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	11/19/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that two of four Residents sampled (Resident 1 and Resident 2) had care plans (a document that outlines a patient's health care needs and the actions and interventions required to address them) for naloxone (a medication that rapidly reverses the effects of an opioid [a strong medication that blocks pain and poses a risk of death by overdose] overdose [when a dose of an opioid is too high, and causes the person's breathing and heartbeat to slow down or stop]).These failures had the potential to result in delayed identification of and interventions for an opioid overdose for Resident 1 and Resident 2.Findings:Review of a facility policy titled, Care Plans, Comprehensive Person-Centered dated March 2022, indicated b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. And e. reflects currently recognized standards of practice for problem areas and conditions.Review of the admission record for Resident 1, indicated she was admitted to the facility on [DATE], with diagnoses including cancer. Review of Resident 1's Annual Minimum Data Set (MDS is a federally mandated assessment tool that measures the health status in nursing home residents) 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 11/10/25 completed by the Social Services Assistant (SSA), indicated Resident 1 had a score of 8 out of 15 indicating she was not able to make her own decisions. Review of Resident 1's physician's orders (written instructions from a doctor detailing specific treatments, medications, or tests for a patient) dated 11/15/25 indicated that Resident 1 had a prescription for naloxone.Review of Resident 1's care plan item titled Narcotic Black Box Care Plan (narcotic - a drug that relieves pain that can cause sleep or drowsiness) (black box - the highest level of safety alert for a prescription medication) (care plan - a written plan for any action to be taken by a nurse to help a patient achieve health goals, based on clinical judgement) dated 11/9/24 for her narcotic pain medication indicated that naloxone administration was not included in her care plan.Review of the admission record for Resident 2, indicated he was admitted to the facility on [DATE], with lumbar spondylosis (age-related wear and tear on the bones and discs of the lower back.)Review of Resident 2's Quarterly MDS, BIMS dated 8/21/25, completed by the SSA, indicated Resident 2 had a score of 13 out of 15 indicating he was able to make his own decisions.Review of Resident 2's physician's orders dated 8/12/25 indicated that Resident 2 had a prescription for naloxone.Review of Resident 2's care plan item titled Narcotic Black Box Care Plan dated 5/26/25 indicated that there was no intervention for administration of naloxone related to his narcotic pain medication.During an interview with the Assistant Director of Nursing (ADON) on 11/19/25 at 11:10 a.m. in her office, the ADON confirmed that if a resident has a physician's order for naloxone, then it should be included in their care plan.

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that three of four residents sampled (Resident 1, Resident 2, and Resident 4) who had naloxone (a medication that rapidly reverses the effects of an opioid [a strong medication that blocks pain and poses a risk of death by overdose] overdose [when a dose of an opioid is too high, and causes the person's breathing and heartbeat to slow down or stop]) prescribed had nurses competent on where their naloxone was stored.This failure had potential to result in delayed treatment of an opioid overdose and death for Resident 1, Resident 2, and Resident 4.Findings: Review of a facility policy titled Opioid Overdose Response (Naloxone) dated October 2023, indicated Naloxone Ordering and Administration 1. Opioid overdose-related deaths can be prevented when naloxone (e.g., Narcan [a brand name for naloxone]) is administered in a timely manner.During a concurrent observation and interview on 11/18/25 at 2:03 p.m. with Licensed Nurse (LN A), LN A was asked where Resident 1's naloxone was stored, LN A stated Probably in the top drawer on the med cart (medication cart - a wheeled cart used in healthcare to store medications, and supplies). Usually in the top left drawer. LN A could not find Resident 1's naloxone in her medication cart.During a concurrent observation and interview on 11/18/25 at 2:06 p.m. with LN A and the Director of Staff Development (DSD), the DSD joined LN A in looking for Resident 1's naloxone in LN A's medication cart. Neither LN A nor DSD could find Resident 1's naloxone in LN A's medication cart. DSD confirmed that Resident 1's naloxone was not in LN A's medication cart.During a concurrent observation and interview on 11/18/25 at 2:15 p.m. with LN B and DSD, LN B was asked where Resident 2's naloxone was stored, LN B did not respond. LN B and DSD searched LN B's medication cart but could not find it in the medication cart. The DSD confirmed Resident 2's naloxone was not in LN B's medication cart.During a concurrent observation and interview on 11/18/25 at 2:21 p.m. with LN C and DSD, LN C was asked where Resident 4's naloxone was stored, LN C stated, the naloxone should be in the narc drawer (narcotic drawer - a smaller, internal, separately locked drawer on a medication cart for storage of controlled substances such as morphine.) When LN C was asked where else Resident 4's naloxone might be stored, LN C stated, I'll have to find out.Review of the admission record for Resident 