

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Cottonwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ a fully qualified nutrition professional who was employed full time (35 hours a week or more) to oversee the dietary department. This failure had the potential for unsafe food handling, and food borne illness in a highly susceptible population of 95 residents. Findings During the initial kitchen tour on 7/6/26 at 8:49 a.m., a kitchen staff member pointed out the Dietary Services Manager (DSM) as the person in charge of the dietary department. DSM stated he had worked in the position for the past two and a half years. When asked about his qualifications for the position, DSM stated he was in school to become a Certified Dietary Manager (CDM) and his classes would start next semester. DSM clarified he worked under the guidance of a CDM who was located at a sister facility. DSM further stated the facility did not have an onsite Registered Dietitian (RD) and a dietitian was contracted to provide remote resident nutrition care but was not involved in the department's oversite. A review of the facility's organizational chart indicated the department was overseen by the RD. Under the RD position was listed a CDM, who oversaw the DSM, the four cooks and the eight dietary aides. During an interview on 7/6/26 at 4 p.m. with the sister facility's CDM, CDM confirmed facility lacked an onsite RD to oversee the dietary department and she oversaw the DSM. CDM also confirmed she was not at the facility full-time and was onsite for a few hours (two to four hours) a day. A review of the facility's Key Personnel List, dated 7/8/26, indicated the list only included the name and contact information for the DSM. During a phone interview on 7/8/26 at 12:34 p.m. with the contract RD, RD confirmed she worked for another company and could not physically come to the facility due to her other job responsibilities. A review of the facility's Dietitian job description (Med-Pass, Inc., 2003), indicated, the primary purpose . is to plan, organize, develop and direct the overall operation of Food Services Department in accordance with current federal, state, and local standards, guidelines and regulations . to assure that quality nutritional services are provided on a daily basis and that the Food Services Department is maintained in a clean, safe, and sanitary manner . Assist in the recruitment, interviewing, and selection of food service personnel . Determine staffing requirements necessary to meet the department's needs and schedule a sufficient number of personnel for each shift . Make weekly inspections of all food service functions to assure that quality control measures are continually maintained. A review of the facility's Director of Food Services job description (Med-Pass, Inc., 2003), indicated, the primary purpose . is to assist the Dietitian in planning, organizing, developing and directing the overall operation of Food Services Department in accordance with current federal, state, and local standards, guidelines and regulations . to assure that quality nutritional services are provided on a daily basis and that the Food Services Department is maintained in a clean, safe, and sanitary manner . Be a graduate of an accredited course in dietetic training approved by the American Dietetic Association. The Centers for Medicare and Medicaid Services (CMS) established federal (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056098 If continuation sheet Page 1 of 7

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regulations for kitchen management in long-term care facilities which indicated a facility kitchen must employee a DSS full time (35 hours a week or greater). These regulations allowed states to implement their own specific regulatory frameworks. In California, long-term care facilities must employ a full-time Dietary Services Supervisor (DSS). A review of California's Health and Safety Code Section 1265.4 indicated DSS must be a graduate of a state-approved course providing at least 90 hours of classroom instruction in food services supervision prior to employment. It included seven pathways to becoming a dietary manager, all of which provide a certificate or degree to indicate that the graduate has achieved the skills and knowledge needed to manage a facility kitchen. The regulation also indicated DSS shall receive frequently scheduled consultation from a qualified dietitian.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions, when: Hair/facial hair was not properly secured; Bags used for bulk food items were not food grade; The red cutting board (used for meat) was found with a deep gouge; Food service items were stored wet; Counter and cart cleaning did not include a wash and rinse step prior to sanitizing; and The red bucket used for sanitizer was not tested correctly. These failures had the potential of leading to food poisoning for the 95 vulnerable residents eating facility prepared meals. Findings: 1. During the initial kitchen tour on 7/6/26 at 8:49 a.m., the Dietary Services Manager (DSS) was working in the dry storage area. DSS was observed with a beard that was not covered. During a return visit to the kitchen on 7/7/26 at 9:08 a.m., the shared Certified Dietary Manager (CDM) was in the dry storage/dietary office. CDM had a hair net on, but it was pulled back from the front hairline by 1-2 inches (a unit of measure) and loose hair was falling from the sides and back. During a return visit on 7/8/26 at 9:07 a.m. to the kitchen, DSS was preparing the lunch meal. No beard covering was observed. During a concurrent observation and interview on 7/8/26 at 1:31 p.m. with CDM, CDM's hair net was observed not covering the first inch of her hairline. CDM confirmed her hair net was not fully on, and DSS was not wearing a beard net. CDM stated hair nets were required in food services to keep hair out of food which could transfer bacteria to food. A review of the United States (US) Food and Drug Administration's (FDA) 2022 Food Code section 2-402 on Hair Restraints, indicated, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensil, and linens; and unwrapped single-service and single-use articles. 