

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER Roseville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1161 Cirby Way Roseville, CA 95661	

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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>50121</p> <p>Based on observation, interview, and record review, the facility failed to provide care according to professional standards for one of three sampled residents (Resident 1) with an indwelling urinary catheter (a thin tube that is inserted into the bladder, held in place by a soft balloon, and used to drain urine) when:</p> <ol style="list-style-type: none"> 1. There was no active physician order for an indwelling urinary catheter nor was the presence of the catheter included in the plan of care or weekly summary notes. 2. There was no documented evidence of care and management of the urinary catheter and drainage bag according to professional standards. 3. Resident 1's urine collection bag was observed lying on the floor with no privacy cover. <p>These failures, individually and collectively, had the potential for Resident 1 to develop a urinary tract infection (an infection in the system of organs that make urine) which can result in pain, fever, and confusion.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated Resident 1 was admitted in September 2023 with diagnoses including dementia (impaired ability to remember, think, or make decisions), senile degeneration of the brain (progressive decline in memory, language, and problem-solving skills), and type 2 diabetes (a disease that affects the way the body processes sugar).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 4/11/24, the MDS indicated Resident 1 had moderate cognitive impairment (difficulty remembering things, making decisions, concentrating, or learning). The MDS indicated Resident 1 had no indwelling urinary catheter and was frequently incontinent of urine.</p> <p>During a review of Resident 1's Medication Administration Record (MAR), dated July 2024, the MAR indicated an MD order on 7/2/24, for catheterization one-time for retention and to collect a urine specimen. Administration notation indicated that the order was held on 7/3/24 at 9:23 p.m., and to see nurse notes per administration key.</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Nurse's Note (NN), dated 7/3/24 at 6:37 a.m., the NN indicated a licensed nurse offered to place a catheter three times, and the resident refused.</p> <p>During a review of Resident 1's NN, dated 7/3/24 at 12:23 p.m., the NN indicated that a Foley catheter (type of indwelling urinary catheter) with a balloon was inserted, and a sample of urine was obtained.</p> <p>During a review of Resident 1's care plan, last revised 7/11/2024, the care plan did not indicate that Resident 1 had an indwelling urinary catheter, and did not include interventions to manage an indwelling urinary catheter according to professional standards to prevent a urinary tract infection. The care plan did not indicate any updates to Resident 1's focus area of mixed bladder incontinence (lack of control over emptying the bladder).</p> <p>During a review of Resident 1's Nursing Weekly Summary Notes, dated 7/13/24 and dated 7/20/24, the Nursing Weekly Summary Notes indicated that Resident 1 was incontinent and in briefs. There was no documented evidence of an indwelling urinary catheter.</p> <p>During an observation on 7/22/24, at 9:50 a.m., in Resident 1's room, the urinary drainage bag, which was connected to the indwelling urinary catheter was on the floor. This increases the potential for dirt and germs to enter the bag through the drainage spout. The urine drainage bag was without a privacy cover, which is used to conceal the draining urine from public view and protect the dignity of the resident.</p> <p>During an interview on 7/22/24, at 9:55 a.m., with Certified Nurse Assistant (CNA), CNA confirmed that the bag was on the floor and stated, The bag should be covered.</p> <p>During an interview on 7/22/24, at 11:10 a.m., with the Infection Preventionist (IP), the IP stated that the indwelling urinary catheter bag should be covered, never be above the bladder, and should never rest on the floor. IP stated that these practices were needed to prevent urinary tract infections.</p> <p>During an observation and interview on 7/22/24 at 11:45 a.m., in Resident 1's room, Resident 1's urinary drainage bag had a privacy cover but was still resting on the floor.</p> <p>During an interview on 7/22/24, at 12:01 p.m., with Licensed Nurse (LN), LN confirmed Resident 1 had an indwelling urinary catheter. LN listed the care required for a resident with an indwelling urinary catheter as monitoring urinary output, cleaning around the catheter with soap and water every shift, and if leaking or clogged, flushing or replacing it. When asked to find these orders for the catheter, LN could not find them and stated, [Resident 1] doesn't have an order. Strange. LN stated that she could not find documentation of care or monitoring provided for Resident 1's indwelling urinary catheter. LN further stated that the urine collection bags should be covered and should not be on the floor. LN stated that if care was not completed as stated, the resident could develop an infection.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review of Resident 1's medical record on 7/22/24, at 12:12 p.m., with the Director of Nursing (DON), the DON stated there was no active physician order for an indwelling urinary catheter for Resident 1. In addition, the DON stated that the indwelling urinary catheter was not in Resident 1's care plan and that there was no documentation of care and monitoring of the catheter. The DON stated that inserting and maintaining an indwelling urinary catheter required a physician order. The DON stated that the initial catheter order would trigger a set of orders to address the care and monitoring of the catheter. The DON stated that urinary catheter bags should be covered and never on the floor. The DON stated that failure to follow these practices can lead to increased risk for infection.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Indwelling Catheter Insertion, Female Resident, dated August 2022, the P&P indicated, Verify that there is a Physician's order, and, Report information in accordance with facility policy and professional standards of practice.</p> <p>During a review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the policy indicated, .care plans are revised as information about the residents and the residents' conditions change.</p>		