STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055886	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSEVILLE CARE CENTER	**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)
F 0687 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record and document review, the facility failed to maintain Resident 1's toenails at an appropriate length and provide documented evidence foot and nail care occurred regularly by facility staff or podiatrist. This failure to provide regular nail trimming and foot care put Resident 1 at an increased risk of injury or infection. Findings: According to the Face Sheet (Admission Profile), Resident 1 was admitted to the facility in January of 2020 with cognitive deficits and a need for assistance with personal care; Resident 1 was not a diabetic (someone with high blood sugar). Resident 1 spent 6 months at the facility and was discharged at the end of July 2020. During an interview with Family Member 1 (FM 1) on 8/27/2020 at 1:30 p.m., FM 1 stated that on the day of discharge, Resident 1's toenails were in poor condition. FM 1 specified the toenails were too long and appeared as though Resident 1 had not received any recent nail care. FM 1 recalled that during her stay at the facility, Resident 1 complained of pain in one of her toes. At the same time, a bruise was identified under the nail of Resident 1's left great toe. FM 1 continued, staff were notified of the bruised nail bed and made an assessment. You'd think (facility staff) would have noticed the condition of her other toenails then, FM 1 stressed. FM 1 provided the Department with photographs of Resident 1's toes taken shortly after discharge. The left great toenail appeared dry and cracked. A purplish black discoloration was observed at the base of the nail bed. The nail edge was unevenly shaped, with one side long enough to catch on a sock or blanket. The photo further revealed the toenails of the other four toes were of varying lengths and extended well beyond the tips of each toe (claw-like). Similarly, the photo of the right foot revealed long, dry toenails. The tip of the right great toenail appeared unevenly shaped and rough, as though the edge had been peeled away, not cut. Two sharp-edged (appearing) toenails extended well beyond the tip of each toe (claw-like). According to a 2010 facility policy and procedure titled, Care of Fingernails/Toenails, Nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .Stop and report to the nurse supervisor .if nails are are too hard or too thick to cut with ease. The following information should be recorded in the resident's medical record: 1. The date and time the nail care was given. 2. The name and title of the individual (s) who administered the nail care. 3. The condition of the resident's nail and nail bed .4. Any difficulty in cutting the resident's nails. 5. Any problems or complaints made by the resident with his/her hands or feet 6. If the resident refused treatment, the reason(s) why and the intervention taken. and 7. The signature and title of the person recording the data. A review of the July 2020 Physician order [REDACTED]. The order was initiated 2/20/2020. Resident 1 also had a recurring order for,Consult-Podiatry as needed for mycotic (infected with fungus)/[DIAGNOSES REDACTED] (thick) nails . In an interview with Licensed Nurse 1 (LN 1) on 9/8/2020 at 12:50 p.m., LN 1 explained the Certified Nursing Assistants (CNAs) assess the residents' toenails on shower days, which are twice a week. The CNAs can trim resident toenails, LN 1 said, if the nails are easy to cut, and the resident is neither diabetic nor at risk of bleeding. Otherwise, a podiatrist must trim the nails. LN 1 acknowledged the importance of keeping toenails short and maintaining nail integrity. Toenails that are too long may be bumped and cause injury to the resident, LN 1 said, the nail may catch on something and come off. Documentation of toenail care or treatment was limited to the assessment and monitoring of the discoloration to Patient 1's left great toe, identified 7/3/2020. Despite request, the facility was unable to provide documented evidence that foot care and/or treatment, such as toenail trimming, was performed by facility staff, or a podiatrist, during Resident 1's 6 month stay.

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.