STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056327	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Creek Skilled Nursing & Rehabilitation Cent	1224 Rossmoor Parkway Walnut Creek, CA 94595

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** 48616 Based on interview and record review, the facility failed to manage pain for one out of four sampled residents (Resident 1), when Resident 1 did not received pain medication as desired for 13 hours. This failure resulted in Resident 1 suffering from severe pain and a feeling of neglect. Findings: During a review of Resident 1's Admission Record, dated May 2024, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with active diagnosis that included thoracic fusion (an operation in the middle region of the spine) and chronic pain. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated April 2024, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) was 15 out of 15, indicating cognitively intact. During a review of Resident 1's Nursing Admission Data Collection and Baseline Care Plan Tool, the Nursing Admission Data Collection and Baseline Care Plan Tool indicated Resident 1's date and time of admission was 3/22/24 at 7:00 p.m. Further review of the tool indicated, Resident 1's pain interventions were to monitor for presence of pain every shift and to administer pain medication. During a review of Resident 1's Physician Order (PO) Summary, dated March 2024, the PO indicated the following orders of: Oxycodone 5 mg by mouth every 6 hours as needed for moderate to severe pain and Monitor for Presence of Pain every shift using pain scale 0-10. 0=No pain, 1-2=least pain, 3-4=mild pain, 5-6=Moderate pain, 7-8=severe pain and 9-10=very severe pain. During a review of Resident 1's Progress Notes (PN), dated 3/22/24 through 3/23/24, the PN indicated Resident 1 had pain on a number scale of four on 3/22/24 at 9:31 p.m. Further review of PN did not indicate a pain management was provided and that pain was assessed again that night. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	During a review of Resident 1's Medication Administration Record (MAR), dated March 2024, the MAR indicated that oxycodone 5 mg was first administered on 3/23/24 at 8:25 a.m. for very severe pain of a nine. Further review of the MAR indicated Resident 1 received the same doses of medication on that same day at 2:00 p.m. and 7:14 p.m. for pain scales of 8 and 7 respectively. There was no indication on the MAR Resident 1 received pain medication on the night of 3/22/24. During a telephone interview on 5/30/24 at 2:57 p.m. with Resident 1, Resident 1 stated on the night of her admission, she did not receive pain medication because it was not available which had caused Resident 1 to suffered from severe pain for 13 hours and felt neglected. During a telephone interview on 6/11/24 at 8:30 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she admitted Resident 1. LVN 1 stated Resident 1 had moderate pain and needed pain medication that night. LVN 1 stated the oxycodone medication was not available at that time due to medication prescription issues, however, Resident 1 was given a Tylenol and an ice pack to manage the pain while LVN 1 worked on Resident 1's prescription. LVN 1 stated that she did not have proof of these measures because it was not documented. LVN 1 stated the Tylenol and ice packs were administered by the Charge Nurse, when asked who the Charge Nurse was, LVN 1 was unable to recall. During an interview on 6/11/24 at 10:00 a.m. with LVN 2, LVN 2 stated he was the charge nurse for Resident 1 when she was admitted . LVN 2 stated Resident 1 was on a pain scale of seven and LVN 2 was unable to recall giving pain medication. LVN 2 further stated that nothing was done because there was no documentation. LVN 2 stated that it should have been the admitting nurse's responsibility to address Resident 1's pain. During an interview on 6/11/24 at 10:20 a.m. with Director of Nursing (DON), DON stated that LVN 1 should have addressed Resident 1's pain after it was identified. DON stated she did not find any documentation on the electronic medical record that Resident 1's pain was managed the night Resident 1 was admitted . DON stated Resident 1's pain should have been address and not left unmanaged because it would cause further pain and frustration to the resident. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated October 2022, the P&P indicated The purpose of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's needs and that address the underlying causes of pain . Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition .Pain management is a multidisciplinary care process that includes the following: Recognizing the presence of pain .Identifying and using specific strategies for different levels and sources of pain.