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	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Creek Care Center	1139 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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs for three out of eight sampled residents (Resident 5, Resident 6, and Resident 7) when:1. Resident 5 and Resident 6's call light buttons were not within their reach; and,2. Resident 7's call light system was broken and was not provided with an alternative call system.This failure placed Resident 5, Resident 6, and Resident 7's safety at risk and had the potential for the residents' needs not to be met.Findings:1a. A review of Resident 5's clinical record indicated Resident 5 was admitted February of 2026 and had diagnoses that included fracture (a break in the continuity of a bone) of the neck bone and dementia (memory loss that interferes with daily functions).A review of Resident 5's physician's order, dated 2/9/26, indicated Resident 5 had no capacity to make decisions.A review of Resident 5's care plan, dated 2/9/26, indicated, [Resident 5] is at risk for falls with or without injury related to .fracture .altered mental status .Keep call light within reach.During a concurrent observation and interview on 2/9/26 at 12:50 p.m. with Resident 5, in Resident 5's room, Resident 5 was observed lying on his bed, awake, wearing a neck brace, and his call light button was on the floor, under the bottom of his bed. Resident 5 stated he did not know where his call light button was at.During a concurrent observation and interview on 2/9/26 at 1:25 p.m. with Certified Nurse Assistant (CNA) 1, in Resident 5's room, CNA 1 confirmed that Resident 5's call light button was on the floor, under the bottom of his bed. CNA 1 stated the call light button should be placed near Resident 5 where he could reach it so Resident 5 could call for help in case of emergency or if he needs any assistance.1b. A review of Resident 6's clinical record indicated Resident 6 was admitted August of 2023 and had diagnoses that included diabetes (elevated sugar in the blood) with polyneuropathy (a condition characterized by damage to multiple peripheral nerves causing numbness, burning pain, and muscle weakness) and retinopathy (a serious, progressive eye disease causing blurred vision and potential blindness, abnormalities of gait and mobility, and muscle weakness.A review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 11/19/25, indicated Resident 6 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 6 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 6's MDS Functional Abilities, dated 11/19/25, indicated Resident 6 needed partial/moderate assistance with toileting hygiene, shower/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. A further review of Resident 6's MDS Functional Abilities indicated Resident 6 needed setup or clean-up assistance with lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer, and needed substantial/maximal assistance with tub/shower transfer and walking.A review of Resident 6's care plan, revised 11/22/23, indicated, Falls: [Resident 6] is at risk for falls with or without injury elated [sic] to .repeated falls .A review of Resident 6's care plan intervention, dated 8/19/23, indicated, Keep call light within reach. A review of Resident 6's care plan intervention, dated (continued on next page)

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/6/26, indicated, Educate/remind resident to call for assistance with all transfers.During a concurrent observation and interview on 2/9/26 at 1:30 p.m. with Resident 6, in Resident 6's room, Resident 6 was observed lying on her bed, awake, and her call light button was on the floor, under the bottom of her bed. Resident 6 stated she could not reach her call light button at the moment.During a concurrent observation and interview on 2/9/26 at 1:46 p.m. with CNA 2, in Resident 6's room, CNA 2 confirmed that Resident 6's call light button was on the floor, under the bottom of her bed and the call light chord was stuck on the bed frame. CNA 2 stated Resident 6 was able to use call light button. CNA 2 also stated Resident 6's call light button should always be within her reach so she could call if she needed help with anything. CNA 2 further stated there would safety issues like risk for falls if Resident 6 would not be able to call for help when she needs assistance.2. A review of Resident 7's clinical record indicated Resident 7 was admitted in August of 2025 and had diagnoses that included fracture of left upper arm, diabetes, muscle weakness, and congestive heart failure (a condition in which the heart cannot pump oxygen-rich blood efficiently to the rest of the body).A review of Resident 7's MDS Cognitive Patterns, dated 12/4/25, indicated Resident 7 had a BIMS score of 13 out of 15 which indicated Resident 7 had an intact cognition. A review of Resident 7's MDS Functional Abilities, dated 12/4/25, indicated Resident 7 needed substantial/maximal assistance with toileting hygiene, shower/bathing self, upper and lower body dressing, and putting on/taking off footwear, and needed partial/moderate assistance with personal hygiene. A further review of Resident 7's MDS Functional Abilities indicated Resident 7 needed supervision or touching assistance with rolling left and right, sit to lying, and lying to sitting on side of bed, and needed partial/moderate assistance with sit to stand, chair/bed-to-chair transfer, and toilet transfer.A review of Resident 7's care plan, revised 8/28/25, indicated, Falls: [Resident 7] is at risk for falls with or without injury related to .Fx [fracture], Fall hx [history] .heart failure .Educate/remind resident to call for assistance with all transfers .Keep call light within reach.During an interview on 2/9/26 at 1:46 p.m. with CNA 2, CNA 2 stated Resident 7's call light usually gets broken and would not work. CNA 2 further stated staff would try to fix Resident 7's call light but then it would get broken again.During an interview on 2/9/26 at 2:05 p.m. with Resident 7, at the therapy room, Resident 7 stated he just recently got transferred to his room, but he feels annoyed and he does not feel comfortable staying in his room because his call light has been broken since last Thursday [2/5/26]. Resident 7 further stated facility staff were aware that his call light button was broken but had not fixed it.During a concurrent observation, interview, and record review on 2/9/26 at 2:14 p.m. with CNA 3, in Resident 7's room, CNA 3 checked and confirmed that Resident 7's call light system was broken, and Resident 7 was not provided with an alternative call system. CNA 3 stated she was not aware that Resident 7's call light was broken. CNA 3 also stated Resident 7 should be provided with a functioning call system because Resident 7 should always be able to call for assistance and in cases of emergency, Resident 7 should be able to call for help. CNA 3 further stated they would write in the maintenance logbook or directly call the maintenance staff if a facility equipment was broken. The Maintenance Logbook was then reviewed and CNA 3 confirmed that there was no report that Resident 7's call light has been broken. During a concurrent observation and interview on 2/9/26 at 2:23 p.m. with the Maintenance Supervisor (MS), in Resident 7's room, the MS checked and confirmed that Resident 7's call light system was broken and stated he needs to replace it. The MS stated a staff told him this morning that Resident 7's call light was broken but he has not fixed it.During an interview on 2/9/26 at 4:50 p.m. with the Director of Nursing (DON), the DON stated she would expect that residents would be provided with a working call light system and it should be placed within the reach of the residents. The (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON further stated there would be safety concerns if residents' call lights were not working or not within their reach.A review of the facility's policies and procedures titled, Answering the Call Light, dated 10/2010, indicated, 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .7. Report all defective call lights to the nurse supervisor promptly.