DON). The DON confirmed Resident 2's call button was on the floor. The DON stated the call button should not be on the floor. An interview was conducted on 2/20/25 at 9:53 a.m. with the Certified Nursing Assistant (CNA) inside Resident 2's room. The CNA stated she normally clips the call button in the blanket. The CNA further stated Resident 2 was constantly moving and she repositioned resident an hour ago. In a follow-up interview on 2/20/25 at 3:02 p.m., the DON stated her expectation was for call lights to be placed within reach at all times when resident is in the room. The DON confirmed Resident 2 will not be able to reach the call light when it was on the floor. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure revised 12/2023 and titled, CALL LIGHT ANSWERING indicated, It is the policy of this facility to provide the resident a means of communication with nursing staff . Place the call device within resident's reach before leaving the room .The nursing staff will check the placement of the call light during care.