DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/30/2015 FORM APPROVED OMB NO 0938-0391

| FATEMENT OF DEPICIENCIES YO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED C 04/27/2015 | | |
|---|--|--|--|---|--------------|--|
| 555801 | | | | | | |
| IAME OF PROVIDER OR SUPPLIER PINE CREEK CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETIO | |
| F 000 | | | F 000 | | | |
| F 281 SS=D | | | PLAN OF CORRECTIONS "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 are 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 trunsmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations." F281 Corrective Action for the affected resident Resident A was discharged. Charge nurse who failed to get the order for flushing the nephrostomy was inserviced one on one on nephostomy care which included need for order for flushing on 3/17/15 Licensed staff was inserviced on nephrostomy care which included need for flushing on 3/25/15 | | | |

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 projection to the cationts. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether of 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

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| AND PLAN OF CORRECTION IDENTIFICAT | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DAT | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--|---|--|-------------------------------|--|--|
| | | 555801 | | | C 04/27/2015 | | | |
| NAME OF PROVIDER OR SUPPLIER PINE CREEK CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1139 CIRBY WAY ROSEVILLE, CA 95561 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PRÉFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE EAPPROPRIATE | (X5) COMPLETION DATE | | |
| F 281 | dated 1/10/15 at 6 flushed Resident / normal saline. A F 1/11/15 at 9:59 p.r Resident A's neph saline. Review of Resident Indicated no order nephrostomy tube. During an Interview (DON), on 3/11/15 she was unable to LN 1 to flush Resident 1/10 and 1/11/15. Review of the "Nu Regulations" reverse Regulations reverse and Indirect and Indirect and Indirect and Indirect and Implement a treat rehabilitative registred to (Nursing Practice Issued by the Bostsued by the Bostsued Indirect and Indirect | nt A's Resident Progress Note, :51 p.m., indicated LN 1 A's nephrostomy tubes with Resident Progress Note, dated m., indicated again LN 1 flushed rostomy tubes with normal at A's physician's orders for LN 1 to flush Resident A's | | Identification of other resident potentially at risk Residents with nephrostomy the identified through an audit by Maccords. There were no other residents is that has nephrostomy. Measures will be put into plan systemic changes to ensure the deficient practice does not out DON/Designee will review ide residents' orders and look at or specific to flushing the nephost DON/Designee will carry out it order for nephrostomy flushing DON will inservice all licensed on nephostomy care and policy getting physician's order for all procedures. Monitoring Process DON/Designee will review all nephostomy orders from admiss nephrostomy flushing order. DON/Designee will report to Cassurance Committee for reviewall and recommendation and recommendation coded. Corrective actions will be command 29, 2015 | be will Medical dentified ce and te cur intified der tomy. MD's inurses of l guality sion, on if | | | |