

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Copper Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45315</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe infection control practices were followed when staff did not properly wear a surgical mask (face covering) and a Certified Nurse Assistant (CNA) drank water while walking down a hallway that contained COVID-19 positive residents.</p> <p>This failure had the potential to spread COVID-19 to other residents, potentially leading to a decline in health status.</p> <p>Findings:</p> <p>A review of an undated document titled, Important Reminders, indicated, the Proper way to wear a mask, was for the mask to cover the nose, mouth, and chin. Important Reminders indicated, Personal food and drink was not allowed in hallways or at nurse ' s station. The image of a properly worn mask, that was included in the Important Reminders, included a person wearing a surgical mask.</p> <p>During an observation on 8/21/22 at 2:00 pm, located on Cherry Hall (the name of the unit that contained residents who tested positive for COVID-19), CNA B was observed walking down the entire length of Cherry Hall wearing a surgical mask that did not cover her nose. While CNA B walked down the hallway, CNA B was observed pulling the surgical mask below her chin and drinking water from a cup that had no lid, on three separate occasions.</p> <p>During an interview on 8/21/24 at 2:06 pm, CNA B stated, surgical masks were required to be worn by staff on Cherry Hall due to COVID-19 positive residents. CNA B confirmed, the surgical mask was not being worn properly and stated, it should have covered her nose and was not. CNA B was asked about removing mask from face to drink water while walking down Cherry Hall, and CNA B stated, unawareness that CNA B could not drink water while walking down Cherry Hall.</p> <p>During an observation on 8/21/24 at 2:33 pm, the facility ' s Treatment Nurse (TN, performed resident wound care treatments), had been observed standing at the nurse ' s station, located on Cherry Hall. TN was observed talking to Licensed Nurse (LN A) and two other staff members at the nurse ' s station. TN's surgical mask was not covering the nose for the entirety of the observation. TN was observed walking away from the nurse ' s station. After TN walked past a room with an open door, TN pulled the surgical mask up and covered TN ' s nose. The sign located outside of the room with an open door indicated, the resident was positive for COVID-19.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/21/24 at 3:10 pm, TN stated, surgical masks should cover the nose, mouth, and chin. TN was asked about the observation made while TN was at the nurse ' s station on Cherry Hall. TN confirmed, having a conversation with facility staff at the nurse ' s station and stated, the observation made, of TN wearing the surgical mask under her nose, was incorrect.</p> <p>During a concurrent observation and interview, on 8/21/24 at 3:45 pm, LN A was observed standing at the nurse ' s station on Cherry Hall. LN A ' s surgical mask was not covering the mouth or nose. Upon arrival to the nurse ' s station, LN A repositioned the surgical mask and covered up the mouth and nose. LN A confirmed, LN A ' s mouth and nose was not covered and should have been. LN A confirmed being present at the observation made earlier at 3:10 pm. LN A confirmed, while TN was at the nurse ' s station, TN ' s nose was not covered by the surgical mask.</p> <p>During an interview on 8/22/24 at 4:08 pm, Director of Staff Development (DSD, responsible for training staff and was also the CNA supervisor) stated, education had been provided to the facility staff regarding proper use of the surgical mask. DSD stated, the surgical mask should cover the nose, mouth, and chin. DSD stated, staff should not drink water in the hallways of the facility and stated, CNA B should have utilized the staff ' s breakroom.</p> <p>During a concurrent interview and record review on 8/22/24 at 12:38 pm, Infection Preventionist (IP), stated, on 8/7/24 an in-service training was provided to staff regarding infection control. IP stated, a properly worn surgical mask covered the nose, mouth, and chin. IP confirmed, facility staff were not permitted to eat or drink at the nurse ' s station or in the facility hallways.</p>		