2. During a concurrent observation and interview during the initial kitchen tour on 7/6/26 at 9:14 a.m. with DSS, plastic bags were observed holding the bulk food stored in containers. DSS was unsure if the plastic bags were food-grade. DSS provided information on the bags on 7/6/26 at 2:10 p.m., which indicated the bags used were trash bags. The information on the Sysco liner rolls trash bags (40 inches x 48 inches) included the following statement: Culinary application is not applicable as this is a non-food item. According to the United States Department of Agriculture (www.fsis.usda.gov/oa/pubs/meatpack.htm), the use of plastic trash bags is not recommended for food storage or cooking because they are not food grade plastic and chemicals from them may leach into the food. 3. During a concurrent observation and interview during the initial kitchen tour on 7/6/26 at 9:25 a.m. with DSS, one out of six cutting boards appeared with deep gouges on the cutting surface. The red cutting board (used for beef products) was observed with an inch long gouge on the cutting surface. DSS confirmed the observation. A review of the US FDA's 2022 Food Code section 4-501.12 on Cutting Surfaces, indicated, Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic (disease causing) microorganisms (microbes) transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. 4. During a concurrent observation and interview during the initial kitchen tour on 7/6/26 at 9:49 a.m. with DSS, one out of two food processor bowls was observed wet inside when the top cover was removed. DSS confirmed that it was wet inside. During a concurrent observation and interview during the initial kitchen tour on 7/6/26 at 10:02 a.m. with DSS, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	three steam table pans (one large and two small) were observed stored and ready to use but were wet inside. DSS confirmed and stated staff were trained to fully dry items before putting them away.A review of the US FDA's 2022 Food Code section 4-901.11 on Equipment and Utensils, Air-Drying Required, indicated, After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried . before contact with food; and (B) May not be cloth dried . Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils.5. During a return visit to the kitchen on 7/6/26 at 9:52 a.m., Dietary Aide (DA) 1 was observed cleaning the tray carts. DA 1 proceeded to grab a cloth from the red sanitizer bucket and wipe down the carts. No cleaning or rinsing was observed prior to wiping with sanitizing solution.During a return visit to the kitchen on 7/7/26 at 9:24 a.m., the [NAME] (CK) was slicing the pre-cooked Roast Beef before placing it in the oven for lunch. Once finished, CK moved on to clean up the counter from the accumulated drippings and meat residue. CK grabbed a cloth from the red sanitizer bucket and wiped down the counter, before moving on to the next cooking task. No cleaning or rinsing steps were observed prior to wiping with sanitizer solution.During a return visit to the kitchen on 7/8/26 at 9:12 a.m., DA 2 was asked about the process for cleaning carts and counters. DA 2 stated he would clean carts or counters by wiping them down with a cloth from the red sanitizer bucket. No other steps were given.During an interview on 7/8/26 at 1:31 p.m. with CDM, CDM stated the expected process for cleaning carts and counters was staff should first clean with soap and water and then follow with the sanitizer. CDM further stated cleaning was needed to remove food debris to make sanitizing effective.A review of the facility's policy titled, Sanitization (Med-Pass, Inc. 2001), indicated, All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils . The policy further indicated, For fixed equipment or utensils that do not fit in the dishwashing machine, washing shall consist of the following steps: a. Equipment will be disassembled as necessary to allow access of the detergent . b. Removable components will be scraped to remove food particle accumulation and washed according to manual or dishwashing procedures.A review of the US FDA's 2022 Food Code section 4-603.15 on Equipment, Washing, Procedures for Alternative Manual Warewashing, indicated, Some pieces of equipment are fixed or too large to be cleaned in a sink. Nonetheless, cleaning of such equipment requires the application of cleaners for the removal of soil and rinsing for the removal of abrasive and cleaning chemicals, followed by sanitization.6. During a concurrent observation and interview during a return visit to the kitchen on 7/7/26 at 9:39 a.m. with CK and CDM, CK was asked to demonstrate the process for checking the sanitizer to determine if it was still effective. CK obtained the bottle of sanitizer testing strips and dropped a strip in the bucket and left in the solution for 15 seconds. When removed, the strip had changed to a lime green color that was not on the color chart for appropriate sanitation strength. CDM confirmed the correct strength had not been obtained. CK went on to refill the red bucket with new sanitizer. CDM showed CK the directions on the testing strip bottle which indicated leaving the strip in the solution for one to two seconds. During a concurrent observation and interview during a return visit to the kitchen on 7/8/26 at 9:12 a.m. with DA 2 and DSS, DA 2 demonstrated testing of the sanitizer in a red bucket in the cook's area. DA 2 removed a testing strip from the bottle and held it in the sanitizing solution for 10 seconds. When removed, the strip turned into a lime green color that was not on the chart. When prompted, DA 2 read the directions on the strip bottle and noted that he had left the test strip in solution too long. DSS confirmed the strip did not indicate effective sanitizing strength.A review of A Guide to Using Sanitizer Test Strips (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(https://www.cooksdirect.com/using-sanitizer-test-strips-in-foodservice) indicated in the section on the Importance of Proper Sanitization that Effective sanitization is crucial for preventing the spread of foodborne illnesses and maintaining a clean and healthy environment in your kitchen and beyond. By regularly checking sanitizer concentrations, you can be confident that your surfaces, utensils, and equipment are properly sanitized.Steps to Use Sanitizer Test Strips1. Dip and Retrieve: Dip the test strip into the sanitizing solution. Quickly retrieve the strip, ensuring it is fully wet.2. Wait for Reaction: Allow the test strip to react with the sanitizer for the specified time (usually a few seconds).3. Compare Colors: Compare the color of the test strip to the color chart provided by the manufacturer. Match the color as closely as possible to determine the concentration of the sanitizer.4. Adjust Concentration if Needed: If the concentration is below the recommended level, adjust the amount of sanitizer accordingly.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to follow the plan of care for one of 23 sampled residents (Resident 29), when a communication board/binder was not accessible for staff to communicate with Resident 29. This failure decreased the facility's potential to effectively communicate and meet Resident 29's needs. Findings: A review of Resident 29's admission Record, indicated she was admitted to the facility in June 2026 with multiple diagnoses including dependence with personal care and unsteady gait with history of repeated falls. During an observation on 7/6/26 at 12:20 p.m. in Resident 29's room during lunchtime, Certified Nurse Assistant (CNA) 3 was observed delivering the lunch tray and then exiting the room without responding to Resident 29's questions asked in Spanish. During an interview on 7/6/26 at 9:49 a.m. with Licensed Nurse (LN) 3, LN 3 stated Resident 29 communicates in Spanish. LN 3 further stated she did not use a communication board to interact with Resident 29, and instead she only used gestures and actions. During a concurrent observation and interview on 7/8/26 at 12:36 p.m. with the Speech Therapist (ST) in Resident 29's room, ST confirmed staff did not use a communication board/binder when communicating with Resident 29. ST stated she asked staff to use a communication board when interacting with Resident 29 as it would be beneficial during mealtimes and care provision. During a concurrent observation and interview on 7/8/26 at 1:30 p.m., with the Assistant Social Services Director (ASSD) and LN Supervisor (LNS), ASSD confirmed Resident 29 only speaks Spanish and no communication board/binder was available in her room. ASSD and LNS searched for the binder at the nurses' station, and both confirmed no communication board or binder was located at the station. During a concurrent interview and record review on 7/9/26 at 10 a.m. with the Assistant Director of Nursing (ADON), Resident 29's care plan dated 6/21/26 and speech therapy document dated 6/19/26, were reviewed. ADON stated Resident 29 should have been provided with a communication board/binder for staff use during care to ensure her needs were appropriately addressed. A review of the facility's policy titled, Translation and/or Interpretation of Facility Services, revised in 5/2017, indicated, This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. The coordinator of this facility's language access program is the Director of Social Services, or his/her designee.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure a physician order was followed for one of 23 sampled residents (Resident 29), when Resident 29's physician order for one-on-one feeding was not implemented. This failure increased Resident 29's potential for low meal consumption. Findings: A review of Resident 29's admission Record, indicated she was admitted to the facility in June 2026 with multiple diagnoses including cognitive communication deficit and dysphagia (difficulty in swallowing). A review of Resident 29's Order Summary Report (OSR), indicated a soft bite-sized texture diet order, dated 6/29/26, along with a directive for one-on-one feeding at every meal during each shift starting 6/20/26. During an observation on 7/6/26 at 12:20 p.m. in Resident 29's room, Certified Nurse Assistant (CNA) 3 was observed serving the lunch tray to Resident 29. CNA 3 left Resident 29 without assisting her with feeding. During concurrent observations and interviews on 7/6/26 at 12:35 p.m., 7/7/26 at 12:40 p.m., and 7/9/26 at 8 a.m. with CNA 4 and CNA 5 in Resident 29's room during mealtime, Resident 29 was observed staring at her tray on the table without eating. Both CNA 4 and CNA 5 stated Resident 29 eats independently and does not require help when eating. During a concurrent observation and interview on 7/9/26 at 8 a.m. with the Speech Therapist (ST), ST confirmed Resident 29 was not assisted while eating. ST stated Resident 29 required one-on-one feeding during mealtimes due to cognitive and swallowing concerns. During a concurrent interview and record review on 7/9/26 at 10 a.m. with the Assistant Director of Nursing (ADON), Resident 29's OSR dated July 2026, meal percentage log for July 2026, and speech therapy documents dated 6/19/26, 7/7/26, and 7/8/26, were reviewed. ADON confirmed Resident 29 consumed about 11 to 37 percent (a unit of measure) of each meal between 7/6/26 to 7/9/26. ADON stated Resident 29 should have received assistance during meals according to the ST recommendation. ADON further stated the physician orders should have been followed as prescribed to ensure residents maintain adequate nutrition and to prevent weight loss. A review of the facility's policy titled, Nutrition and Weight Management Policy, dated 10/2025, indicated, The facility provides care and services to each Resident to ensure the Resident maintains acceptable parameters of nutritional status. Develop and Implement approaches.		