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	07/30/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review the facility failed to ensure residents' rights to personal privacy and confidentiality of his or her personal medical information, when meal tray tickets were found thrown into the general trash. This had the potential to compromise resident privacy and confidentiality for the 95 residents residing in the facility.During a concurrent observation and interview on 7/27/25, at 9:13 a.m. , with the Dietary Aide (DA) in the kitchen, DA was observed throwing away residents' meal tickets into a garbage can. DA stated meal tickets that are left on meal trays are thrown into the kitchen garbage can and the garbage can is then later emptied into the outside garbage bin. DA confirmed the meal tickets contained resident's names and diet information and that anyone can access them after the meal tickets are dumped into the outside garbage bins. During an interview on 7/27/25, at 10:23 a.m., with the Dietary Supervisor (DS), the DS stated the expectation was for staff to remove meal tickets from the meal trays and collect them in the DS's office for the DS to later shred. The DS confirmed the meal tickets contained resident's names and diet orders, and if they are leaked or dumped outside, the personal information will be exposed to the public. During a review of the facility's document titled, Resident [NAME] of Rights, undated, indicated, Patients shall have the right:.confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure two out of 25 sampled residents (Resident 110 and Resident 92) received appropriate pain management services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's order when Resident 110 and Resident 92 pain medication orders were not consistently followed.This failure had the potential for Resident 110 and Resident 92 to develop medication dependence (the inability of the individual to function normally in the absence of the drug), overdose, not achieve pain relief, and not attain their highest practicable well-being. Findings:1a. A review of Resident 110's clinical record indicated Resident 110 was admitted July of 2025 and had diagnoses that included fracture (break in continuity of a bone) of left femur (thigh bone) and muscle weakness. A review of Resident 110's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 7/20/25, indicated Resident 110 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 110 had an intact cognition (mental process of acquiring knowledge and understanding).During an interview on 7/28/25 at 3:03 p.m. with Resident 110, in Resident 110's room, Resident 110 stated he has been experiencing pain and has been taking pain medications for it.A review of Resident 110's active physician's order, dated 7/16/25, indicated, Norco Tablet [a medication for pain which contains a combination of hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever] 5-325 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 4 hours as needed for Moderate pain 4-6/10 [numeric pain scale from 1 to 10; 1-3 is mild pain, 4-6 is moderate pain, 7-10 is severe pain] .A review of Resident 110's active physician's order, dated 7/16/25, indicated, Norco Tablet 5-325 MG . Give 2 tablet by mouth every 4 hours as needed for Severe pain 7-10/10 .A review of Resident 110's Care Plan Report, dated 7/22/25, indicated, Alteration in functional mobility and presence of pain related to .Fracture .Administer prescribed pain medication.A review of Resident 110's medication administration records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of July 2025 indicated Resident 110 received 1 tablet of Norco which was indicated for moderate pain on the following occasion:7/18/25 at 11:20 a.m.- pain level was 8 (severe pain)A review of Resident 110's MAR for the month of July 2025 indicated Resident 110 received 2 tablets of Norco which was indicated for severe pain on the following occasion:7/29/25 at 2:37 a.m.- pain level was 6 (moderate pain)During a concurrent interview and record review on 7/29/25 at 1:04 p.m. with Licensed Nurse (LN) 3, Resident 110's clinical records were reviewed. LN 3 confirmed that Resident 110's pain medication orders were not consistently followed. LN 3 stated that nurses should follow the physician's order when administering pain medications.1b. A review of Resident 92's clinical record indicated Resident 92 was admitted June of 2023 and had diagnoses that included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), diabetic polyneuropathy (a nerve damage condition resulting from high sugar levels in the blood often causing pain, numbness, and tingling), and muscle weakness. A review of Resident 92's MDS Cognitive Patterns, dated 5/19/25, indicated Resident 92 had a BIMS score