

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/21/2021
NAME OF PROVIDER OR SUPPLIER POWAY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15632 POMERADO ROAD POWAY, CA 92064		
(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. The investigation was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Complaint number: CA00705902 Category: Quality of Care/Treatment A deficient practice was identified. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 38512.	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by Poway Healthcare to the allegation or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions set forth in Federal and State law. None of the actions taken by the facility pursuant to the Plan of Correction should be considered an admission that a deficiency existed or that additional measures should have been in place at the time of the Survey. This Plan of Correction serves as our credible Allegation of Compliance with Federal and State Regulations.		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656			

RECEIVED
CA DEPT OF PUBLIC HEALTH

FEB - 1 2022

LICENSING & CERTIFICATION
SAN DIEGO DISTRICT OFFICE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/21/2021
NAME OF PROVIDER OR SUPPLIER POWAY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15632 POMERADO ROAD POWAY, CA 92064		
(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) COMPLETION DATE
F 656	<p>Continued From page 1</p> <p>treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to develop an effective care plan for management of a nephrostomy tube (a tube leading out of the kidneys to outside of the body for urine) for one resident (1).</p> <p>This failure resulted in Resident 1 experiencing four separate incidents of the nephrostomy tube becoming dislodged.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on 4/25/15 with diagnoses to include pyelonephritis (an infection of the kidneys), per the Resident Face Sheet.</p>	F 656	<p>F 656</p> <p><i>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</i></p> <p>Resident 1 with nephrostomy in place and immediate, direct care staff education provided regarding nephrostomy care.</p> <p>No other Residents in the facility with a nephrostomy tube at this time.</p> <p><i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All residents have the potential to be affected by this deficient practice. Sweep of the building conducted and no other residents identified with nephrostomy tubes in place at this time</p> <p><i>What measures will be put into place or what systemic changes will the facility make to ensure that deficient practice does not recur.</i></p> <p>All staff educated regarding nephrostomy care. In addition, upon hire and annually all new staff will be trained on nephrostomy care. Within 24 hours of new admission, patients admitted with a nephrostomy will receive 1:1 nephrostomy care training.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/21/2021
NAME OF PROVIDER OR SUPPLIER POWAY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15632 POMERADO ROAD POWAY, CA 92064		
(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) COMPLETION DATE
F 656	<p>Continued From page 2</p> <p>On 11/16/20, a record review was conducted.</p> <p>On 1/3/20, Resident 1 returned to the facility after hospitalization for placement of a nephrostomy tube.</p> <p>On 1/3/20, a care plan was initiated for care of the nephrostomy tube. Long term goals were listed as, "Will have nephrostomy care managed appropriately as evidenced by: not exhibiting signs of infection or...trauma." Nine approaches to managing the tube were listed, five of which were exclusive to nursing care. Four approaches to managing the tube listed Certified Nursing Assistants (CNA's) as the discipline responsible:</p> <ol style="list-style-type: none"> 1. Monitor I&O (intake and output, the amount of liquids consumed and the amount of urine output,) 2. Cleanse the tubing site with soap and water, 3. Observe the tubing to make sure it was intact and draining, and 4. Place bag below the bladder and observe every shift. <p>On 4/2/20 at 2:52 P.M., the Director of Staff Development (DSD, a nurse responsible for education and training of CNA's) documented Resident 1's nephrostomy tube had fallen out while a CNA was assisting her in the bathroom. Resident 1 was sent to the hospital to replace the tube.</p> <p>The nephrostomy care plan was updated with an approach to, "Ensure tubing is secure prior to transfers/turning resident to prevent dislodgement." Nursing was the discipline assigned.</p>	F 656	<p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>DON or designee to evaluate staff that are caring for residents with nephrostomy tubes 3x/week x 4, then weekly ongoing.</p> <p>Any negative findings to be reported to the QA committee to ensure facility compliance.</p> <p><i>Individual responsible:</i></p> <p>Director of Nursing</p> <p><i>Date of completion:</i></p> <p>February 4, 2022</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

POWAY HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**15632 POMERADO ROAD
POWAY, CA 92064**

(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) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

F 656

Continued From page 3

On 4/2/20, a short-term care plan was implemented by the DSD regarding the dislodged tube. The care plan included three nursing approaches to maintain Resident 1's tube. The approaches were:

1. Monitor site for signs of infection,
2. Notify MD of any changes,
3. Secure tubing before moving/transferring resident.

