PRINTED: 07/25/2012
FORM APPROVED

California Department of Public Health

OK per 8/6/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000560	A. BUILDING _____ B. WING _____	C 07/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREEK CARE CENTER	1139 CIRBY WAY ROSEVILLE, CA 95661

(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 a complaint #CA00224032. Representing the Department of Public Health: HFEN, 2450/29328 HFEN, 20435 Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	A 000	**This Plan of Correction constitutes the facility's written credible allegation of compliance for the deficiencies noted.** **This Plan of Correction is prepared as part of the quality assurance process for the provider. This Plan of Correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such is protected from discovery.**	
A 215	T22 DIV5 CH3 ART3-72315(j) Nursing Service--Patient Care (j) Fluid intake and output shall be recorded for each patient as follows: This Statute is not met as evidenced by: Based on staff interview and medical record reviews, the facility failed to ensure a complete recording of Patient 1's input and output (I&O) when Patient 1's I & O form was not filled out completely. This resulted in the facility's inability to know whether Patient 1's fluid needs were met. Findings: Patient 1 was admitted to the facility on 10/28/09 with diagnoses of rehabilitation, pneumonia, muscle weakness, chronic airway obstruction, dehydration, constipation, and dementia. Review of Patient 1's Input and Output Record from 10/28/09 till 2/15/10 indicated that there were incomplete entries on the following dates: October 29, 31	A 215	**A215** **Corrective Action(s) for the affected resident** No corrective action can be taken. Residents discharged from the facility **Identification of other residents potentially at risk** Medical Records will audit I&O forms by 8/25/12 to identify other residents potentially affected by the deficient practice	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/31/12

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A 215	Continued From page 1 November 1, 2 December 7, 9, 10, 11, 12, 13, 14, 17, 25, 26, 28, 29, 31 January 5, 13, 17, 20, 22 The Registered Dietitian was interviewed on 5/20/10 at 8:30 a.m. When asked about the incomplete documentation on the I & O sheets she stated that she did not inform the Director of Nursing Services for "they know what they are supposed to do". The Director of Staff Development was interviewed on 5/17/10 at 8 a.m. She confirmed that the I & O forms were incomplete. She also stated that she plans to conduct a 1:1 training on making sure these forms are completely filled out.	A 215	residents potentially affected by the deficient practice **Immediate measures and systemic changes to ensure the deficient practice does not recur** Staff will be inserviced by 8/25/12 regarding proper keeping and filing of patient health records. When copies of patient health records are requested, Medical Records will audit the record to ensure confidentiality prior to delivery. **Monitoring Process**	
A 969	T22 DIV5 CH3 ART5-72543(a) Patients' Health Records (a) Records shall be permanent, either typewritten or legibly written in ink, be capable of being photocopied and shall be kept on all patients admitted or accepted for care. All health records of discharged patients shall be completed and filed within 30 days after discharge date and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no case less than 7 years. All exposed X-ray film shall be retained for seven years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending physician, the facility staff or any authorized officer, agent, or employee of either, or any other person authorized by law to make such request.	A 969	Medical Records will monitor through periodic random patient health record audits for compliance. Findings will be reported to the Quality Assurance committee for evaluation and recommendations Corrective action(s) will be completed by 8/25/12	

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A 969	Continued From page 2 This Statute is not met as evidenced by: Based on interviews and record reviews, the facility failed to contain the health record information of Patient B confidential when some copies of Patient B's health record information were given to Patient A's family member. Findings: Patient A's son requested some copies of Patient A's health records. In an interview on ~~4/13/12~~ 4/13/10 at 10:45 a.m., with the Administrator, he confirmed that he brought a sealed envelope that contained documents to be given to the son of Patient A. When Patient A's son opened the envelope, it revealed copies of health records of Patient B. The Medical Record staff and Director of Nursing confirmed as well. Review of Patient B's health records indicated that Patient B's medication sheet, chest x-ray results, four sheets of care plans, and skin/wound records were the health records in the sealed envelope given to Patient A's son.	A 969	**Immediate measures and systemic changes to ensure the deficient practice does not recur** Staff will be inserviced by 8/25/12 regarding proper recording of fluid intake and output for each patient **Monitoring Process** Medical Records will monitor through periodic random audits for compliance Findings will be reported to the Quality Assurance committee for evaluation and recommendations Corrective action(s) will be completed by 8/25/12 **A969** **Corrective Action(s) for the affected resident** No corrective action can be taken. Residents discharged from the facility **Identification of other residents potentially at risk** Medical Records will audit patient records by 8/25/12 to identify other	