of 15 out of 15 which indicated Resident 92 had an intact cognition. A review of Resident 68's MDS Health Conditions indicated Resident 92 received scheduled and as needed pain medications and non-medication intervention for pain. During an interview on 7/29/25 at 3:03 p.m. with Resident 92, in Resident 92's room, Resident 92 stated she has been taking pain medications for her pain.A review of Resident 92's active physician's order, dated 12/30/24, indicated, Norco Oral Tablet 5-325 MG . Give 1 tablet by mouth every 8 hours as needed for moderate to severe pain 4-10/10 .A review of Resident 92's Care Plan Report, dated 6/8/23, indicated, Alteration in comfort due to pain related to: .Chronic Physical Disability, Diabetic Neuropathy .Administer prescribed pain medicationA review of Resident 92's MAR for the month of June and July 2025 indicated Resident 92 received Norco which was indicated for moderate to severe pain on the following occasions:6/15/25 at 2:41 a.m.- pain level was 0 (No pain)7/26/25 at 7:18 p.m.- pain level was 0 (No pain)During a concurrent interview and record review on 7/29/25 at 1:04 p.m. with LN 3, Resident 92's clinical records were reviewed. LN 3 confirmed that Resident 92's pain medication order was not consistently followed. LN 3 stated that nurses should always follow the physician's order when administering pain medications.During an interview on 7/29/25 at 3:20 p.m. with the Director of Staff Development (DSD), the DSD stated that nurses should always follow the physician's parameters when administering pain medications to resident. The DSD also stated that it would be a risk for over-medication if a resident was given too strong medication. The DSD further stated that if a resident was

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to ensure safe and effective pharmaceutical services for two out of 25 sampled residents (Resident 110 and Resident 92) when Resident 110 and Resident 92's controlled drug (drug with potential for abuse) use and removal signed out from the Controlled Drug Record (CDR- a paper log of controlled drug removal for administration to resident) was not documented in their Medication Administration Record (MAR-a legal document that list administered drugs). This failed practice may contribute to unsafe medication use and handling, and risk of controlled drug diversion.Findings:1a. A review of Resident 110's clinical record indicated Resident 110 was admitted July of 2025 and had diagnoses that included fracture (break in continuity of a bone) of left femur (thigh bone) and muscle weakness. A review of Resident 110's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 7/20/25, indicated Resident 110 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 110 had an intact cognition (mental process of acquiring knowledge and understanding).A review of Resident 110's active physician's order, dated 7/16/25, indicated, Norco Tablet [a medication for pain which contains a combination of hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever] 5-325 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 4 hours as needed for Moderate pain 4-6/10 [numeric pain scale from 1 to 10; 1-3 is mild pain, 4-6 is moderate pain, 7-10 is severe pain] .A review of Resident 110's active physician's order, dated 7/16/25, indicated, Norco Tablet 5-325 MG . Give 2 tablet by mouth every 4 hours as needed for Severe pain 7-10/10 .A random audit of Resident 110's MAR and the CDR for Norco, for July 2025, indicated nursing staff did not document Norco administration on the MAR when signed out from CDR as follows: 2 tablets on 7/27/25 at 1 p.m., 2 tablets on 7/27/25 at 5 p.m., and 2 tablets on 7/27/25 at 9:04 p.m.During a concurrent interview and record review on 7/29/25 at 1:04 p.m. with Licensed Nurse (LN) 3, Resident 110's CDR and MAR were reviewed. LN 3 confirmed the finding of Norco being signed out of the CDR but was not accurately documented on the MAR on three occasions. LN 3 stated that Norco administration should be both signed out in the CDR and signed in the MAR for better records. 