The three interventions listed Nursing as the responsible discipline. No additional interventions were listed for CNA's.

On 5/27/20 at 3:38 P.M., LN 1 documented the tubing had, "...came off by accident..." while a CNA was assisting Resident 1 into bed. Resident 1 was sent to the hospital to have the tube reinserted. LN 1 added a short-term care plan, listing the goal to not have any complications from the tube removal. Seven approaches were listed, all were the responsibility of nursing staff. None of the seven approaches involved transferring of the resident. None of the approaches were assigned to the CNA's.

On 7/26/20 at 6:27 P.M., LN 2 documented the nephrostomy tube had come out. No explanation was given for the dislodged tube. Resident 1 was sent to the hospital to replace the tube.

On 7/27/20, a short-term care plan was implemented by LN 3 regarding the dislodged tube. The care plan included four nursing approaches to maintain Resident 1's tube. Nursing was the discipline assigned to the approaches.

On 9/20/20 at 5:15 P.M., LN 4 documented that a CNA had asked him to assess Resident 1's

F 656

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

POWAY HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**15632 POMERADO ROAD
POWAY, CA 92064**

(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) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

F 656

Continued From page 4

nephrostomy tube. LN 4 documented the tube was leaking, and had been pulled out of Resident 1's body approximately 20 centimeters (7.8 inches). No explanation was given for the dislodged tube. Resident 1 was sent to the hospital to replace the tube.

On 9/21/20, the DSD implemented a short-term care plan regarding the dislodged tube. The care plan included one approach, with the discipline of Nursing assigned. The approach was, "Send resident to (hospital) for further assessment." No further interventions were listed.

On 11/16/20 at 3 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated she investigated each incident of dislodgement. The DON stated, "Probably the DSD did education for the CNA's..." The DON did not have evidence of the education. Per the DON, the care plan should have been updated with approaches appropriate for the CNA's, such as checking the tubing before transferring the resident. Per the DON, the care plans were, "Mostly for nursing." The DON stated the Interdisciplinary Team (IDT, a group of healthcare professionals who work with the resident to create an individualized plan of care) did not meet to discuss the dislodged tube. The DON stated she had not considered an IDT regarding the nephrostomy tube.

On 11/16/20 at 3:30 P.M., an interview was conducted with the DSD. The DSD stated the CNA's report to her. The DSD stated she had not done any education or training for the CNA's regarding the nephrostomy tubing, and she was not aware CNA's were involved in the tubing dislodgement except for the 4/2/20 incident. Per

F 656

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/21/2021
NAME OF PROVIDER OR SUPPLIER POWAY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15632 POMERADO ROAD POWAY, CA 92064		
(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) COMPLETION DATE	
F 656	<p>Continued From page 5</p> <p>the DSD, the DON was responsible for investigating the reasons for the tubing coming out. The DSD stated the DON had not informed her of any additional investigations for Resident 1. The DSD stated the IDT would need to investigate the rationale, and update the care plan to reflect any changes for Resident 1. The DSD stated the IDT could discuss different ideas for maintaining the tubing among all of the caregivers, especially CNA's. Per the DSD, "The role to investigate, and to conduct an IDT, is the DON's."</p> <p>On 11/16/20 at 4:40 P.M., an interview was conducted with the DON. The DON stated she had interviewed Resident 1 following the first incident, but nobody interviewed Resident 1 or the other caregivers after that. The DON stated, "We absolutely did not investigate the reasons for the dislodgement. We should have. And we should have held an IDT to determine the best way to prevent it from happening again."</p> <p>Per a facility document, revised 3/1/14 and entitled Certified Nurse Assistant (CNA) Job Description, "...Transfer---Use correct transfer technique and equipment according to plan of care...Assist with the planning, implementation and evaluation of plans of care for assigned residents and report information about conditions...and suggestions for alternative approaches..."</p> <p>Per a facility policy, revised January 2011 and entitled Care Planning - Interdisciplinary Team, "Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident...2. The care plan is based on the</p>	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

