

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 555206	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2020
NAME OF PROVIDER OF SUPPLIER BOULDER CREEK POST ACUTE		STREET ADDRESS, CITY, STATE, ZIP 12696 MONTE VISTA ROAD POWAY, CA 92064	
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 0656 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide personal catheter (device to drain urine) care, and monitor for signs of infection every shift per the plan of care for one of two sampled residents (1). As a result, Resident 1 had an increased risk of infection. Findings: Per the facility's Admission Record, Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Per the facility's Order Summary Report, dated 3/29/20, Resident 1's physician orders [REDACTED]. The facility's Treatment Administration Record, dated 5/1/2020 - 5/31/2020 was reviewed. The area marked Foley catheter care with soap and water every shift and monitor indwelling catheter site every shift for signs and symptoms of infection, for the night shift of 5/13/20 and 5/14/20 was not signed as completed. On 6/4/20 at 8:52 A.M., a telephone interview was conducted with LN 1 (Licensed Nurse). LN 1 stated, if she did not sign the Treatment Administration Record for Foley catheter care with soap and water or monitor indwelling catheter site for signs and symptoms of infection, then it meant she did not complete the tasks. LN 1 further stated, if she did not complete the tasks, it was because she was too busy on those shifts. On 6/5/20 at 10:30 A.M., a telephone interview was conducted with the DON (Director of Nursing). The DON stated, when the LNs signed the treatment record it was evidence they completed the task. Per the facility's policy, titled Catheter Care, Urinary, revised September 2014, .Documentation; The following should be recorded in the resident's medical record: 1. The date and time that catheter care was given . 8. If the resident refused the procedure, the reason(s) why and the intervention taken . Per the facility's policy, titled Physician Services, revised April 2013, . 4. Physician orders [REDACTED].		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE (X6) DATE	

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.