California Department of Public Health

Ken 1/25/12

FORM APPROVED

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 09/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREEK CARE CENTER Sierra Hills 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 Complaint CA00173406. Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: HFEN 2104/25738	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 162	T22 DIV5 CH3 ART3-72311(a)(1)(B) Nursing Service–General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. This Statute is not met as evidenced by: Based on medical record review the facility failed to identify care needs for Patient 08-08-01 (01) when there was no care plan indicating that this patient needed the assistance of 2 persons for care. Findings: Patient 01 was admitted to this facility on 3/15/08 for rehabilitation and with diagnoses including a dislocated knee, osteoarthritis, lumbago and depressive disorder. Physicians orders/notes dated 11/11/08 identified that Patient 01 had	A 162	**A162** **Corrective Action(s) for the affected resident** The affected resident's care plan was corrected for the appropriate level of assistance. **Identification of other residents potentially at risk** Medical Records will audit resident working care plans and by 1/30/12 to identify other residents having the potential to be effected by the same deficient practice.	

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A 162	Continued From page 1 chronically and subacutely dislocated right knee orthoplasty (knee replacement). She was also referred for an orthopedic consult. A complaint was referred to the Department that on 11/13/08 that 2 persons from the Office of MediCal Fraud and Elder Abuse heard Patient 01 screaming in pain from her room. When they entered they observed 1 CNA (Certified Nursing Assistant) trying reposition Patient A while changing linens. A review of a nursing noted dated 11/13/08 at 10:50 a.m. indicated that Patient 01 had a knee immobilizer on the right knee and had complained of severe pain. The nurse documented that Patient 01 had received multiple doses of scheduled pain relief medication, (morphine) and PRN (as needed) doses Vicodin with little pain relief. The physician was notified and ordered injectable morphine which Patient 01 received at 10:10 a.m., and 1:40 p.m. This was validated on the Medication Administration Record (MAR). A review of the medical record showed that there was no care plan regarding how much assistance this patient would need with activities of daily living (ADLs) such as turning in bed, assist with hygiene or changing clothes. However, review of the ADL sheet that the CNA's fill out each shift indicating how much assistance the patient needs for issues such as bed mobility, transferring, eating, etc, indicated that Patient 01 needed extensive assistance of 2 people. Under the section marked bed mobility (indicating how the patient moves in bed, turns side to side and positions body while in bed) is marked the 3 different shifts with care needs indicated by a number, i.e., 3 meaning extensive assistance,	A 162	**Immediate measures and systemic changes to ensure the deficient practice does not recur** Staff will be inserviced by 1/30/12 regarding following resident working care plans to provide appropriate resident care needs. **Monitoring Process** The Administrator will monitor through periodic random audits conducted by Medical Records to monitor for compliance Findings will be reported to the Quality Assurance committee for evaluation and recommendations Corrective action(s) will be completed by 1/30/12	

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A 162	Continued From page 2 and a 1 meaning 1 person assist or 2 meaning 2 person assist. For Patient 01 all the boxes for each shift are marked 3 for extensive assist and 2 for the number of people needed to assist her to move about.	A 162		
A 806	T22 DIV5 CH3 ART5-72523(b) Patient Care Policies and Procedures (b) All policies and procedures required of these regulations shall be in writing, made available upon request to physicians and other involved health professionals, patients or their representatives, employees and the public shall be carried out as written. Policies and procedures shall be reviewed at least annually, revised as needed and approved in writing by the patient care policy committee. This Statute is not met as evidenced by: Based on Policy & Procedure review the facility failed to follow it policy titled Administration of Medications and Treatments when a medication was not documented for Patient 8. Findings: Patient 8 was admitted to the facility on 10/4/08 with diagnoses including protein-calorie malnutrition, history of cancer and pneumonia. On 11/8/08 Patient 8 was sent to the Emergency Department for an evaluation. Upon return to the facility the Emergency Department physician recommended that Patient 8 was to drink 4 liters of GoLYTELY over the course of about 4 hours. Patient 8's facility physician was contacted by phone and endorsed this order. This order was hand written on the Medication Administration Record (MAR).	A 806	**A806** **Corrective Action(s) for the affected resident** The affected resident discharged from the facility on 12/6/08 **Identification of other residents potentially at risk** Medical Records will audit resident MARs by 1/30/12 to identify other residents having the potential to be effected by the same deficient practice. **Immediate measures and systemic changes to ensure the deficient practice does not recur** Staff will be inserviced by 1/30/12 regarding the facility Administration of Medications and Treatments policy and procedure.	

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A 806	Continued From page 3 Review of Patient 8's nursing notes dated 11/8/08, at 10:45 p.m., noted that Patient 8 started ingesting the GoLYTELY at 4:10 p.m. and was able to ingest only 2 liters the tried to go to the bathroom. However, there was no notation on the MAR that any of this medication was given to Patient 8. Review of other portions of the MAR showed that other medications were documented with times given and initials of the person administering the medication. Review of a Policy and Procedure, undated, identified under Procedure: The Licensed Nurse if responsible for the following established Policy/Procedure in the administration and documentation of medications: 19. The Licensed Nurse is to initial each (facility bold) dose immediately after administration in the appropriate time slot on the medication administration record	A 806	**Monitoring Process** The Director of Nursing will monitor through periodic random audits conducted by Medical Records to monitor for compliance Findings will be reported to the Quality Assurance committee for evaluation and recommendations Corrective action(s) will be completed by 1/30/12	