POWAY HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE


**15632 POMERADO ROAD
POWAY, CA 92064**

(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) COMPLETION DATE
F 656	<p>Continued From page 6</p> <p>resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes...j. Nursing Assistants responsible for the resident's care..."</p> <p>Per a facility policy, revised August 2006 and entitled Using the Care Plan, "The care plan shall be used in developing the resident's daily care routines...2. The Nurse Supervisor uses the care plan to complete the CNAs daily/weekly work assignment sheets...3. CNAs are responsible for reporting...any change in the resident's condition and care plan goals and objectives that have not been met..."</p>	F 656		

EDUCATION PROGRAM
LESSON PLAN

DATE: 1/28/22

Course Subject: Tubing-Nephrostomy

Facility Provider Number: F-0734 Instructor Name/Title: Shelly Insko DSD/Elizabeth Barbieri DON Signature: 

Course Objectives / Performance Standard	Course Content	Teaching Methods	Methods of Evaluation
<ol style="list-style-type: none"> 1. Nursing staff will understand proper care of residents with tubing- nephrostomy 2. Nursing staff will understand the importance of securing tubing and ensuring tubing remains in place/intact 3. Nursing staff will understand the procedure if tubing is dislodged 	<p>Policy & Procedure for Nephrostomy Tube, care of</p> <p>Competency Assessment form for nephrostomy tube care</p> <p>Tubing should be secured prior to every transfer, turning & positioning of resident to ensure tubing does not get dislodged during movement. LN to ensure device is secured, CNA to verify tubing is secured before moving resident.</p>	<p>Lecture, Discussion</p> <p>Hand Out</p>	<p>Question & Answer</p> <p>Clinical Evaluation</p> <p>Demonstration</p>

Nephrostomy Tube, Care of

Level III

Purpose

The purpose of this procedure is to provide guidelines for the care of the resident with a percutaneous nephrostomy tube.

Preparation

1. Verify that there is a physician's order for this procedure.
2. Review the resident's care plan to assess for any special needs of the resident.
3. Assemble equipment and supplies as necessary.

General Guidelines

1. Assess the resident for indications of bleeding in the flank area every 4 hours x 2 after insertion of the nephrostomy tube, then every 8 hours.
2. Check placement of the tubing and integrity of the tape during assessments.
 - a. Drainage should be below the level of the kidneys.
 - b. There should be no kinks in the tubing.
 - c. If the tubing is dislodged, cover stoma with sterile 4x4 and notify the Attending Physician immediately.
3. Empty drainage bag once per shift and as needed.
4. Change drainage bag monthly, or as needed.
5. Measure output as follows:
 - a. Initially every hour x 4 hours; then
 - b. Every 4 hours x 24 hours; then
 - c. Every 8 hours.
6. Measure output from the right and left kidneys separately. (Record urinary and nephrostomy output separately.)
7. After nephrostomy tube insertion, output may be bloody but should change to light pink within 24 hours.
8. Change dressings every 1-3 days, or as ordered.
9. Use sterile technique during dressing changes.

Equipment and Supplies

For Dressing Changes:

1. Sterile 4x4 drain dressings;
2. Povidone-iodine swabs;
3. Sterile saline/4x4 gauze/sterile basin/forceps if NSS is ordered;
4. Clean gloves;
5. Sterile gloves;
6. Adhesive tape;
7. Disposable underpad;
8. Sterile drape; and
9. Waste bag.

continues on next page

3. Open gauze pads, iodine or alcohol swabs, and pre-filled syringe.
4. Wash your hands and put on sterile gloves.
5. Cleanse the junction between the nephrostomy tube and the drainage tube with iodine or alcohol swabs.
6. Disconnect the tubes and place the ends of both tubes in sterile cups.
7. Connect the syringe to the nephrostomy tube using a male adapter, if necessary.
8. Slowly instill 2-3 ml of saline into the nephrostomy tube. DO NOT IRRIGATE WITH MORE THAN 3 ML OF SALINE.
9. Slowly aspirate the saline back into the syringe. If there is resistance, remove the syringe and reattach the nephrostomy tube to the drainage tube and allow the solution to drain by gravity.

Documentation

The following information should be recorded in the resident's medical record.

1. The date and time the procedure was performed.
2. Name and title of the person(s) who performed the procedure.
3. The resident's response to the procedure.
4. Assessment data obtained during the procedure:
 - a. Color, quality and amount of drainage (or irrigation output);
 - b. Signs and symptoms of infections (pus, redness, swelling, tenderness);
 - c. Signs of tube obstruction;
 - d. Signs of skin breakdown around the dressing site; and
 - e. Any problems or complaints from the resident during the procedure.

