STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055512	A. BUILDING _____ B. WING _____	C 09/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF CREEK CARE CENTER	107 CATHERINE LANE GRASS VALLEY, CA 95945

(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 the investigation of two complaints. Complaints : 360913 and 360049. The Inspection was limited to the specific complaints and do not reflect the findings of a full inspection of the facility. Representing the Department: 31602, HFEN A deficiency was written for Complaint 360049 at F441. Two deficiences were written for Complaint 360913 at F283 and F323.	F 000	This Plan of Correction is submitted as the facility's credible allegation of compliance. 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 protected from discovery. This Plan of Correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and/or guidelines. As this transmission is required by law it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations.	
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to recapitulate Resident 1's respite stay by providing a discharge summary. This had the potential to deny Resident 1 full health care disclosure of events and care delivered at this facility for future care from healthcare providers.	F 283	**F283** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice** Resident 1 has discharged from the facility **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** All residents with a discharge plan have been audited for completion of discharge paperwork. **What measures will be put into place or**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Josem CMM TITLE Administrator (X6) DATE 9/27/13

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.

A Pro The Athletic, SSD 10/22/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055512	A. BUILDING _____ B. WING _____	C 09/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF CREEK CARE CENTER	107 CATHERINE LANE GRASS VALLEY, CA 95945

(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 283	Continued From page 1 Findings: A record review conducted on 8/9/13 indicated that a discharge summary, titled "Discharge and Transfer- Physician Discharge Summary" was not completed for Resident 1's respite stay starting on 6/6/13 and discharge to another facility on 6/8/13. The discharge summary for Resident 1 indicated the following: -Under the section, Observation Details, Admission Status documentation space was blank. -Under the section, Recapitulation of Stay, the following areas for documentation were blank: Significant Changes in Condition; Outstanding Events; Hospitalization; and Final Diagnosis/Condition Upon Discharge. This discharge summary was signed by the physician's provider designee, the Family Nurse Practitioner, and dated 7/12/13, over 1 month after Resident 1 left the facility. During an interview conducted on 8/9/13 at 11:30 am, DON validated that the discharge summary was not completed.	F 283	**systemic changes the facility will make to ensure that the deficient practice does not recur** Medical Records or designee will audit all residents with a discharge plan for completion of discharge paperwork. Nurses were in-serviced regarding discharge paperwork. **How the facility plans to monitor its performance to make sure that solutions are sustained, must be integrated into the quality assurance system.** Medical Records or designee will report results of audits to the QA committee. Will be completed by 10/10/13	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**F323** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice** Resident 1 has been discharged from the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055512	A. BUILDING _____ B. WING _____	C 09/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF CREEK CARE CENTER	107 CATHERINE LANE GRASS VALLEY, CA 95945

(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 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement the plan of care with regard to falls for Resident 1. This failure had the potential to contribute to untimely response to Resident 1's fall by not placing a tab alarm (a type of alarm to alert staff when a resident attempts to move unassisted from the alarmed object, usually a bed or chair) to the recliner chair in which he slept. Findings: Resident 1 was admitted to the facility on 6/6/13 for respite care with diagnoses that included difficulty walking, seizures, and falls. In an interview conducted on 7/11/13 at 5:20 pm, Family Member (FM) 1 stated that Resident 1 rang his call bell because he needed assistance to get up from his recliner in the early morning of 6/8/13. FM stated that Resident 1 got up unassisted because no one responded to his call bell and then he fell. A record review conducted on 8/9/13 of a Care Plan for falls dated 6/6/13 indicated, under Approach, for the care provider to "Apply tab alarm in wheelchair and Recliner." A review of Resident 1's Progress notes, dated 6/6 through 7/5/13 did not indicate that a tab alarm was on Resident 1's recliner or that it was checked for functionality. During an interview on 8/9/13 at 11:30 am, Director of Nursing validated that there was no	F 323	**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** Medical Records or designee audits new admissions fall risk assessments and care plans. IDT reviews orders based upon results of the assessments. **What measures will be put into place or systemic changes the facility will make to ensure that the deficient practice does not recur** Nurses have been inserviced regarding placement of safety devices, functionality, and documentation. **How the facility plans to monitor its performance to make sure that solutions are sustained, must be integrated into the quality assurance system.** Medical Records or designee will report results of the audit to the QA committee. Will be completed by 10/10/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055512	A. BUILDING _____ B. WING _____	C 09/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF CREEK CARE CENTER	107 CATHERINE LANE GRASS VALLEY, CA 95945

(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 323	Continued From page 3 documentation of a tab alarm placed on Resident 1's recliner chair or that it was checked or functional.	F 323	**F441** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified as being directly affected. **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** All residents are potentially at risk. **What measures will be put into place or systemic changes the facility will make to ensure that the deficient practice does not recur** Infection control nurse or designee inserviced staff regarding hand washing, transport of linen, passing trays, spills and clean-up. Infection control nurse or designee will do rounds during meal service. **How the facility plans to monitor its performance to make sure that solutions are sustained, must be integrated into the quality assurance system.** Infection control nurse or designee will report results of inservice and rounds to the QA committee. Will be completed by 10/10/13	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food; if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055512	A. BUILDING _____ B. WING _____	C 09/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF CREEK CARE CENTER	107 CATHERINE LANE GRASS VALLEY, CA 95945

(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 441	Continued From page 4 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe hand washing practice during a dining meal service. This failure had the potential for spread of infectious organisms to facility residents. Findings: During an observation of lunch dining conducted on 7/12/13 at 1 pm, Resident 2 spilled milk over herself and onto the floor. Dietary Services Supervisor (DDS) 4 cleaned the floor with napkins. She was then assisted by Certified Nursing Assistant (CNA) 5, who brought in towels and laid them on the floor after the napkins were picked up by DDS 4. DDS 4 threw the napkins in the trash, then went to a lunch tray she was testing and proceeded to eat. She did not wash her hands or use hand sanitizer. CNA 5 laid the towels down on the floor over the spill and then went to the tray cart and touched trays without washing her hands or using hand sanitizer. In interviews conducted on 7/12/13 at 1:05 pm, DDS 4 validated that she did not wash her hands after cleaning up the milk spill on the floor. CNA 5 validated that she did not wash her hands after handling the towel she laid on the floor.	F 441		