

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Eskaton Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3939 Walnut Ave. Carmichael, CA 95608	
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. 32096 Based on interview and record review, the facility failed to manage one of three sampled residents (Resident 1's) pain timely when Licensed Nurse (LN) delayed administration of the breakthrough pain medication for the resident. This failure resulted in Resident 1 being in pain, feeling ignored and mistreated. Findings: Review of Resident 1's clinical record, Resident Face Sheet, indicated the resident was admitted to the facility with diagnoses that included chronic pain syndrome, chronic pancreatitis (inflammation of the pancreas) and low blood oxygen. In an interview on 4/30/24 at 12:25 p.m., the Interim Director of Nursing (IDON) at the IDON's office, the IDON stated on 4/22/24 Resident 1 was upset and complained that LN 1, who worked at night shift, did not give her pain medication on time and made excuses that she was busy or that Resident 1 was not her only resident, justifying the delayed pain medication administration. The IDON stated Resident 1 expressed she felt miserable and being mistreated by LN 1 not getting pain medications when she needed. In an interview on 4/30/24 at 12:50 a.m. with Resident 2, the former Resident 1's roommate, in her room, Resident 2 stated that Resident 1 had to wait to get her pain medications at night. Resident 2 stated that she witnessed, a few days ago, when Resident 1 asked LN 1 where her pain medication was, LN 1 said to her that she had a two-hour leeway to administer the pain medication. Resident 2 recounted that Resident 1 then told LN 1 that she would request her pain medication two hours in advance to get it on time, LN 1 raised her voice to Resident 1 and said to the resident that she could ask for pain medication whenever she wanted but it was LN 1's discretion when to give the medication. Resident 2 stated Resident 1 was in pain and did not know when to ask for pain medications because she was prohibited to ask. Review of Resident 1's clinical record, Medication Administration Record (MAR) for April 2024 included a physician order for Norco (a narcotic medication) 5/325 mg (milligram) 1 tablet every 4 hours as needed for pain. The MAR indicated Resident 1 reported her pain was at 7 to 9 out of 10 pain scale whenever she requested for Norco. The resident received Norco round the clock, during her 5-day stay at the facility, every 4 hours, regularly for pain control; however, the MAR showed delayed Norco administrations when LN 1 was on duty at nights as follows: (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	4/19/24 at 8:01 p.m. by PM LN; 4/20/24 at 2:41 a.m. by LN 1 (6 hours and 40 minutes from the previous administration) There was no more Norco administration during the night shift until 7:30 a.m. by the AM LN. 4/21/24 at 7:46 p.m. by PM LN; 4/22/24 at 12:50 a.m. by LN 1 (5 hours from the previous administration); 5:12 a.m. by LN 1 Review of the facility's policy and procedure, 2007, stipulated, Medications are administered as prescribed . In a concurrent interview and record review on 4/24/24 at 1:50 p.m. at the IDON's office, the IDON verified the delayed pain medication administrations for Resident 1 on 4/19/24 and 4/21/24 by LN 1. The IDON stated Resident 1 had back pain, pancreatitis, and generalized pain. The IDON stated as needed basis pain medication had no two-hour administration window as it was for breakthrough pain control, therefore, LN 1 should have administered the medication as quick as possible when resident requested.		