

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/05/2025
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Physician ordered restorative nursing services (a program that helped residents maintain or improve their highest possible level of physical function) was provided to one out of 24 sampled residents (Resident 15). This failure had the potential for a decline in functional status and to negatively impact psychosocial well-being. Findings: A review of the facility's undated policy and procedure (P&P) titled, Restorative Nursing Program, indicated, residents would receive restorative nursing care as needed to maintain safety and independence in their functional ability. A review of Resident 15's admission Record, dated 7/15/25, indicated, Resident 15 was admitted to the facility on [DATE] with the diagnoses of muscle weakness and difficulty in walking (ambulation). Resident 15 was their own responsible party (decision maker). A review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 10/16/25, indicated that a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment was conducted. Resident 15 scored a 14 out of 15, indicating good memory. The MDS indicated Resident 15 required staff supervision while ambulating. During an interview on 12/2/25 at 2:15 pm, Resident 15 stated, I'm done with my rehab [therapy that helped a person regain their independence], but I'm still here. Resident 15 denied receiving restorative nursing services and stated, I had it twice. During a review of the care plan (a detailed plan that included resident goals and resident care instructions) titled, RNA [Restorative Nurse Assistant] Program, dated 10/22/25, indicated, Resident 15 would receive assistance from the RNA to ambulate 50 to 100 feet three times a week or as tolerated. The care plan indicated, Resident 15's goal was to maintain strength and activity tolerance to prevent a decline in functional mobility. The care plan indicated Resident 15 required a four-wheeled walker (a metal frame on wheels that was used to assist with ambulation) and facility staff to stand by and assist as needed while ambulating. During an interview on 12/3/25 at 2:56 pm, Physical Therapist (PT) stated, when PT discharged the resident from the therapy program, we establish the RNA program with written instructions for what the RNA will do with the resident. PT confirmed, a referral to RNA program for Resident 15 was provided to the nursing department. A review of the Restorative Nursing Program Referral, dated 10/22/25, indicated, PT referred Resident 15 to the restorative nursing program for ambulation three times a week or as needed and required staff assistance with ambulation for safety. A review of the Physician's order, dated 10/22/25, indicated Resident 15 would receive restorative nursing services three times a week for ambulation. During a concurrent interview and record review on 12/3/25 at 3:04 pm, with RNA, Resident 15's RNA documentation (an untitled document that indicated what days of the week the resident received restorative nursing care), dated 10/21/25 through 12/1/25 was reviewed. RNA confirmed, the RNA documentation indicated that Resident 15 did not receive documented restorative nursing care from 10/22/25 to 11/10/25. RNA confirmed, the RNA documentation indicated, Resident 15 received restorative nursing services once between 11/11/25 and 11/17/25 and none from 11/18/25 to 11/24/25. RNA confirmed, the RNA documentation indicated, during the week of 11/25/25 to 12/1/25, Resident 15 was offered (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restorative nursing services twice, refused both times, and no other attempts were made. RNA stated, when documenting on the RNA form, we document the time or how many steps they take. Sometimes when we are short staffed, we are pulled onto the floor to work as a CNA [Certified Nurse Assistant]. RNA confirmed, on days that RNA was utilized as a CNA, residents did not receive restorative nursing care. During a concurrent interview and record review on 12/3/25 at 3:31 pm, with Director of Nursing (DON), Resident 15's RNA documentation, dated 10/21/25 through 12/1/25 was reviewed. DON stated, if the order indicated, ambulate the resident three times a week, they should ambulate three times a week. DON confirmed, Resident 15's RNA documentation indicated that Resident 15 did not receive Physician ordered restorative nursing care services.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet resident adaptive equipment needs for one of 24 residents (Resident 33) when Registered Nurse (RN) G was not aware of Resident 33's adaptive equipment needs and unable to provide information on where to find adaptive equipment for Resident 33 to meet his needs. This failure had the potential to affect Resident 33's ability to drink fluids independently. Findings: During a review of facility job description titled Job Description: Registered Nurse dated 2/2024, indicated RN was to, review nurses' notes to ensure they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care, and that such are provided in accordance with the resident's wishes, RN was to provide direct nursing care as necessary, RN was to report problem areas to the Director and assist in developing and implementing corrective action, RN was to keep the Director informed of the status of residents and other related matters through written/oral reports, and the RN was to recommend to the Director the equipment and supply needs of the department. During a record review of Resident 33's admission record, he was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition involving constriction of the airways and difficulty or discomfort in breathing), muscle wasting (the decrease in muscle mass and size that occurs when protein breakdown exceeds muscle protein growth), dementia (a decline in memory, thinking, and other cognitive abilities that is severe enough to interfere with daily life), and dysphagia (difficulty swallowing). During an observation on 12/3/25 at 9:21 am, RN G was observed as he held Resident 33's black lid to his bedside water cup. RN G was observed as he taped clear desk tape over a sipping port on the lid. Family Member (FM) 1 walked up to the nursing station and asked, Where are we on my [Resident 33's] drinking cup? RN G replied to FM 1 that he was working on it. RN G held up the black lid with clear tape and asked FM 1, Will this work? FM 1 replied, I guess. During an observation and interview on 12/3/25 at 9:24 am, with FM 1, she stated that she had requested facility staff give Resident 33 a drinking cup with a lid that did not have a sipping port on it so that the water would not spill on Resident 33's shirt when he drank from the straw. RN G entered Resident 33's room, held up an adult sippy cup and asked FM 1 Will this work? FM 1 replied, I guess so. When RN G exited the room, FM 1 was observed to be upset and perplexed and stated, Are they really going to give him a sippy cup? During an interview on 12/3/25 at 9:40 am, with RN G and Director of Nursing (DON), RN G stated it was his first time being on this hall. RN G confirmed he had not made himself familiar with the residents and their needs on the hall prior to his shift. RN G confirmed he took Resident 33's black lid from his room up to the nursing station and further applied clear desk tape to the lid. RN G stated he was unfamiliar with the adaptive supplies the facility kept on hand. RN G stated he spoke to Assistant Director of Nursing (ADON) C, and they both agreed to put tape on the lid as a short term solution. RN G stated he did not know who else he could ask for help to locate an assistive device with a lid that did not leak. DON confirmed that RN G did not ask for help from her, and that facility expectation was for RN G to ask DON for help. During an interview with DON on 12/3/25 at 12:06 pm, DON stated facility expectation was for RN G to make himself familiar with the hall and residents he was assigned to at the start of his shift. DON stated RN G was expected to read the residents' recent progress notes. DON confirmed Resident 33 needed to be reassessed for a drinking device that fit his needs.		