

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/05/2024
NAME OF PROVIDER OR SUPPLIER  English Oaks Convalescent & Rehabilitation Hospita		STREET ADDRESS, CITY, STATE, ZIP CODE 2633 West Rumble Rd Modesto, CA 95350	

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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369</b></p> <p>Based on interview and record review, the facility failed to provide adequate pain management for one of seven sampled Residents (Resident 1) when Resident 1's pain medication was not ordered in a timely manner.</p> <p>This failure led to Resident 1 experiencing unnecessary pain which had the potential to affect her physical and psychosocial well-being.</p> <p>Findings:</p> <p>A review of Resident 1's ADMISSION RECORD, indicated she was admitted to the facility in May of 2024, with diagnoses which included osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down).</p> <p>A review of Resident 1's clinical record, Progress Notes, dated 5/18/24, at 2:20 PM, indicated, .Pt [patient] is requesting an order for Norco [narcotic pain-relieving medication] 5/325 mg [milligrams- unit of measure] for pain as Tylenol [non-narcotic pain-relieving medication] does not help with pain. Communication placed in . [physician medical group communication binder] .</p> <p>A review of Resident 1's clinical record, Progress Notes, dated 5/18/24, at 8:48 PM, indicated, .Pt began complaining of 9/10 [9 out of 10, severe pain] hip pain stating that she has been in this pain since early morning hours. Tylenol has been ineffective for pain, pt is growing increasingly angry .and stated staff has not helped her at all. Writer has used non pharmacological strategies like repositioning, distraction, and elevation of BLE [bilateral lower extremities, both legs] with little to no effect on pain. MD has been faxed on AM, called and messaged on PM, pending response of MD .</p> <p>A review of Resident 1's clinical record, Progress Notes, dated 5/19/24, at 11:29 PM, indicated, .Writer followed up with MD regarding Norco script that was signed 6/19 instead of 5/19 making the script invalid. MD aware. [Name of Pharmacy] states script still has not been updated but rather sent twice as 6/19. Pending MD correction.</p> <p>A review of Resident 1's clinical record, Progress Notes, indicated the first dose of medication, .Norco Oral Tablet 5-325 MG .moderate/severe pain in hips . was administered on 5/20/24, at 7:50 AM.</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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's clinical record, Progress Notes, dated 7/4/24, at 5 AM, indicated, .Medication Administration Note .Norco 5-325 MG .2 tablet .c/o [complains of] 8/10 gen [severe generalized] body pain .</p> <p>During an interview in Resident 1's room, on 7/5/24, at 1:34 PM, Resident 1 stated she had not received a pain pill since last night. Resident 1 further stated the facility did not have her pain pills available. Resident 1 stated, .my pain is usually around eight or nine [severe pain] and they ran out .</p> <p>During an interview on 7/5/24, at 1:40 PM, Licensed Nurse (LN) 3 confirmed Resident 1's last dose of Norco was administered on 7/4/24, at 5 AM. LN 3 stated when a medication was running out the nursing staff would send a re-order request to the pharmacy and enter an order in the electronic health record (EHR) for the physician to sign. The pharmacy could not dispense the medication until the order was signed by the physician. LN 3 further stated on holidays and after-hours nursing staff could call or fax the physician to sign the orders. LN 3 stated the order requested on 7/4/24 was signed by the physician on 7/5/24.</p> <p>A review of Resident 1's clinical document titled, Order Entry, indicated, .Prescribed Order Start Date: 7/4/2024 23:45 [11:45 PM] .Medication: Norco Oral Tablet .Signed By: [Name], Nurse Practitioner .Signed Date: 7/5/2024 13:20 [1:20 PM] .</p> <p>During an interview on 7/5/24, at 4 PM, the Director of Nurses (DON) stated medications should be re-ordered by staff when there are approximately seven doses left to allow time for the order to be processed. The DON further stated the risk of not having Resident 1's medication available was unrelieved pain which could affect Resident 1's ability to sleep and participate in daily activities.</p> <p>During a telephone interview on 7/10/24, at 11:28 AM, the DON stated the physician's medical group binder was used for non- urgent matters. The physicians reviewed the information in the binder on their daily rounds. The DON further stated if nursing staff had an urgent patient need, like severe pain, an order should be received within an hour. The DON stated if staff were unable to contact the physician, they should have escalated the concern to a supervisor, the DON or the Medical Director to ensure an order was received.</p> <p>A review of a facility policy and procedure titled, Medication and Treatment Orders, revised July 2016, indicated, .Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available .</p> <p>A review of a facility job description titled, Charge Nurse, dated 2003, indicated, Report all discrepancies noted concerning physician's orders .to the Nurse Supervisor .Order prescribed medications .as necessary and in accordance with established policies .</p>		