

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2024
NAME OF PROVIDER OR SUPPLIER  College Oak Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4635 College Oak Drive Sacramento, CA 95841	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>45770</p> <p>Based on interview and record review the facility failed to provide services according to professional standards of quality for one of 3 sampled residents (Resident 1) when Resident 1's pain medication was not administered per physician order.</p> <p>This failure decreased the facility's potential to safely follow the physician's order which led to unmet pain needs.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Orders indicated he was admitted to the facility in July 2024 with diagnoses including dislocation of left hip.</p> <p>In an interview on 8/6/24 at 11:35 a.m. with Resident 1, Resident 1 stated he was at the facility for rehabilitation therapy after hip and knee surgery. Resident 1 verbalized that on the night of 8/2/24, he asked for pain medication due to an 8 out of 10 pain (8/10, indicating severe pain). Resident 1 further stated the Licensed Nurse (LN) who was in-charge that night just gave him 1 tablet of oxycodone (narcotic pain medication) 5 milligrams (mg, unit of measurement) only.</p> <p>A review of Resident 1's Order Summary Report, dated 7/25/24 revealed two orders for oxycodone 5 mg tablet, to give 1 tablet for moderate pain and to give 2 tablets for severe pain, given as needed every four hours.</p> <p>A review of Resident 1's Medication Administration Record (MAR) the MAR indicated that on 8/2/24 at 11:54 p.m., an LN gave Resident 1 one tablet of oxycodone 5 mg for an 8/10 pain.</p> <p>A review of Resident 1's care plan interventions, initiated 7/25/24, indicated, Resident is at risk for pain . Administer medication as ordered and observe for side effects and effectiveness of medication.</p> <p>In a concurrent interview and record review on 8/6/24 at 1:13 p.m. with LN 1, Resident 1's MAR was reviewed. LN 1 confirmed that Resident 1 was only given one tablet of oxycodone 5mg for a pain of 8/10.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a concurrent interview and record review on 8/6/24 at 3:12 p.m. with the Director of Nursing (DON) Resident 1's MAR and physician orders were reviewed. the DON confirmed that the night shift LN only gave one tablet of pain medication to Resident 1 for an 8/10 complaint of pain. DON acknowledged the LN should have followed the physician's order and given Resident 1 two tablets instead of one because of severe pain. DON further stated it was her expectation for the nurses to always follow the physician order to properly care for their residents and to prevent them from making mistakes.</p> <p>A review of the facility's Policy and Procedure (P&amp;P) titled Administering Medications revised 4/2019 the P&amp;P stipulated Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders .</p> <p>Based on interview and record review the facility failed to provide services according to professional standards of quality for one of 3 sampled residents (Resident 1) when Resident 1's pain medication was not administered per physician order.</p> <p>This failure decreased the facility's potential to safely follow the physician's order which can lead to unmet health needs.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Orders indicated he was admitted to the facility in July 2024 with diagnoses including dislocation of left hip.</p> <p>In an interview on 8/6/24 at 11:35 a.m. with Resident 1, Resident 1 stated he was at the facility for rehabilitation therapy after hip and knee surgery. Resident 1 verbalized that on the night of 8/2/24, he asked for pain medication due to an 8 out of 10 pain (8/10, indicating severe pain). Resident 1 further stated the Licensed Nurse (LN) who was in-charge that night just gave him 1 tablet of oxycodone (narcotic pain medication) 5 milligrams (mg, unit of measurement) only.</p> <p>A review of Resident 1's Order Summary Report dated 7/25/24 revealed two orders for oxycodone 5 mg tablet, to give 1 tablet for moderate pain and to give 2 tablets for severe pain, given as needed every four hours.</p> <p>A review of Resident 1's Medication Administration Record (MAR) the MAR indicated that on 8/2/24 at 11:54 p.m. an LN gave Resident 1 one tablet of oxycodone 5 mg for an 8/10 pain.</p> <p>A review of Resident 1's care plan interventions, initiated 7/25/24, indicated, Resident is at risk for pain . Administer medication as ordered and observe for side effects and effectiveness of medication.</p> <p>In a concurrent interview and record review on 8/6/24 at 1:13 p.m. with LN 1, Resident 1's MAR was reviewed. LN 1 confirmed that Resident 1 was only given one tablet of oxycodone 5mg for a pain of 8/10.</p> <p>(continued on next page)</p>		

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