

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Rock Creek Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 260 Racetrack Street Auburn, CA 95603	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>49950</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident needs were accommodated for one of six sampled residents (Resident 3), when Resident 3's call light was not within reach.</p> <p>The failure had the potential to result in the resident not attaining her highest practicable physical, psychosocial, and emotional well-being.</p> <p>Findings:</p> <p>Resident 3 was admitted to the facility in June 2024 with multiple diagnoses that included osteoarthritis (deterioration of tissue that lines the joints) and muscle weakness. A review of Minimum Data Set (MDS, and assessment tool), dated 6/11/23, indicated Resident 3 had moderately impaired cognition.</p> <p>During an interview on 7/3/24, at 11 a.m., with Resident 2, Resident 2 stated that her roommate, Resident 3 was unable to push the call light. Resident 2 further stated that she had to push the call light for Resident 3 on multiple occasions. Resident 2 further stated that Resident 3 also had to call out for help when she is unable to push the call light.</p> <p>During a concurrent observation and interview on 7/3/24, at 11:15 a.m., with Resident 3, Resident 3 was lying in bed on her right side facing the wall. Resident 3's call light was wrapped the left side rail and not within reach. Resident 3 stated that she was unable to reach the call light because it was difficult for her to turn side to side.</p> <p>During an interview on 7/3/24, at 11:17 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 confirmed that Resident 3 was unable to reach her call light. CNA 1 stated that, If the resident can't use the call light, they can fall if trying to use the bathroom or get a drink.</p> <p>During an interview on 7/3/24, at 11:50 a.m., with the Infection Preventionist (IP), the IP stated that a resident's needs may not be met if call lights are not within their reach.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light dated 12/23, the P&P indicated .when the resident is in bed or confined to a chair be sure the light is within easy reach of the resident .</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Accommodation of Needs, revised 12/22, the P&P indicated, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning .The resident's individual needs and preferences shall be accommodated to the extent possible .shall be evaluated upon admission and reviewed on an ongoing basis .adaptations may be made to the physical environment .providing access to assistive devices .assisting residents in maintaining independence, dignity and well-being.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>49950</p> <p>Based on interview and record review, the facility failed to follow physician orders to ensure professional standards of quality were maintained for one of six sampled residents (Resident 1), when Resident 1's surgical staples were not removed on the date ordered by the physician.</p> <p>This failure had the potential to cause an infection in Resident 1's wound.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility in April 2024 with multiple diagnoses that included a fracture of the right lower leg and rhabdomyolysis (a breakdown of muscle tissue). A review of the Minimum Data Set (MDS, and assessment tool), dated 4/24/24, indicated Resident 1 was cognitively intact.</p> <p>During a review of Resident 1's Admission Summary Note dated 4/18/24, the Admission Summary Note indicated, .Skin/Head to toe assessment .laceration to right side of forehead, 5 staples in place (Remove in 10-14 days, 4/24-4/28) .</p> <p>During a review of Resident 1's Order Summary dated 4/18/24, the Order Summary indicated, Laceration upper right forehead- 5 staples in place (Remove in 10-14 days, 4/24-4/28).</p> <p>During a review of Resident 1's Care Plan (CP) dated 4/19/24, the CP indicated, .Surgical incision: Resident has a surgical incision laceration to right forehead, and is at risk for dehiscence, delayed healing, infection .</p> <p>During a review Resident 1's Skin/Wound Note dated 5/3/24, the Skin/Wound Note indicated, .5 staples removed from right forehead surgical site .</p> <p>During an interview on 7/3/24, at 11:50 a.m., with the Infection Preventionist (IP), the IP stated that staples are removed by the treatment nurse. The IP further stated that physician orders should be followed.</p> <p>During an interview on 7/3/24, at 1:15 p.m., with the Treatment Nurse (TN), the TN confirmed that there was a physician's order to remove Resident 1's forehead staples between 4/24/24-4/28/24. The TN stated that Resident 1's forehead staples were removed on 5/3/24. The TN further stated that there is a risk for infection if staples are not removed as ordered.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Physician Orders,dated 10/23, the P&P indicated, . the licensed staff shall carry out physician/nurse practitioners' orders as prescribed .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the undated document titled, Nursing Practice Act Rules and Regulations, the document indicated, Article 2. Scope of Regulation 2725 (b). The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following: (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing- Stated of California Department of Consumer Affairs).rvices that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures. (Nursing Practice Act Rules and Regulations Issued by Board of Registered Nursing- Stated of California Department of Consumer Affairs).</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49950</p> <p>Based on interview and record review, the facility failed to ensure pharmacy services were maintained for one of six sampled residents (Resident 2), when Resident 2 did not receive chlorthalidone (a medication used to treat alcohol withdrawal symptoms) according to physician orders.</p> <p>This failure resulted in Resident 2 to have experienced uncomfortable symptoms and had the potential to cause Resident 2 to relapse during alcohol detoxification.</p> <p>Findings:</p> <p>Resident 2 was admitted to the facility June 2024 with multiple diagnoses that included fibromyalgia (a chronic condition involving widespread body pain and tiredness) and alcohol abuse. A review of Minimum Data Set (MDS, an assessment tool), dated 6/28/24, indicated Resident 2 was cognitively intact.</p> <p>During an interview on 7/3/24 at 11 a.m. with Resident 2, Resident 2 stated that chlorthalidone was ordered when she was admitted to the facility. Resident 2 further stated that she did not receive the medication until three days later. Resident 2 further stated, It was not cool; I had a concern there. I needed it (chlorthalidone) to detox. It was hard when I didn't get that medication. They had a doctor's order, so it didn't make sense that they didn't have the medication.</p> <p>During an interview on 7/3/24 at 11:50 a.m. with the Infection Preventionist (IP), the IP stated that three days is an unacceptable time frame to receive medications after being ordered. The IP further stated that residents can have side effects if they do not receive medications when ordered.</p> <p>During a review of Resident 2's Interdisciplinary (IDT) Note dated 6/25/24, the IDT indicated, . Psychotherapeutic Med: Chlorthalidone .</p> <p>During a review of Resident 2's Order Summary dated 6/25/24, Resident 2 had an order for Chlorthalidone Hcl (hydrochloride) oral capsule 5 mg (mg, a unit of measurement) Give 1 capsule by mouth every 24 hours as needed .</p> <p>During a review of Resident 2's Medication Administration Note (MAR) dated 6/26/24, the MAR indicated, . chlorthalidone .awaiting delivery from pharmacy, not in E-kit (emergency kit that contains small quantity of medication that can be dispensed when pharmacy services are not available) .</p> <p>During a review of Resident 2's MAR dated 6/27/24, the MAR indicated, . chlorthalidone .delivery from the pharmacy waiting .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Physician Orders, dated 10/23, the P&P indicated, .the licensed staff shall carry out physician/nurse practitioners' orders as prescribed .</p>		