PRINTED: 10/21/2020
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555801	A. BUILDING _____ B. WING _____	C 10/21/2020

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

Reed 11/5/20 (10A)

For accepted 11/5/2020 per AM-ES

(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 survey for the investigation of complaint #CA00699674. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 32096 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	Nothing in this Plan of Correction should be interpreted as an admission of guilt or error. Rather this is part of our process to improve the outcomes at Pine Creek Care Center. *How corrective action will be accomplished for those residents found to have been affected by the deficient practice.* The resident was assessed for any neurological deficit and was found to be in the same condition as before the fall occurred.	POC not needed (10A)
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor 1 of 3 sampled residents (Resident 1's) neurological status after a fall per Resident 1's Fall Care Plan when there was no neurological assessment completed which included vital signs, level of consciousness, motor function of hand grasp, and pain response. There was no Licensed Nurse (LN's) follow up Progress Notes prior to Resident 1's emergency room transfer. This failure had the potential to place the resident	F 684	*How facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The MDS nurse will do a search of all falls in the month of October to verify our policy was followed when there was an unwitnessed fall. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* Our team will review the Fall Care Plan and Neurological Assessment Flowsheet to make sure that we have an	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 11/3/2020

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.

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F 684	Continued From page 1 at risk for a delayed identification of change of condition after the fall and increased the potential for unmet care needs for Resident 1. Findings: Resident 1 was admitted to the facility on 6/6/2020 with diagnoses that included heart disease with an advanced age and muscle weakness. Review of Resident 1's clinical record, Clinical Admission, dated 6/6/20, indicated her baseline vital signs (baseline status of the body's vital functions) were all within normal range upon admission. Resident 1's oxygen saturation [SpO2, number of hemoglobin bound to oxygen in the blood, normal rate 95% < in room air] was 97% in room air. Resident 1's respiration rate [the number of breaths per minute, normal rate for an adult at rest is 12 to 20 breaths per minute] was 18 and the body temperature was 97.7°F [normal 97°F (36.1°C) to 99°F (37.2°C)]. Review of Resident 1's clinical record, "FSI-Fall Scene Investigation Report," dated 6/9/20, indicated the resident had an unwitnessed fall and was found on the floor in her room at 4 a.m. Review of Resident 1's clinical record included: > 6/9/20 at 4:30 a.m.: LN 1 documented, Vitals Results, SpO2 96%, Respiration 18 > 6/9/20 at 4:34 a.m.: LN 1 documented, Resident Progress Notes, "patient had unwitnessed fall at 3:50 a.m. and the patient on floor, the patient said that I try to go home..."	F 684	appropriate response to an unwitnessed fall. Nursing leadership will in-service Licensed Nurses on use of Fall Care Plan and Neurological Assessment Flowsheet. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* DON or designee will monitor to verify that unwitnessed falls follow Fall Care Plan. After any unwitnessed fall, IDT will meet together and review the fall and verify that policies are followed. MDS will report to the QA team on a quarterly basis any issues with our unwitnessed falls program. *Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.* All corrective will be completed by 11/11/20.	

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F 684	Continued From page 2 > 6/9/20 at 5:33 a.m., Certified Nurse Assistant (CNA 1) documented, Vitals Result, urine 200 milliliter. No vital signs entered. > 6/9/20 at 7:38 a.m.: LN 1 documented, Resident Progress Notes, "Patient noticed at 6:30 a.m. difficulty breathing and noticed her hand was swollen, then check her spO2 that time her spo2 is 71 [71%] then start the o2 at 2% (sic) [supplemental oxygen at 2 liters] her saturation is 82 [82%], then increase the o2 at 3% (sic) [3 liters], her saturation is 84 [84%], then increase o2 at 5 [5 liters] her saturation is 95 [95%, with 5 liters of supplementary oxygen supply]...to call 911 send the patient to the emergency..." Review of Resident 1's clinical record, Fall Care Plan, initiated on 6/8/20, indicated Resident 1 was at risk for falls. On 6/9/20, the Care Plan indicated nursing staff to start Resident 1's neurological assessment, "Started Neurochecks [Neurological Assessment Flowsheet]" after the fall. Review of a blank Neurological Assessment Flowsheet instructed nursing staff to check the resident every 15 minutes x 4 times for the first hour, then every 30 minutes x 2 times for the second hour followed by every hour x 2 times and so on. The neurological assessments delineated vital signs, level of consciousness, motor function of hand grasp, and pain response to be checked. The flowsheet indicated staff to document the date and time of each assessment. Review of Resident 1's clinical record did not include the Neurological Assessment Flowsheet as indicated in the Fall Care Plan or any documented evidence that Resident 1's neurological status was monitored post fall on	F 684		

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F 684	Continued From page 3 6/9/20. Resident 1's clinical record did not indicate when Resident 1's oxygen saturation started to deteriorate or how long the resident had had shortness of breath prior to her difficulty breathing and her swollen hand noted at 6:30 a.m. Review of the hospital Emergency Room Physician's Notes, [Resident Name] dated 6/9/20, indicated, "...Temp [temperature] (!) 93.9 °F..Resp [respiration] 42...She had low oxygen saturation at the skilled nursing facility and so they transferred her in. On arrival, she [Resident 1] still was working somewhat to breathe...The patient's temperature was also found to be low at 93.9 degrees rectally." In a telephone interview on 8/3/20 at 9:52 a.m., Resident 1's family member stated Resident 1 was transferred to the emergency room after she fell early morning of 6/9/20 and passed on 6/11/20 in the hospital. The family member voiced when Resident 1 arrived at the hospital her body temperature was very low. The family member questioned how long Resident 1 had been on the floor before she was found by staff. The family member expressed her frustration and stated she wondered whether the facility staff made periodic rounds to check the safety of residents in the facility. In a telephone interview on 8/27/20 at 9:22 a.m., the Assistant Director of Nursing (ADON) verified Resident 1's Care Plan for Fall risk that listed neurochecks to be started after the fall on 6/9/20. The ADON stated the facility was not able to locate Resident 1's Neurological Assessment Flowsheet and verified there was no vital signs or LNs Progress Notes documented in the clinical	F 684		

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F 684	Continued From page 4 record between the fall and the hospital transfer. The ADON acknowledged there was a potential for delayed identification of Resident 1's change of condition since it was unknown when and for how long Resident 1 had shortness of breath and/or low oxygen saturation before Resident 1 was noted to have difficulty in breathing at 6:30 a.m. The ADON indicated the facility practice was to provide residents care according to the care plan.	F 684		