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	07/23/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to follow the discharge process for one of three sampled residents (Resident 1), when Resident 1 was transferred to an acute hospital and Resident 1's Responsibility Party (RP) was not informed of intent to discharge the resident or provided with notice of bed-hold.This failure resulted in Resident 1 being denied return to the facility causing disruption of care. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in June 2025 with multiple diagnoses including metabolic encephalopathy (a change in brain function due to a systemic illness affecting the body's metabolism), dementia with behavioral disturbance (loss of memory and brain function with symptoms including agitation, aggression, psychotic symptoms, and mood changes), and enterocolitis due to clostridium difficile (bacterial infection of the bowel that can cause inflammation and diarrhea). A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 7/4/25, indicated Resident 1 had Brief Interview for Mental Status (BIMS- tool to assess cognition) of 4 out of 15, that indicated Resident 1 had severe cognitive impairment. A review of Resident 1's MDS, Behavior, dated, 7/4/25, indicated Resident had delusions (belief that is persistently held but is untrue) and had behavioral symptoms including hitting, scratching, rummaging, smearing bodily wastes that put Resident 1 at risk for physical injury, interfered with care, and put others at risk for injury. A review of Resident 1's Order Summary Report indicated order dated 7/18/25 .Send Resident to acute on 7/18/25 due to increased behaviors resulting in concerns for safety . A review of Resident1's Order Summary Report indicated order dated 7/12/25 .Please call [Resident 1's RP] if patient refuses labs or medication, or becomes agitated or combative . A review of Resident 1's Order Summary Report indicated order dated 6/27/25 .Seroquel [antipsychotic medication used to improve mood, thoughts and behaviors] .Give 6.25 mg [milligrams] by mouth at bedtime for hospital delirium [change in mental abilities resulting in lack of awareness of surroundings] MB [manifested by] agitation/inability to sleep causing distress to self . A review of Resident 1's Change in Condition Evaluation, dated 7/18/25 indicated .patient has been combative, not following directions, not cooperative with care; patient wondered [sic] into other patients' rooms, eating their food or took their drink; patient wonders [sic] into nurses station and starts to open peoples' hand bags and takings thingsout [sic] .Recommendations of Primary Clinician(s) . [name of physician] and management are informed with order to send patient to acute care. Management stated that [RP] has been informed about the transfer .A review of Resident 1's Notice of Proposed Transfer/Discharge, dated 7/18/25, indicated . Transfer/Discharge Reasons .The transfer or discharge is necessary for the resident . A review of Resident 1's Progress Notes, Type: Physician Progress Note, dated 7/18/25, indicated .The patient was very agitated and screaming and shouting at the nursing staff, and case was discussed with the [RP] also that we increase the dose of Seroquel, but the patient was non-compliant and the daughter was also refusing any interventions. So it was suggested that the patient is not safe here and need to go to acute care facility because of safety concerns. So the patient was sent to acute care facility as the patient was non-compliant and the [RP] was also non-compliant with the treatment plan .With underlying cognitive impairment with dementia .Patient and family both refusing to increase the dose of Seroquel. Patient need to go to acute care facility for further evaluation . A review of Resident 1's Progress Note, Type: Nurse's Note, dated 7/18/25 at 12:55 p.m., indicated .Received orders from [name of physician] to increase patients Seroquel from 6.25mg to 12.5mg due to increased behavioral issues. Patient has been combative, hitting care staff, throwing things at other patients, eating other patients food and hard to reorient and redirect. Patient's [RP] notified by charge nurse of increasing agitation this morning .called patient's [RP] to relay doctors order . writer notified her of .order to increase Seroquel from 6.25mg to Seroquel 12.5mg . or send patient to acute for increasing agitation and combativeness for patients/care staff safety if family not agreeable to medication changes. [RP] refused medication changes and was notified patient would be sent to acute for safety purposes . A review of Resident 1's Progress Note, Type: Nurse's Note dated 7/18/25 at 10:27 a.m., indicated .Called [RP] back at 10:42am .and explained to her .resident is still agitated and hitting staff members and going into other Resident's rooms . a safety risk -for our residents and our staff . [RP] was agreeable at this time and said she will be in the facility shortly to help with agitation and well as speak with [name of physician] of the POC [plan of care] going forward .Called [name of physician] .informed him of the above behaviors-he stated we could either 1-Increase Seroquel to 12.5 mg per dose. 2- Send resident out to acute for further evaluation due to increased agitation . [RP] was not agreeable to all options .Send out to acute was initiated due to safety