1b. A review of Resident 92's clinical record indicated Resident 92 was admitted June of 2023 and had diagnoses that included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), diabetic polyneuropathy (a nerve damage condition resulting from high sugar levels in the blood often causing pain, numbness, and tingling), and muscle weakness. A review of Resident 92's MDS Cognitive Patterns, dated 5/19/25, indicated Resident 92 had a BIMS score of 15 out of 15 which indicated Resident 92 had an intact cognition.A review of Resident 92's active physician's order, dated 12/30/24, indicated, Norco Oral Tablet 5-325 MG . Give 1 tablet by mouth every 8 hours as needed for moderate to severe pain 4-10/10 .A random audit of Resident 92's MAR and the CDR for Norco, for July 2025, indicated nursing staff did not document Norco administration on the MAR when signed out from CDR as follows: 1 tablet on 7/16/25 at 12:30 p.m., and 1 tablet on 7/16/25 at 6 a.m.During a concurrent interview and record review on 7/29/25 at 1:04 p.m. with LN 3, Resident 92's CDR and MAR were reviewed. LN 3 confirmed the finding of Norco being signed out of the CDR but was not accurately documented on the MAR on two occasions. LN 3 stated that the Norco administration should have been signed on both CDR and MAR. During an interview on 7/29/25 at 3:20 p.m. with the Director of Staff Development (DSD), the DSD stated that nurses should always sign off the CDR and MAR when administering controlled medications. The DSD further stated there would be a risk for medication error or controlled drug diversion (unlawful channeling of regulated pharmaceuticals from legal sources to the illicit marketplace) if the CDR and MAR are not both signed.During an interview on 7/30/25 at 10:08 a.m. with the Director of Nursing (DON), the DON stated she would expect the nurse to sign both the CDR and MAR when administering controlled medications. The DON further stated that the process of administering controlled drug should be placing the narcotic medication in the cup, then signing the CDR, then administering the medication, and lastly signing the MAR.A review of the facility's policy and procedure (P&P) titled, Administering Pain Medications, revised 10/2022, indicated, Steps in the Procedure .6. Administer pain medications as ordered .Document the following in the resident's medical record: 1. Results of the pain assessment; 2. Medication; 3. Dose .Report other information in accordance with facility policy and professional standards of practice.A review of the facility's P&P titled, Administering Oral Medications, revised 10/2010, indicated, Steps in the Procedure .9. Prepare the correct dose of medication: .b. For narcotics, Check the narcotic record for the previous drug count and compare

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to ensure safe medication administration practices when the facility's medication error rate was more than 5% (percentage- number or ratio that expressed as a fraction of 100) for a resident census of 95. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of five errors out of 34 opportunities which resulted in a facility wide medication error rate of 14. 71% in four out of 11 residents (Resident 34, 40, 32, and 27) observed for medication administration.These failures had the potential for unsafe and ineffective medication use of Resident 34, 40, 32, and 27 and had the potential to negatively affect the residents' medical conditions.Findings:1. During a medication administration observation which started on 7/27/25 at 10:01 a.m. with Licensed Nurse (LN) 2, LN 2 administered a total of three pills to Resident 34 which included 1 tablet of baclofen (a medication used to treat muscle spasms, cramping, and tightness) 5 mg (milligrams- unit of measurement) and 1 capsule of gabapentin (a medication used to treat nerve pain and muscle spasm) 300 mg.A review of Resident 34's active physician's order, dated 4/9/25, indicated, Baclofen Oral Tablet 5 MG (Baclofen) Give 1 tablet by mouth three times a day for Muscle Spasticity.A review of Resident 34's active physician's order, dated 4/9/25, indicated, Gabapentin Oral Capsule 300 MG (Gabapentin) Give 1 capsule by mouth two times a day for Neuropathy [nerve pain].A review of Resident 34's medication administration records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of July 2025 indicated Resident 34's morning dose of baclofen and gabapentin were both scheduled at 8 a.m.During a concurrent interview and medication order review on 7/27/25 at 1:36 p.m. with LN 2, LN 2 acknowledged the observed medication administration of baclofen and gabapentin to Resident 34 which were two hours after the scheduled time. LN 2 stated she was aware that the medications aware were administered late. LN 2 also stated nurses are supposed to administer the medications an hour before or after the scheduled time. LN 2 further stated there was a risk for a delayed effect of the medications when it was administered late to Resident 34.2. During a medication administration observation which started on 7/28/25 at 9:47 a.m. with LN 4, LN 4 administered a total of six pills to Resident 40 which included 1 tablet of apixaban (a medication used to treat and prevent blood clots) 5 mg.A review of Resident 40's active physician's order, dated 5/8/25, indicated, Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day related to OTHER PULMONARY EMBOLISM [blockage in one of the arteries in your lungs usually caused by a blood