STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review, the facility failed to honor resident rights for one out of three sampled residents (Resident 1) when Resident 1's caregiver (CG) requested a nurse to be present at the care conference meeting (a group of medical professionals that met to discuss resident care and care planning with the resident, family members, or caregivers), and nursing was not notified of the request. This failure had the potential for Resident 1 and Resident 1's representatives to not be allowed to participate in resident care planning. Findings: A review of the facility's policy and procedure titled, Care Planning- Interdisciplinary Team, revised 3/1/22, indicated, the Interdisciplinary Team (IDT, a group of medical professions that meet to discuss resident care and care planning) was responsible for .the development of resident care plans and nursing was included in the IDT. A review of the undated Admission Record, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of hypertensive heart disease (heart problems that were caused by high blood pressure) and diabetes. Resident 1 was her own responsible party (made own decisions about heath care). During an interview on 5/14/24 at 12:27 pm, CG stated, CG had a conversation with the facility's social worker (SW) and requested nursing to be present at Resident 1's care conference meeting due to concerns of diabetes and bathroom assistance. During a concurrent record review and interview, on 5/31/24 at 9:29 am, with SW, Resident 1's Care Conference Meeting note, dated 4/22/24 was reviewed. SW confirmed a request had been made for nursing to be present at Resident 1's care conference meeting. SW stated, the Care Conference Meeting note indicated, the IDT team members present included the SW, physical therapy, and the occupational therapist. SW stated, Resident 1 was medically stable, and didn't require nursing to be present, and the care conference meeting was focused on care received from physical therapy and occupational therapy. SW confirmed, nursing should have been included in the care conference and was not. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/31/24 at 10:26 am, Director of Nursing (DON) stated the SW had not informed DON there was a request made for nursing to be present at the care conference meeting and confirmed DON was not present at the care conference meeting that occurred on 4/22/24.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45315 Based on interview and record review, the facility failed to provided one out of three sampled residents (Resident 2) with food that was served in a safe manner when Resident 2 was served a chef's salad that contained moldy cherry tomatoes. This failure had the potential for spoiled food to be eaten and could cause illness. Findings: A review of the facility's policy and procedure titled, Food and Nutrition Services, revised 10/1/17, indicated, Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. A review of the undated Admissions Record, indicated, Resident 2 was admitted to the facility 5/3/24 with the diagnoses of depression (a sad mood) and atrial fibrillation (an irregular heartbeat that caused poor blood flow and had the potential to cause blood clots to form in the heart). Resident 2 was her own responsible party and made her own decisions. During an interview on 5/17/24 at 10:48 am, Resident 2 stated, she had been served moldy tomatoes. During an interview on 5/31/24 at 8:35 am, the facility's dietary manager in training/lead cook (DM) stated, Resident 2 had ordered a chef's salad and Resident 2 had sent back the chef's salad due to moldy cherry tomatoes. DM stated performing a visual inspection of the chef salad and confirmed, Resident 2 had been served a chef salad with moldy cherry tomatoes. During an interview on 5/31/24 at 11:38 am, Registered Dietician (RD) stated, RD was notified that Resident 2 had been served a chef salad with moldy cherry tomatoes and observed a photo of the moldy cherry tomatoes taken with Resident 2's cell phone. RD stated the expectancy was for staff to visually inspect food prior to serving it to the residents and stated, the chef salad should not have been served.

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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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review the facility failed to provide one out of three sampled residents (Resident 1) with outside services when a request was made for Resident 1 to be seen by her cardiologist (doctor that specialized in the heart) and a referral was not initiated. This had the potential for a decline in resident health status. Findings: A review of the facility's policy and procedure (P&P) titled, Referrals, revised 12/1/08, indicated Social Services or designee shall coordinate most resident referrals. The P&P indicated, Social Services or designee will document the referral in the resident's medical record. A review of the undated Admission Record, indicated, Resident 1 was admitted to the facility on [DATE] with the diagnoses of hypertensive heart disease (heart problems that were caused by high blood pressure) and diabetes. Resident 1 was her own responsible party (made own decisions about heath care). During an interview on 5/14/24 at 12:27 pm, Resident 1's care giver (CG) stated, during a care conference meeting (a group of medical professionals that met to discuss resident care and care planning with the resident, family members, or caregivers), the social worker (SW) had been informed that Resident 1 wanted to been seen by Resident 1's cardiologist. CG stated, Resident 1 had not been seen by the cardiologist and had concerns due to Resident 1's history of heart problems. During a concurrent interview and record review on 5/31/24 at 9:29 am, Resident 1's Care Conference Meeting note, dated 4/22/24 was reviewed with SW. SW stated, the Care Conference Meting note, indicated, the next step was to make a cardiology appointment for Resident 1. SW stated inability to find the documents that would be faxed to the cardiologist requesting an appointment for Resident 1 and confirmed there was no documentation in Resident 1's medical records that supported a referral had been made.