STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000008	A. BUILDING _____ B. WING _____	C 08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH CARE	625 COTTONWOOD STREET WOODLAND, CA 95695

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of complaint #CA00278016. Representing the Department of Public Health: HFEN 1672/17121 The inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.	A 000	The following constitutes the facilities response to the findings of the California Department of Public Health and does not constitute an admission of guilt or agreement of the facts alleged or conclusion set forth on the summary statement of deficiencies. The plan of correction is prepared as required by the provision of the Health and Safety Code, 42 CFR and constitutes the facilities written credible allegation of compliance.	
A 179	T22 DIV5 CH3 ART3-72313(a)(2) Nursing Service–Administration of Medication (a) Medications and treatments shall be administered as follows: (2) Medications and treatments shall be administered as prescribed. This Statute is not met as evidenced by: Based on interviews, clinical record review and facility policy review, the facility failed to follow Patient 1's physician's orders when two follow-up appointments were missed. Findings: On 8/12/11 at 7:20 a.m., an unannounced visit was conducted at the facility to investigate a complaint related to Quality of Care/Treatment. Patient 1 was admitted to the facility on 6/23/11 with diagnoses that included osteomyelitis (bone	A 179	T22 DIV5 CH3 ART3-72313(a)(2) Nursing Service-Administration of Medication (a) Patient 1 was discharged from the facility 7/21/11. (b) The Director of Nursing Services (DNS) performed an audit of new admissions from 7/1/11 to present and no additional follow-up appointments were missed. (c) New admissions orders will be audited by the admitting nurse to identify follow-up appointments. A copy of the appointment will be provided to the Activities Director or designee for transportation scheduling. The Activities Director logs the appointment into the appointment calendar in her office and at the appropriate nursing station.	

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A 179	Continued From page 1 infection)/infected hardware and cerebral palsy (disorders that involves brain and nervous system functions such as movement, learning, hearing, seeing, and thinking.) Review of Patient 1's physician's orders sent to the facility from the General Acute Care Hospital (GACH) contained the following orders. "Follow-up with Plastics: 6/30 and 7/7 Follow with ID (Infectious Disease) 7/7." Further review of Patient 1's clinical record revealed physician's orders written on the facility's order sheet by RN 2 dated 6/23/11. The physician's orders indicated under "Other Orders: F/U (follow-up) with Plastics 6/30 and 7/7 follow with ID 7/7." On 8/12/11 at 8:14 a.m., an interview was conducted with Registered Nurse 1 (RN 1), charge nurse of Unit 2. (Patient 1 resided on Unit 2 when he lived in the facility.) When questioned about patients' follow-up appointments and how staff were aware of the appointments and dates, RN 1 stated patients' follow-up appointments were written in a calendar at the nurses' station. This calendar was presented and there was no notation for 6/30/11 or 7/7/11. The Director of Nursing (DON), who was present during the interview with RN 1 produced a copy of the calendar dated July 21, 2011 which indicated Patient 1 had an appointment with ID at 9 a.m. This notation also indicated transportation had been arranged. On 8/12/11 at 8:35 a.m., an interview was conducted with RN 2. RN 2 stated she transcribed the orders from the GACH onto the facility's order sheet and faxed them to the physician for signature. RN 2 stated the RN working on the unit would be responsible to for	A 179	Continued from page 1 The DNS or designee will review the admission chart after admission to monitor the scheduling of follow-up appointments. Additionally, the DNS or designee will audit the charts of patients having returned from a physician's appointment to identify follow-up appointments to forward to the Activities Director for transportation scheduling and notation on the appointment calendar. (d) The DNS is responsible for monitoring patient appointments. Any identified issues will be brought to the Administrator and forwarded to the QA committee for review and recommendation.	

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A 179	Continued From page 2 checking the orders against those obtained from the GACH and carrying them out. On 8/12/11 at 8:43 a.m., an interview was conducted with DON. The DON stated she was the one who "found the missed orders" for the F/U appointments and rescheduled an appointment for 7/21/11. On 8/15/11 at 10:02 a.m., during a telephone call from the DON, she stated the facility did not have a policy related to "following physician's order, they just follow regulations." The facility failed to follow Patient 1's physician's orders or Title 22 regulations when Patient 1 missed follow-up appointments for 6/30/11 and 7/7/11.	A 179		