clot] .A review of Resident 40's MAR for the month of July 2025 indicated Resident 40's morning dose of apixaban was scheduled at 8 a.m.During a concurrent interview and medication order review on 7/29/25 at 9:51 a.m. with LN 4, LN 4 acknowledged the observed medication administration of apixaban to Resident 40 which was almost two hours after the scheduled time. LN 4 stated she was running late on administering the medications. LN 4 further stated Resident 40 would not be able to maintain the therapeutic level [the amount of the drug in the body that is considered to be effective in treating a condition] of the medication in the body if the medication was administered late.During an interview on 7/30/25 at 9:10 a.m. with the Consultant Pharmacist (CP), the CP stated nurses should give attention and follow the scheduled time of medication administration. The CP also stated nurses have a 1-hour window- before or after the scheduled time, to administer the medication and 2 hours was not acceptable.During an interview on 7/30/25 at 10:08 a.m. with the Director of Nursing (DON), the DON stated that scheduled medications should be administered either 1 hour before or after the scheduled time.Requested the facility's medication administration policies and procedures (P&P) discussing the timing of administering medications but none was provided.3. During a medication administration observation which started on 7/27/25 at 12:01 p. m. with LN 5, Resident 32 had a blood sugar reading of 166 milligrams/deciliter (md/dl- unit of measurement) and LN 5 administered 2 units (unit of insulin measurement) of insulin lispro (a fast-acting type of insulin used to manage high blood sugar) to Resident 32.A review of Resident 32's physician's order, dated 7/22/25, indicated, Insulin Lispro Injection Solution 100 UNIT/ML [milliliters- unit of measurement] (Insulin Lispro) Inject as per sliding scale [a method of managing blood sugar levels where insulin doses are adjusted based on current blood sugar reading]: .151 - 200 = 2 UNITS .subcutaneously [under the skin] before meals related to TYPE 2 DIABETESMELLITUS [a chronic condition causing too much sugar in the blood] .During an interview on 7/27/25 at 12:35 p.m. with Resident 32, Resident 32 stated he has not eaten yet and was still waiting for his lunch meal.During a concurrent observation and interview on 7/27/25 at 1:12 p.m. with

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure two of 25 sampled residents (Resident 32 and Resident 27) was free from significant medication error when Resident 32 and Resident 27 did not receive their prescribed insulin (medication used to manage blood sugar level) in accordance with the physician's order and standards of practice.This failure has the potential to result in Resident 32 and Resident 27 experiencing hypoglycemia (too low blood sugar level) and other unnecessary insulin side effects which could negatively affect the resident's health.Findings:1. A review of Resident 32's clinical record indicated Resident 32 was admitted July of 2025 and had diagnoses that included diabetes mellitus (a chronic condition causing too much sugar in the blood) and muscle weakness.A review of Resident 32's physician's order, dated 7/21/25, indicated, Resident does not have the capacity to understand and sign admission agreement, to participate in plan of care, and to make health care decisions d/t [due to] Diagnosis of: Altered mental status .A review of Resident 32's physician's order, dated 7/22/25, indicated, Insulin Lispro [a fast-acting type of insulin used to manage high blood sugar] Injection Solution 100 UNIT/ML [unit/milliliters- unit of measurement] .Inject as per sliding scale [a method of managing blood sugar levels where insulin doses are adjusted based on current blood sugar reading]: .151 - 200 = 2 UNITS [unit of insulin measurement] .subcutaneously [under the skin] before meals related to TYPE 2 DIABETES MELLITUS [a chronic condition causing too much sugar in the blood] .During a medication administration observation which started on 7/27/25 at 12:01 p.m. with LN 5, Resident 32 had a blood sugar reading of 166 milligrams/deciliter (md/dl- unit of measurement) and LN 5 administered 2 units of insulin lispro to Resident 32.During a concurrent observation and interview on 7/27/25 at 1:12 p.m. with Certified Nurse Assistant (CNA) 2, in Resident 32's room, CNA 2 was observed delivering Resident 32 his lunch meal. CNA 2 confirmed that observation and stated Resident 32 needs total assistance with his meal so she would need to assist Resident 32 with his lunch meal after she delivers all the lunch meals to other residents.During a concurrent observation and interview on 7/27/25 at 1:21 p.m. with CNA 2, in Resident 32's room, CNA 2 started to assist