STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555281	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oroville Hospital Post-Acute Center	1000 Executive Parkway Oroville, CA 95966

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** 43755 Based on interview and record review the facility failed to ensure pain medication was administered, in accordance with the resident ' s comprehensive care plan, and the resident ' s goals for care and preferences for one of three residents (Resident 1) who were sampled for pain management. This failure caused Resident 1 to experience increased pain and discomfort with the potential to experience a decline in her health condition. Findings: The facility ' s policy titled Pain Policy undated, indicated The Center [facility] evaluates for, and attempts to manage/minimize, pain in residents. The facility ' s policy titled Medication Administration undated, indicated Medications are administered in accordance with written orders of the prescriber [Physician]. Medications are to be administered within 60 minutes of scheduled time A review of Resident 1 ' s undated Face Sheet indicated that Resident 1 was admitted on [DATE] with diagnoses including a broken leg, muscle weakness, lung disease, and pain. A review of Resident 1 ' s Admission Minimum Data Set (MDS, a clinical assessment), dated 4/9/24, indicated Resident 1 had pain frequently and the pain occasionally disturbed her sleep and activities. Resident 1 was able to understand and make her own health care decisions and participate in her treatment plan. A review of Resident 1 ' s Care Plan, titled Acute [severe]/chronic [constantly recurring] pain r/t [related to] left femoral neck intertrochanteric fracture [broken left leg], chronic back pain, and arthritis dated 4/3/24, indicated interventions included Anticipate the resident ' s need for pain relief and respond immediately to any complaint of pain. A review of Resident 1 ' s Care Plan titled The resident is on pain medication therapy . dated 4/3/24, indicated interventions included, Administer ANALGESIC [painkilling] medication as ordered by physician. (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	A review of Resident 1 ' s Physician ' s Orders dated 4/23/24, indicated Resident 1 had an order for Norco (a narcotic with two medications mixed into one tablet to treat pain) Tablet 10-325 mg (10 mg of Hydrocodone [a strong pain medication that acts on the central nervous system] and 325 mg of Acetaminophen [a milder pain medication]). The order read to give 1 tablet by mouth every four hours for pain. The scheduled times for this medication was: midnight, 4:00 am, 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm. During an interview with Resident 1 on 6/25/24 at 3:07 pm, Resident 1 was sitting on her bed and indicated she had broken her leg in 4 places, and it was painful. Resident 1 indicated she was supposed to get pain medication every 4 hours for her pain, but the nurses were late bringing it to her and then the pain would get bad. Resident 1 stated I have talked to them several times about this (receiving pain medication at the scheduled time). Resident 1 also indicated she was taking pain medication at home, before she broke her leg, for back pain and arthritis. Resident 1 indicated that when she did not get the pain medication every 4 hours, she would get behind on the pain (meaning the pain would increase and it would be harder to get the pain at an acceptable level). Resident 1 stated, The day before yesterday it was about 5:15 pm (when she received the pain pill, one hour and fifteen minutes after ordered time) and I was in pain. Resident 1 continued to indicate that there were many times that she received the pain pill late and it was mostly during the evening time. She said, One time it was two hours late. A review of Resident 1 ' s June Medical Administration Record (MAR) on 6/27/24 at 3:10 pm, indicated that from 6/11/24 through 6/26/24, Resident 1 received a total of 87 NORCO pills and 12 of those pills were given to her 60 minutes or more after the scheduled time. The MAR revealed: *6/15/24 - time scheduled was 4:00 pm, she received NORCO at 5:06 pm, from LVN A. *6/15/24 - time scheduled was 8:00 pm, she received NORCO at 9:03 pm, from LVN B. *6/16/24 - time scheduled was 8:00 pm, she received NORCO at 10:19 pm, from LVN B. *6/17/24 - time scheduled was 8:00 pm, she received NORCO at 9:30 pm, from LVN B. *6/18/24 - time scheduled was 8:00 pm, she received at NORCO 10:05 pm, from LVN C. *6/19/24 - time scheduled was 4:00 am, she received at NORCO 5:02 pm, from LVN C. *6/19/24 - time scheduled was 8:00 pm, she received at NORCO 10:49 pm, from LVN C. *6/20/24 - time scheduled was 4:00 am, she received at NORCO 6:11 am, from LVN C. *6/20/24 - time scheduled was 4:00 pm, she received at NORCO 5:13 pm, from LVN A. *6/22/24 - time scheduled was 12:00 pm, she received at NORCO 1:09 pm, from LVN unidentified. *6/22/24 - time scheduled was 8:00 pm, she received at NORCO 10:02 pm, from LVN B. *6/23/24 - time scheduled was 4:00 pm, she received at NORCO 5:06 pm, from LVN unidentified. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Executive Nurse Director (END) and review of Resident 1 ' s MAR on 7/31/24 at 2:52 pm, the END confirmed that the NORCO tablet had been given late (over the 60-minute leeway time as per the policy) on 12 occasions over a two-week period, from 6/11/24 to 6/26/24 and should not have been. During an interview on 7/31/24 at 3:02 pm, LVN A indicated that Resident 1 liked her pain medications on time. LVN 1 confirmed that on 6/15/24 he gave the NORCO at 5:06 pm which was not according to policy. LVN 1 indicated he did not remember why he gave it late, but he should not have. He stated, It does get busy out there after 3:30 pm. During an interview on 7/31/24 at 3:36 pm, LVN B confirmed that sometimes she would give medication late. LVN B indicated the nurses had to share medication carts (a locked cart that stored resident ' s medications) during the night shift which made it difficult to get the medications she needed when she needed to administer them. During an interview on 7/31/24 at 3:51 pm, LVN C stated, That was me being forgetful. I would sign the medication (NORCO) out of the narcotic count book (Controlled Drug Record, a book that kept track of all controlled pain medications) and give it to Resident 1 on time but sign the MAR later, that is why the times are recorded late, but I did give them on time. I am trying to get better. It was busy. I have a tendency to pop out (push the pills out of the packaging) the medications and then chart later. LVN C indicated the narcotic count book will verify she gave the meds on time. During an interview with the END and a review of the narcotic count book titled Controlled Drug Record on 7/31/24 at 4:06, the END verified that the signed medications recorded on the Controlled Drug Record for the 12 times as described above had not been signed out at the scheduled time as LVN C had described but had been signed out at the same time it was recorded in the MAR. The END confirmed that the NORCO had been given late and not as their policy describes. The END stated, narcotics should be given at their scheduled time.