California Department of Public Health

10/19/11

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 09/13/2011

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 #CA00262170. Representing the Department of Public Health: HFEN 1662/17069 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		
A 822	T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the policy, "General Dose preparation and Medication Administration," was implemented to ensure Patient A did not receive an antibiotic that she was allergic to. Findings: Patient A's clinical record was reviewed on 3/21/11 and indicated she was admitted to the facility 11/18/10 with the following diagnoses esophagus stricture, aftercare following surgery of the digestive system, speech disturbance and dysphasia (difficulty in swallowing). Further review of Patient A's clinical record revealed her "Record of Admission," February's "Physician Orders" and February's "Medication Record" all indicated Patient A was allergic to	A 822	The following constitutes the facilities response to the findings of the Department of Public Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies. This plan of correction is prepared as required by the provisions of the Health and Safety Code, 42 CFR and constitutes the facilities written credible allegation of compliance. T22 DIV 5 ART5-72523(a) Patient Care Policies and Procedures 1. The patient discharged from the facility on 3/10/2011. 2. Based upon daily review of new orders by medical records no additional deficiencies were noted. 3. Licensed staff received in-service at the time of the incident and additionally on 10/17/11 by the Director of Nursing Services (DNS) regarding proper dose preparation and medication administration.	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 10/17/11

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A 822	Continued From page 1 Penicillin. A Nurse's Note, dated 2/11/11 at 3:00 p.m., indicated Patient A complained of coughing blood stained sputum and wheezing was heard upon auscultation. The licensed nurse, from day shift, documented she placed a call to the physician, left a message and documented she would pass this information on to the p.m. shift. Review of Patient A's clinical record revealed a faxed prescription was received on 2/11/11 for Augmentin (Penicillin antibiotic) 500 mg by mouth three times a day for 7 days. Documentation indicated this order was noted by the Registered Nurse (RN) 1 on 2/11/11 at 5:40 p.m. A Nurse's Note, dated 2/11/11 at 7:39 p.m., RN 1 documented that new orders were received from the physician's office and Patient A's first dose of antibiotic was given at around 5:40 p.m. Review the "Emergency Drug Kit-Log Book," indicated on 2/11/11 at 4:30 p.m. Augmentin 500 mg was signed out by RN 1, for Patient A. Review of Patient A's February Medication Record revealed Patient A received Augmentin 500 mg on 2/11/11 at around 5:00 p.m. Review of the policy, "General Dose preparation and Medication Administration," with a revision date 5/1/10, indicated "Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: ....Check for allergies to the medication..." During an interview with the Director of Nurses (DON), on 3/22/11 at 10:30 a.m., she confirmed Patient A's clinical record indicated she was	A 822	Continued from page 1 Additionally, the pharmacy routinely provides a check on new medication orders and notifies facility of possible adverse or potential allergic reactions. 4. Licensed staff are responsible to honor the five rights of medication administration. The Director of Nursing Services will monitor facility medication administration to ensure the facility policy is executed. Any anomalies will be forwarded to the QA committee for review and recommendation.	

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A 822	Continued From page 2 allergic to Penicillin and should have not received the antibiotic Augmentin. The facility failed to ensure that RN 1 checked Patient A's allergies prior to the administration of the antibiotic Augmentin, a Penicillin antibiotic, that Patient A's clinical record clearly indicated she was allergic to.	A 822		