Resident 32 with his lunch meal. CNA 2 confirmed the observation.During an interview on 7/27/25 at 2:59 p.m. with LN 5, LN 5 confirmed that Resident 32's insulin lispro was administered too early. LN 5 stated that Resident 32's insulin lispro should have been administered before meals as per the doctor's order. LN 5 stated he was not sure why the lunch meal was late for today2. A review of Resident 27's clinical record indicated Resident 27 was admitted June of 2024 and had diagnoses that included diabetes mellitus, need for assistance with personal care, and muscle weakness.A review of Resident 27's physician's order, dated 6/20/24, indicated, Resident has the capacity to understand and sign admission agreement, to participate in plan of care, and to make health care decisions. A review of Resident 27's physician's order, dated 3/4/25, indicated, Insulin Lispro Injection Solution 100 UNIT/ML . Inject 6 unit subcutaneously before meals related to TYPE 2 DIABETES MELLITUS .A review of Resident 27's physician's order, dated 3/4/25, indicated, Insulin Lispro Injection Solution 100 UNIT/ML . Inject as per sliding scale: .151 - 200 = 3 units . subcutaneously before meals related to TYPE 2 DIABETES MELLITUS .During a medication administration observation which started on 7/27/25 at 12:29 p.m. with LN 2, Resident 27 had a blood sugar reading of 167 mg/dl and LN 2 administered a total of 9 units of insulin lispro to Resident 27.During an interview on 7/27/25 at 1:09 p.m. with Resident 27, Resident 27 stated he has not eaten his lunch meal yet.During a concurrent observation and interview on 7/27/25 at 1:21 p.m. with CNA 3, in Resident 27's room, CNA 3 was observed delivering Resident 27's lunch meal. CNA 3 confirmed that observation.During an interview on 7/27/25 at 1:37 p.m. with LN 2, LN 2 confirmed that Resident 27's insulin lispro was administered too early. LN 2 stated that Resident 27's insulin lispro should have been administered before meals as per the doctor's order to prevent hypoglycemia.During an interview on 7/30/25 at 9:10 a.m. with the CP, the CP stated insulin lispro is a fast-acting insulin and the general rule is that it should be given 15 minutes before meals.During an interview on 7/30/25 at 10:08 a.m. with the DON, the DON stated she would expect nurses to follow the standard of practice in administering insulin lispro which is 15 minutes before meals.A review of the facility's P&P titled, Insulin Administration, revised 9/2014, indicated, 3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order .General Guidelines .Onset of action - how quickly the insulin reaches the bloodstream and begins to lower blood glucose .Type .Rapid-acting [fast-acting] .Onset .10-15 min [minutes] .A review of an online article from Drugs.com titled, How fast does insulin

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored in accordance with the facility's policies and procedures (P&P), and accepted professional principles for a census of 95 when:1. A total of 5 loose pills were found in medication cart 4;2. An opened Polymyxin B-tmp eye drop (an eye drop used to treat bacterial eye infections), an opened Incruse Ellipta inhaler (a medication used to treat airflow obstruction in adults), and an opened Symbicort inhaler (a medication used to treat breathing difficulty) had no opened date label; and,3. A used Latanoprost eye drop (a prescription medication used to manage elevated eye pressure) was not discarded after 28 days.These failures had the potential for diversion of the loose medications, and for residents to receive medication that was expired or with unsafe or reduced potency.1. During a concurrent observation and interview which started on 7/27/25 at 3:13 p.m. with Licensed Nurse (LN) 6, of medication cart 4, a total of five loose pills were found inside the second and third-right drawer of the medication cart. LN 6 confirmed the observation. LN 6 stated there should not be loose pills inside a medication cart because staff would not know what medication those are anymore.During an interview on 7/30/25 at 9:10 a.m. with the Consultant Pharmacist (CP), the CP stated it's not acceptable to have any loose pills inside the medication carts because loose tablets should not be reused, and the medication cart should be kept clean.During an interview on 7/30/25 at 10:08 a.m. with the Director of Nursing (DON), the DON stated that loose pills inside the medication carts should not be allowed because of safety concerns for residents. A review of the facility's P&P titled, Administering Oral Medications, revised 10/2010, indicated, Steps in the Procedure .5. Select the drug from the unit dose drawer or stock supply. 6. Check the label on the medication and confirm the medication name and dose with the MAR [medication administration record]. 