

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2025
NAME OF PROVIDER OR SUPPLIER  The Pines at Placerville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1040 Marshall Way Placerville, CA 95667	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review, the facility failed to ensure the medical record for one of four sampled residents (Resident 1's) was accurate, consistent and timely when the clinical assessments were contradictory and inconsistent among healthcare professionals. This failure had the potential to lead to incorrect clinical decisions, delays in care and an increased risk of misdiagnosis and inappropriate treatment for Resident 1. Findings: Resident 1 was admitted to the facility in March of 2025 with diagnoses which included heart failure and heart disease from plaque (fat, cholesterol, calcium and other substance inside the walls of the arteries that could cause a blood clot or limit blood flow) buildup. A review of Resident 1's Order Summary Report (ORS), 4/1/25, indicated, Resident has capacity to make his decisions related to. A review of Resident 1's Progress Notes (PN), dated 6/10/25, indicated, Type: IDT [Interdisciplinary Team] NOTE. He [Resident 1] has been observed independently walking throughout facility and is not a risk for contractures; appropriate for D/C [discharge] form [from] RNA [Restorative Nursing Assistant] program at this time. A review of Resident 1's PN dated, dated 6/20/25, The PN indicated, Type: IDT NOTE. OT [Occupational Therapy] conducted AE [Adverse Event] audit; met with resident to assure that they were able to independently and efficiently feed themselves with/without AE. [Resident 1's name] is independent with feeding with/without AE. A review of Resident 1's Nursing - Weekly Summary (NWS), dated 6/29/25, indicated Resident 1 was independent with ADL's (Activities of Daily Living) which included: Bed Mobility, Transfer and Dressing. The NWS also indicated that Resident 1's Oral Intake scored an average of 100%, which means that Resident 1 was consuming all the food and fluids offered to him. A review of Resident 1's NWS, dated 7/27/25, indicated that Resident 1 was independent with ADL's which included Bed Mobility, Transfer and Dressing. The NWS also indicated that Resident 1's Oral Intake scored an average of 100%. The NWS also indicated Resident 1 was alert and oriented to person, place, time and situation indicating full cognitive awareness. A review of Resident 1's NWS, dated 8/3/25, indicated that Resident 1 remains independent with ADL's which included Bed Mobility, Transfer and Dressing. The NWS also indicated that Resident 1's Oral Intake scored an average of 100%, which means that Resident 1 was consuming all the food and fluids offered to him. The NWS also indicated Resident 1 was alert and oriented to person, place, time and situation indicating full cognitive awareness. A review of Resident 1's Care Plan (CP), dated 8/1/24, indicated, Expresses/indicates a preference to: Return home with part time caregiver. Projected stay is expected to be of short duration. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool used in nursing homes), dated 8/2/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating a normal cognitive function and indicated Resident 1 was independent in all Functional Abilities which included eating, toileting, showering, transferring and walking. A review of Resident 1's PN, dated 8/13/25, indicated, Type: Social Service Note. It is noted that this res [Resident 1] does not need or require SNF [Skilled Nursing Facility] level of care, it has been determined he no longer meets the Medicare or Medicaid guidelines for continued nursing home care. During an interview on 8/20/25 at 12:20 p.m., with the License Nurse (LN) 1, LN 1 stated that Resident 1 was independent in performing all ADLs and required assistance only with medication administration. LN 1 further stated that the resident was consistently compliant with his medications. During an interview on 8/20/25 at 12:30 p.m., with the License Nurse Supervisor (LNS), LNS stated that Resident 1 was, Extremely independent and he has his own primary care doctor. During an interview on 8/20/25 at 12:43 p.m. with the Social Services Director (SSD), the SSD stated that Resident 1 was fully independent and did not require SNF level of care. The SSD also stated, He does everything on his own. I explained to them that he does not need this level of care and there are other options that fit his needs. The SSD further described Resident 1 as high functioning. During an interview on 8/20/25 at 1:35 p.m., with Director of Nursing (DON), the DON stated, [Complainant] came to me a couple of months ago and began questioning why the patient does not have physician assessments in his chart. I explained to her that he has a doctor outside of the facility and that he is in total care of [Resident 1's name]. The DON stated, He [Resident 1's primary care physician (PCP)] would call me after hours and explain to me that he will get information to me the next business day, that did not happen. The DON further stated that [Complainant] requested justification for the patient's need for SNF level care. During a telephone interview on 8/21/25 at 2:40 p.m. with the DON, the DON confirmed that Resident 1 was stable and independent, and based on facility documentation and assessments, the resident did not require a SNF level of care. The DON further stated, The facility was also investigating this incident involving his stay since last</p>		

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F 0841  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.  (continued on next page)		

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F 0841  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Based on observations, interviews, and record review, the facility failed to ensure Medical Director provided oversight and coordination of care for one of four sampled residents (Resident 1) when the MD did not step in and resolve differing clinical opinions about whether Resident 1 was ready for discharge. This failure placed the resident at risk for being discharged prematurely or kept unnecessarily in Skilled Nursing level of care and raised concerns for care coordination, accountability and patient safety. Findings: Resident 1 was admitted to the facility in March of 2025 with diagnoses which included heart failure and heart disease from plaque (fat, cholesterol, calcium and other substance inside the walls of the arteries that could cause a blood clot or limit blood flow) buildup. 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