1, indicated she was admitted to the facility on [DATE], with diagnoses including cancer. Review of Resident 1's Annual Minimum Data Set (MDS - a federally mandated assessment tool that measures the health status in nursing home residents) 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 11/10/25 completed by the Social Services Assistant (SSA), indicated Resident 1 had a score of 8 out of 15 indicating she was not able to make her own decisions. Review of Resident 1's physician's orders (written instructions from a doctor detailing specific treatments, medications, or tests for a patient) dated 11/15/25 indicated that Resident 1 had a prescription for naloxone.Review of the admission record for Resident 2, indicated he was admitted to the facility on [DATE], with lumbar spondylosis (age-related wear and tear on the bones and discs of the lower back.)Review of Resident 2's Quarterly MDS, BIMS dated 8/21/25 completed by the SSA, indicated Resident 2 had a score of 13 out of 15 indicating he was able to make his own decisions.Review of Resident 2's physician's orders, dated 8/12/25 indicated that Resident 2 had a prescription for naloxone.Review of the admission record for Resident 4 indicated he was admitted to the facility on [DATE], with a break in a bone of his lower spine.Review of Resident 4's admission MDS, BIMS, dated 10/28/25 completed by the Minimum Data Set Nurse (MDS), indicated Resident 4 had a score of 11 out of 15 indicating moderate cognitive impairment.Review of Resident 4's physician's orders, dated 10/27/25 indicated that Resident 4 had a prescription for naloxone.During an interview on 11/19/25 at 11:10 a.m. with the Assistant Director of Nursing (ADON), the ADON indicated that facility nurses are expected to know where the naloxone is stored.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of four residents sampled (Resident 1) was safe from a significant medication error when Licensed Nurse (LN D) crushed Resident 1's morphine sulfate (an opioid which blocks pain and poses the risk of death by morphine overdose [when a dose of an opioid is too high, and causes the person's breathing and heartbeat to slow down or stop]) extended release (a type of medication that is designed to release its ingredients slowly rather than all at once) and gave it to Resident 1.This failure had the potential to result in Resident 1 having a morphine overdose and dying.Findings:Review of the admission record for Resident 1, indicated she was admitted to the facility on [DATE], with diagnoses including cancer. Review of Resident 1's Annual Minimum Data Set (MDS - a federally mandated assessment tool that measures the health status in nursing home residents) 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 11/10/25 completed by the Social Services Assistant (SSA), indicated Resident 1 had a score of 8 out of 15 indicating she was not able to make her own decisions. Review of the facility's policy, titled Crushing Medications, dated October 2024, indicated, Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders. Review of the facility's pharmacy policy, untitled, undated, indicated 'Medication Errors Due to Failure to Follow Manufactures Specifications or Accepted Professional Standards - The following situations in drug administration may be considered medication errors: Crushing Medications that should not be Crushed: Crushing tablets or capsules that the manufacturer states do not crush.'Review of an online document titled Medication Guide Morphine Sulfate Extended-Release Tablets, CII, dated March 2021 from Sun Pharma (the pharmaceutical manufacturer of Resident 1's morphine sulfate extended-release) indicated Swallow morphine sulfate extended-release tablets whole. Do not cut, break, chew, crush, dissolve, snort, or inject morphine sulfate extended-release tablets because this may cause you to overdose and die.During a concurrent observation and interview on 11/19/25 at 9:55 a.m. with Registered Nurse (RN E) at his medication cart (a wheeled cart used in healthcare to store, medications, and supplies) in his assigned hallway, RN E confirmed that Resident 1's current pack of Morphine Sulfate Tab 15 mg ER, last filled on 10/24/25 contained a pharmacy sticker label stating Swallow Whole. Do Not Chew Or Crush. Review of Resident 1's physician's orders (written instructions from a doctor detailing specific treatments, medications, or tests for a patient) dated 11/13/25 indicated that Resident 1 was prescribed Morphine Sulfate ER Oral Tablet Extended Release 15 (milligrams) MG Give two tablet four times a day for pain management.Review of Resident 1's record titled PACS- Medication Administration Record dated 11/15/25 indicated that LN D, administered morphine sulfate 15 mg two tablets at 4:00 p.m. to Resident 1.Review of Resident 1's record titled, Nurse's Note, dated 11/15/25 at 6:23 p.m. written by Licensed Nurse (LN D), indicated that LN D wrote Given morphine 30 mg ER crushed in yogurt.During a phone interview on 11/18/25 at 12:22 p.m. with Family Member (FM), FM stated that LN D did not know any better than to crush the morphine sulfate extended release and did not seem to care.During an interview on 11/19/25 at 11:10 a.m. with the Assistant Director of Nursing (ADON) in her office, ADON confirmed that Morphine Sulfate Extended Release should not be crushed.During an interview on 11/19/25 at 9:20 a.m. with the Administrator (ADM) in his office, the ADM acknowledged that LN D crushing Resident 1's Morphine Sulfate Extended Release was a medication error.