7. Check the expiration date on the medication. Return any expired medications to the pharmacy .2. During a concurrent observation and interview which started on 7/27/25 at 3:13 p.m. with LN 6, of medication cart 4, an opened Polymyxin B-tmp eye drop, an opened Incruse Ellipta inhaler, and an opened Symbicort inhaler were found with no opened date label. LN 6 confirmed the observation. LN 6 stated the eye drop and inhalers should have been labeled with the opened date so staff would know when to discard it.During an interview on 7/30/25 at 9:10 a.m. with the CP, the CP stated staff should label the eye drop and inhalers with the medications' open date, so they know when to discard it. The CP further stated there would be a risk for the medications to be administered after the discard date if it was not labelled with the opened date.During an interview on 7/30/25 at 10:08 a.m. with the DON, the DON stated she would expect opened eye drops and opened inhalers should be labelled with the open date so nurses would know when to dispose the medication properly.A review of the Polymyxin B-tmp eye drop label indicated, .DISCARD UNUSED PORTION AFTER 28 DAYS ., and the area dedicated for the date it was opened was left blank.A review of the facility document titled. Guide for Special Handling of Medications, dated 1/2024, indicated, .Incruse Ellipta .Date when foil tray is opened and discard after 6 weeks or when the counter reads 0, whichever comes first. A review of the facility document titled. Guide for Special Handling of Medications, dated 1/2024, indicated, .Symbicort Inhalation .Date after opening the foil pouch and discard after 3 months or when the dose counter reads 0, whichever comes first. 3. During a concurrent observation and interview which started on 7/27/25 at 3:13 p.m. with LN 6, of medication cart 4, a used Latanoprost eye drop with an opened date of 6/25/25 was found stored in the medication cart. LN 6 confirmed the observation. LN 6 stated the eye drop should have been discarded. LN 6 further stated an eye drop passed the discard date would be less effective and would not achieve the full effect of the medication. During an interview on 7/30/25 at 9:10 a.m. with the CP, the CP stated the used eye drop with an opened date of 6/25/25 should have been discarded after 28 days.During an interview on 7/30/25 at 10:08 a.m. with the DON, the DON stated she would expect that used eye drops passed 28 days should have been discarded. The DON further stated the resident may have gotten expired medication and that was not the facility's protocol.A review of the Latanoprost eye drop label indicated, .DATE OPENED: 6/25/25 .DISCARD UNUSED PORTION AFTER 28 DAYS .

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	07/30/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observation, interview, and record review, the facility failed to provide safe, sanitary care for a census of 95 when:Resident 13's indwelling catheter (tube placed into the bladder to drain urine) drainage bag was uncovered and on the floor;Resident 19's nebulizer tubing was not changed every seven days; and Facility staff did not wear the required PPE when entering an isolation room. These failures increased the risk of infection. 1. Resident 13 was admitted to the facility early 2025 with diagnosis which included sepsis (life threatening complication of an infection), urinary calculus (mineral deposits that form in the urinary tract), and kidney infections. During a review of Resident 13's Order Summary Report [OSR], order date 7/25/25, the OSR indicated, Indwelling catheter .to bedside drainage .Left flank [side of a person's body between the ribs and hips] nephrostomy tube [thin tube placed into the kidney to drain urine] .). During a concurrent observation and interview on 7/27/25 at 10:39 a.m. in Resident 13's room with Licensed Nurse (LN1) of Resident 13. Resident 13 had an uncovered nephrostomy bag which hung from the bedrail, and an uncovered urinary catheter bag which was lying on the floor. LN1 confirmed the findings and stated catheters should not be touching the ground for infection control reasons and should be stored in a bag. During an interview on 7/29/25 at 3:45 p.m. with the Infection Preventionist (IP), the IP was shown a picture of Resident 13's catheter bag uncovered and touching the floor. The IP stated the catheter bag should not touch the floor because of cross contamination. During a review of the facility's policy and procedure (P&P) titled, URINARY CATHETER CARE, dated 3/21, the P&P indicated, The purpose of this procedure is to prevent catheter-associated urinary tract infections . be sure the catheter tubing and drainage bag are kept off the floor . 