STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055039	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Rehab and Care Center	1630 N. Edison Street Stockton, CA 95204

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview, and record review, the facility failed to provide pain management consistent with professional standards of practice for one of one sampled resident (Resident 1) who experienced severe pain when:1) Pain medication was not administered consistent with the physician's orders and reported pain levels,2) Resident 1's physician ordered narcotic (a strong medicine that relieves severe pain and has a high addiction potential) pain medication was not available; and,3) The physician was not notified when Resident 1 reported uncontrolled severe pain (high-level pain). This failure caused Resident 1 to endure unnecessary pain and suffering and placed the resident at risk for prolonged discomfort, emotional distress, and decreased quality of life. Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with a diagnosis of, but not limited to chronic pain syndrome (long-lasting pain that continues even after the original injury or illness has healed), acquired absence of limb (something that develops later in life, not something you were born with), peripheral vascular disease (PVD - poor blood flow to the arms or legs due to narrowed or blocked vessels), pressure ulcer of unspecified site (bed sores caused by pressure, but the exact body location is not clearly identified), chronic cholecystitis (long term inflammation of the gallbladder) and end stage renal disease (ESRD - the final stage of chronic kidney disease).Review of Resident 1's Order Summary Report, dated 1/23/26, in the section titled, Order Summary, indicated, .Acetaminophen [Tylenol, a pain medicine] Oral Tablet 325 MG [mg -milligrams, a unit of measure] Give 2 tablet by mouth every 6 hours as needed for MILD PAIN [low-level pain, a score of 1-3 on a 0-10 numerical rating scale].Oxycodone [a strong prescription pain medicine]-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth two times a day for SEVERE PAIN [as a level 7 to 10 on a 0-10 pain scale, representing pain that is disabling, dominates your senses, and prevents you from performing normal daily activities].Review of Resident 1's Care Plan Report, dated 1/23/26, in the section titled, Focus, indicated, .[Resident 1] is on pain medication therapy, Hydrocodone [a strong prescription pain medicine] r/t [related to] disease process, ESRD, PVD, multiple wounds . In the section titled, Goal, indicated, .[Resident 1] will be free of any discomfort.through the review date. In the section titled, Interventions, indicated, .Administer ANALGESIC [a medicine that relieves pain] medications as ordered by physician.Ask physician to review medication.assess whether pain intensity acceptable to resident [Resident 1].Controlled adequately by therapeutic regimen.or changed regimen required.but pain control not adequate, changes required .Review of Resident 1's clinical record titled, NURSING PROGRESS NOTE, dated 1/23/26, indicated, .Open sores to Coccyx [the tailbone], R [right] buttocks, L [left] knee, and L [left] fibula [the smaller bone on the outer side of your lower leg].Gangrene [when part of the body's tissue dies because it does not get enough blood] to R [right] second digit, AKA [above knee amputation - surgical removal of a body part] to R [right] leg and BKA [below knee amputation] to L [left] leg.[Resident 1] expresses 10/10 pain [severe pain]. Offered PRN [as needed] acetaminophen, but pt [patient - Resident 1] refused and states, that shit will do nothing. [Resident (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1] made aware that his oxycodone will come tonight with pharmacy delivery.Review of Resident 1's clinical record titled, NURSING PROGRESS NOTE, dated 1/27/26, indicated, .Open sores to sacrum [the large, triangular bone at the base of the spine, just above the tailbone], L knee, and L fibula.Gangrene to R second digit, AKA to R leg, and BKA to L leg. Resident [Resident 1] expresses 10/10 pain. Charge Nurse administered PRN [as needed] Tylenol.Review of Resident 1's clinical record titled, NURSING PROGRESS NOTE, dated 1/27/26, indicated, .Pt [Patient - Resident 1] observed yelling/screaming and stating he is in extreme pain, rated 10/10.PRN Tylenol administered at 2100 [9 PM] with no relief reported.Scheduled oxycodone.were due at 2100; however, medications, were not delivered by [Name of Pharmacy]. [Name of Pharmacy] on-call was contacted to request authorization to obtain medications from the narcotic E-kit [emergency kit] due to pt's [patient's - Resident 1] severe pain.on-call stated they were unable to provide clearance .Pt [Patient - Resident 1] continues to report severe pain.Review of Resident 1's clinical record titled, NURSING PROGRESS NOTE, dated 1/28/26, indicated, .Pharmacy staff [Name of staff] reported that the C-II form [a special prescription form used for strong, highly controlled medications] was mistakenly faxed to the wrong physician and stated it would be re-faxed.Discussion held regarding the possibility of obtaining medication from the E-kit due to the patient's [Resident 1] severe pain. Patient [Resident 1] has been screaming in pain since admission. Pharmacist [Name of Pharmacist] stated she could authorize E-kit use if physician provided a verbal order.During a concurrent interview and record review on 2/25/26, at 1:26 PM, with licensed nurse (LN) 3, Resident 1's electronic health record (EHR) was reviewed. LN 3 stated staff managed pain by first assessing the resident's pain level, reviewing the physician's pain medication orders, and administering the medication as