STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Canyon Healthcare Center	1391 Madison Avenue El Cajon, CA 92021

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46982 Based on observations, interviews, and record review, the facility failed to ensure effective pain management services were provided to residents when two of four residents (1, 2) complained of inadequately controlled pain. This failure resulted in psychological harm when the residents experienced unrelieved pain. Findings: Resident 1 was admitted to the facility on [DATE], with diagnoses that included: Type 2 diabetes (a chronic condition of the body's inability to regulate blood sugar levels) with diabetic polyneuropathy (a complication of diabetes affecting nerves in the body, causing sensations of numbness, stabbing pain, burning, tingling or pricking, and can cause insensitivity to temperature changes); other chronic pain. Resident 2 was admitted to the facility on [DATE], with diagnoses that included: other acute (recent) osteomyelitis, (bone infection) right ankle and foot; acute embolism and thrombosis (blood clot blocking vein) of left axillary (upper arm) vein; chronic (over 6 weeks) embolism (a sudden blocking of an artery) and thrombosis (a blood clot within blood vessels) of deep veins of right upper extremity. On 8/9/24 at 10:47 A.M. Resident 2 was interviewed. Resident 2's left arm was swollen and up on pillows for comfort. Resident 2 states she is doing well except for the pain of her arm. Resident 2 stated she takes norco (a narcotic pain reliever) and she can have one pill every four hours if she asked. Resident 2 also stated she would like two pain pills at night to sleep because the pain was so bad and it woke her up at night. Resident 2 stated she bought over the counter Tylenol PM, three times, and staff took it from her bedside. Resident 2 stated no one asked about managing her pain so she can sleep better. Resident 2 reported her pain at 10 on a 1/10 scale, and the pain had been constant since she arrived at the facility. On 8/9/24 at 11:35 A.M., Resident 1 was interviewed. Resident 1 stated he had waited up to three hours for pain medication. Resident 1 said the nurses did not re-order the medication in time, and they run out of his pain medication. Resident 1 stated he received morphine (a strong pain relieving narcotic) twice a day, with dilaudid (a narcotic for pain relief) as needed. Resident 1 stated warm water in the shower also works very well, he would need less pain pills if he could be in the shower three times a week. (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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	055064	A. Building B. Wing	08/13/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/9/24 at 2 P.M. an observation and interview was held with licensed nurse (LN) 1. LN 1 stated there were three ways of re-ordering medication: Call or fax the pharmacy, or order through the computer system. LN 1 stated ordering through the computer was 100% guaranteed not to get the medication. LN 1 stated she called for the order every time. The medications of morphine and dilaudid for Resident 1 were viewed with LN 1; 60 tablets of dilaudid were delivered on 7/26, and 38 tablets were left. Morphine, 60 pills were delivered on 8/1, and 46 were left. LN 1 stated Resident 1 usually takes 1 dilaudid with the morning morphine, and does not ask again on the shift. On 8/12/24 at 1:45 P.M., the pharmacy technician (PharmT) was interviewed regarding refill process specifics for Resident 1. Resident 1's dilaudid medication was re-ordered 7/23/24 and filled on 7/26/24. The delay occurred due to not having a current prescription signed by the physician. Resident 1's Morphine was re-ordered on 7/23/24 and an emergency supply of 14 pills were sent on 7/26/24. On 7/29/24 the morphine was re-ordered, and a supply of 60 was sent 8/1/24. The Pharm T stated narcotics need to be manually re-ordered, and allow time for processing 3-5 days. On 8/12/24 at 2:10 P.M., LN 2 was interviewed. LN 2 stated that refills were requested for pain medications when the last row of the card was reached and observed to be 7 pills on a medication card. LN 2 stated if a resident was requesting pain medication more frequently, he would order sooner. LN 2 stated effectiveness was assessed by following up with the resident after giving the medcation. If a resident was asking for medication frequently, LN 2 stated he might have asked more about the location of the pain, but would not ask too many questions, because LN 2 did not want the resident to think they were not believed. LN 2 stated they did not report frequent pain complaints to the RN (Reistered Nurse) or MD (Medical Doctor). On 8/12/24 at 2:30 P.M., LN 3 was interviewed. LN 3 stated she would re-order pain medication depending on the use of the resident. If a resident is requesting every 4 hours, I would send the request for refill with 15 pills left. Sometimes we run out, and the refill has not been processed, so I call the pharmacy for an authorization to pull the medication from the emergency supply kit. On 8/9/24 at 12:27 P.M., a record review was conducted of Resident 1 and Resident 2's electronic record. The pain medications for Resident 1 included: Gabapentin 600mg four times daily for neuropathy (also called peripheral neuritis - weakness, numbness and pain from nerve damage); Baclofen 5mg twice daily for muscle spasms; Morphine 30mg Extended Release tablet, every 12 hours for chronic pain; dilaudid 4 mg every four hours as needed for pain. The signed e-MAR (medication administration record) for July and August 1 - 12 were reviewed and indicated, Gabapentin was not given on 7/7 at 5 P.M.; 7/17 at 5 P.M., 7/30 at 9 P.M., 8/1 at 5 P.M. and 9 P.M., 8/2/24 at 5 P.M. The Baclofen was given as ordered. Resident 1 was not given ordered Morphine on 7/25/24 at 8 P.M. and again on 7/26/24 at 8 A.M. On 8/12/24 at 3 P.M. a concurrent record review and interview was held with the Assistant Director of Nursing (ADON). The resident notes (emar progress notes) for Resident 1 were reviewed. The medication Gabapentin (for neuropathy) was ordered 600mg tablet four times a day, at 9 A.M., 12 P.M. (noon); 1700 (5 P.M.); and 2100 (9 P.M.). On 7/3/24 at 5 P.M., the medication was not given not variable (sic); on 7/17/24 at 5 P.M., not given, not available. On 7/4/24, a note indicated that dilaudid was taken from the e-kit authorized by (Pharmacy). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's morphine order was reviewed with the ADON: Morphine Sulfate ER Oral tablet, 1 tablet by mouth every 12 hours for chronic pain. The morphine was scheduled to be given at 8 A.M. and at 8 P.M. On 7/25/24 at 8 P.M. Resident 1's Morphine was not given and indicated, waiting on pharmacy delivery. On 7/26/24 at 8 A.M., Resident 1's morphine was not given and indicated, waiting on pharmacy delivery. On 7/26/24 at 8 A.M. another pharmacy note reflected that one time pull per pharmacy, done last night for dilaudid. The ADON stated that the physician was usually alerted if a medication was not available, or a prescription needed to be signed. The ADON stated the issue was followed up the next day. There should not be any missed doses, and it was the responsibility of the LN to order at the correct timing for a refill. If the resident did not receive scheduled pain medication, it would be a cause of increased pain for the resident. The ADON could not locate a referral for pain management for Resident 1, or nursing notes to indicate the physician was notified of the medications not given.