2. A review of Resident 19's clinical record indicated Resident 19 was admitted April of 2024 and had diagnoses that included dementia (memory loss that interferes with daily functions), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and congestive heart failure (a serious condition in which the heart does not pump blood as efficiently as it should). A review of Resident 19's Minimum Data Set (MDS– a federally mandated resident assessment tool) Cognitive Patterns, dated 6/11/25, indicated Resident 19 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 13 out of 15 which indicated Resident 19 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 19's active physician's order, dated 1/3/25, indicated, Ipratropium-Albuterol Solution [a combination medication used to treat difficulty breathing, chest tightness, and coughing] .inhale orally every 6 hours as needed for cough. During an observation on 7/27/25 at 8:37 a.m. in Resident 19's room, Resident 19's nebulizer face mask tubing was labelled 06/04. (continued on next page)

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	056098	A. Building B. Wing	07/30/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/27/25 at 10:28 a.m. with LN 2, in Resident 19's room, LN 2 confirmed that Resident 19's nebulizer face mask tubing was labelled 6/4 which was already more than 7 weeks. LN 2 stated nebulizer face mask tubing was supposed to be changed weekly for infection control. During an interview on 7/29/25 at 3:11 p.m. with the IP, the IP stated that the nebulizer face mask should be changed on a weekly basis to prevent respiratory infection. During an interview on 7/30/25 at 10:08 a.m. with the Director of Nursing (DON), the DON stated she would expect staff to change nebulizer face mask tubing weekly and as needed for infection control. A review of the facility's P&P titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised 10/2010, indicated, 30. Change equipment and tubing every seven days, or according to facility protocol. 3. During a concurrent observation and interview on 7/27/25 at 8:49 a.m., with LN 3, in front of room [ROOM NUMBER], room [ROOM NUMBER] has a signage posted on the wall on the left side of the door which indicated, STOP .CONTACT PRECAUTIONS .EVERYONE MUST: .PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit .Put on gown before room entry. Discard gown before room exit . LN 3 confirmed the observation. LN 3 stated the resident in room [ROOM NUMBER] Bed A was on a contact isolation precaution because of VRE infection (Vancomycin-Resistant Enterococci infection- an infection resistant to some powerful antibiotics) on the wound and possible C-Diff infection (infection with bacteria that can cause severe diarrhea and inflammation of the bowel). During a concurrent observation and interview on 7/27/25 at 9:15 a.m. with Activities Staff (AS) 1, AS 1 went inside room [ROOM NUMBER] not wearing any gloves or gown. AS 1 confirmed the observation. AS 1 stated he was aware about the signage posted in front of the room but was told they only need to wear gloves and gown when going in contact with the Resident in bed A. During a concurrent observation and interview on 7/27/25 at 9:57 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 went inside room [ROOM NUMBER] not wearing any gloves or gown. CNA 1 confirmed the observation. CNA 1 stated she knows that a resident in the room was on contact isolation precaution. CNA 1 further stated they were told that they only need to wear gloves and gown when going in contact with the Resident in bed A. During an interview on 7/29/25 at 3:11 p.m. with the IP, the IP confirmed that the resident in room [ROOM NUMBER] Bed A was on a contact isolation precaution because of VRE infection on the wound and possible C-Diff infection. The IP stated that their practice in the facility was that staff would only wear the required PPE only when directly caring for the infected resident. A review of the facility's P&P titled, Isolation – Categories of Transmission-Based Precautions, revised 10/2018, indicated, Contact Precautions .4. Staff and visitors will wear gloves (clean, non-sterile) when entering the room .5. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of The Centers for Disease Control and Prevention (CDC- the national public health agency of the United States) online article titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, indicated, Contact Precautions are intended to prevent transmission of infectious agents, like MDROs, that are spread by direct or indirect contact with the resident or the resident's environment. Contact Precautions require the use of gown and gloves on every entry into a resident's room . (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html#:~:text=Contact%20Precautions%20require%20the%20use,and%20Conditions%20of%20the%20guideline.)