ordered. LN 3 further stated that after giving the medication, staff reassessed the resident to determine if the medication was effective and notified the physician when necessary. LN 3 reviewed Resident 1's Medication Administration Record (MAR - a written or electronic chart that tracks what medicines a person receives) for 2/1/26 through 2/28/26. LN 3 confirmed that she administered Acetaminophen 325 mg, two tablets by mouth every six hours as needed for mild pain, on 2/13/26, 2/18/26, and 2/19/26. On those dates, Resident 1 reported severe pain scores of 10 on 2/13/26, 10 on 2/18/26, and 8 on 2/19/26. LN 3 acknowledged that these pain scores indicated severe pain and did not match the physician's order, which specified the medication for mild pain only. LN 3 stated that she should have contacted the physician to provide an update on Resident 1's severe pain and request a new order to address the severe pain. LN 3 further stated that Resident 1 had multiple wounds and chronic pain syndrome, and even minor movement caused significant pain. LN 3 acknowledged that nurses needed to address Resident 1's pain promptly instead of waiting for the physician to come to the facility, to ensure appropriate pain management.During a concurrent interview and record review on 2/24/26, at 2:20 PM, with the Director of Nursing (DON), Resident 1's EHR was reviewed. The DON confirmed that Resident 1 had been prescribed Oxycodone-Acetaminophen Oral Tablet 10-325 MG, to be taken by mouth twice daily for severe pain, and Acetaminophen Oral Tablet 325 MG, to be taken by mouth two tablets every six hours as needed for mild pain. The DON stated that mild pain meant a resident reported a pain score between 1 and 3 out of 10, moderate pain meant a score between 4 and 6 out of 10, and severe pain meant a score between 7 and 10 out of 10. The DON further stated that Resident 1 did not have a doctor's order for pain medication to treat moderate pain. The DON explained that she expected licensed nurses to assess Resident 1's pain, contact the doctor, review current pain medication orders, and request medication specifically for moderate pain.During a concurrent interview and record review on 2/25/26, at 3:47 PM, with LN 1, Resident 1's nursing progress notes dated 1/23/26 and 1/27/26, which documented Resident 1's admission and re-admission were (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed. LN 1 stated that on 1/23/26, Resident 1 reported severe pain rated 10 out of 10 and Resident 1 did not receive his prescribed oxycodone because the pharmacy did not deliver the medication. LN 1 further stated that on 1/27/26, she observed Resident 1 yelling and screaming in extreme pain, which he rated as 10 out of 10. LN 1 stated Resident 1 again did not receive his prescribed oxycodone because the pharmacy did not deliver the medication, and the facility did not obtain authorization to access the emergency medication kit. LN 1 further stated that staff did not manage Resident 1's pain effectively because ongoing issues with obtaining oxycodone occurred during both his initial admission and his re-admission.During an interview and record review on 2/25/26, at 4:32 PM, with LN 2, Resident 1's MAR for 1/1/26 through 1/31/26 was reviewed. LN 2 confirmed that she administered Acetaminophen Oral Tablet 325 mg, two tablets by mouth every six hours as needed for mild pain, on 1/28/26 and 1/29/26. On those dates, Resident 1 reported pain scores of 6 on 1/28/26 and 5 on 1/29/26, which indicated moderate pain. LN 2 acknowledged that the physician ordered Acetaminophen 325 mg was for mild pain only. LN 2 stated that she should have reviewed the pain medication orders, reassessed Resident 1's pain level, and contacted the physician to clarify and obtain clear as-needed orders for mild, moderate, and severe pain.During an interview on 2/25/26, at 5:28 PM, with the DON, the DON stated that pain management for Resident 1 was a concern.During an interview on 2/26/26, at 2:12 PM, with the Pharmacist (PH) 1, PH 1 stated the pharmacy received Resident 1's oxycodone order dated 1/23/26. PH 1 further stated that the pharmacy could not dispense the oxycodone until it received a completed Schedule II (C-II) prescription from the physician. PH 1 stated the delay in receiving the completed prescription contributed to the delay in providing pain medication to Resident 1.During an interview on 2/26/26 at 4:30 PM, with the Pharmacist (PH) 2, PH 2 stated that she was not aware of, and was not contacted about, Resident 1's oxycodone concerns. PH 2 further stated that if the facility had contacted her, she could have reviewed the situation, made recommendations, or contacted the dispensing pharmacy to determine the reason for the delay in the oxycodone. PH 2 acknowledged that the facility failed to ensure the availability of the ordered narcotic medication and that Resident 1's severe pain remained untreated as a result.Review of an undated facility policy and procedure (P&P) titled, POLICY AND PROCEDURE ON PAIN ASSESSMENT, indicated, Policy: It is the policy of this facility to assess for pain and provide for patient care services to ensure resident's comfort.For those residents with complaints of pain, further assessment of pain is necessary to determine appropriate interventions to manage pain.Review of an undated facility P&P titled, POLICY AND PROCEDURE ON PAIN MONITORING DURING CARE AND TREATMENT, indicated, .Charge Nurse should review physician order for any order of pain medication administration.Call physician if there is no order for pain medication.Monitor for effectiveness of pain medications and call physician if pain medication is ineffective.Document pain assessment and effectiveness of intervention.