Reporting

Report any of the following signs or symptoms to the physician:

1. Redness, inflammation, reports of pain, or other signs of infection at the insertion site;
2. Reduced output or output below established parameters;
3. Inability to irrigate tube or signs of obstruction of the tube;
4. Signs of skin breakdown around the dressing site; or
5. If the tube becomes dislodged.

References	
MDS Items (CAAs)	Section H, (CAA 6)
Survey Tag Numbers	F684; F691
Other References	
Related Documents	
Version	1.1 (HSMAPR0304)

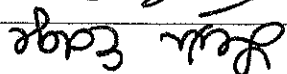
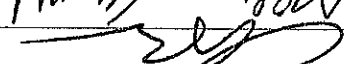
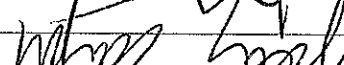
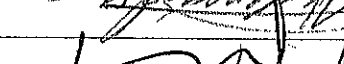
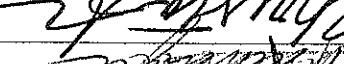
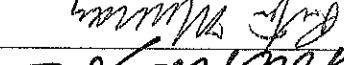
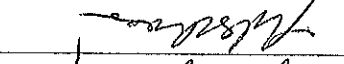
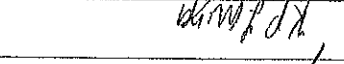
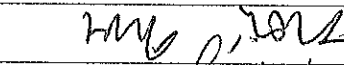
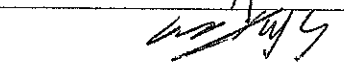
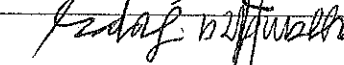



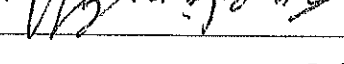
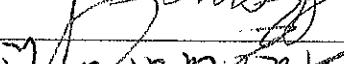
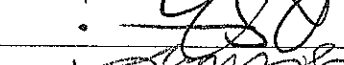

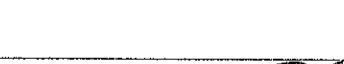

In-Service Sign in Sheet

In Service Course Title: Tubing-Nephrostomy/Catheters/IVs

Facility Provider Number: F-0734 Facility Name: Poway HCC

Instructor Name: Shelly Insko DSD Signature:  Date: 1/28/22 Length 30 min

Method of Training/In-Service: Lecture, discussion

Print Name & Title	Signature	Date
1. Lexi Edge		1/28/22
2. Elizabeth Brown		1/28/22
3. Jody Campbell		1/28/22
4. Tavia Jure		1/28/22
5. Jodie Raymond		01/29/22
6. Christa Abeto		1/29/22
7. Peter Murray		1/29/22
8. Rosemarie Becker		1/29/22
9. Kim Philip Dugga		1/29/22
10. Tori Thomas, CNAP		01/29/22
11. Sherwin Paras		01/29/22
12. Cassandra Lopez		1/29/22
13. Hazel Elgar		1/29/22
14. Chyl Macar		1/29/22
15. Nick Gauthier CNP		1/29/22
16. Edmon Fabian		1/29/22
17. Anelli Lalugan		1/29/22
18. Loreto Parnas		1/29/22
19. Danna Stinson		1/31/22
20. Dan Schwinn		1/31/22

In-Service Sign in Sheet

In Service Course Title: Tubing-Nephrostomy/Catheters/IVs

Facility Provider Number: F-0734 Facility Name: Poway HCC

Instructor Name: Shelly Insko DSD Signature: *Shelly Insko DSD*

Date: 1/28/22 Length 30 min

Method of Training/In-Service: Lecture, discussion

Print Name & Title	Signature	Date
1. Ruth Camargo	<i>[Signature]</i>	2/31/22
2. Catherine Dornas	<i>[Signature]</i>	2/1/22
3. Taylor Wilson	<i>[Signature]</i>	1/31/22
4. <i>[Signature]</i>	<i>[Signature]</i>	1-31-22
5. <i>[Signature]</i>	<i>[Signature]</i>	1-31-22
6. Crystal Zavala	<i>[Signature]</i>	1-31-22
7. Sarah Votel WN	<i>[Signature]</i>	1/31/22
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

1/8/22