STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555770	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMARILLO HEALTHCARE CENTER	**205 GRANADA ST CAMARILLO, CA 93010**

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** Based on interview and record review, the facility failed to provide ordered pain medication to one sampled resident (Resident 1) as per the physician's written order. This failure resulted in Resident 1 not receiving adequate pain relief for over 13 hours. Findings: During a review of Resident 1's medical record from the Acute Care Hospital Discharge Summary Notes dated 8/21/20, indicated Resident 1 was admitted to a long term care facility from an Acute Care Hospital after having undergone a right total knee replacement on 8/16/20. During a telephone interview with Resident 1, on 8/31/20, at 5:00 p.m., Resident 1 stated that when she was admitted to the facility on [DATE], she was in a great deal of pain, and was forced to wait 14 hours before the facility would give her the pain medication, [MEDICATION NAME] (an opioid pain medication to treat moderate to severe pain) ordered for her by her physician. During a review of Resident 1's medical record, the document titled, Order Summary Report dated 8/21/20, indicated on the, admission orders [REDACTED]. The orders were verified with the Attending Physician (MD) by the Admitting Nurse (LN1) on 8/21/20 at 7:30 p.m. During a review of Resident 1's medical record, the document titled, Medication Administration Record, [REDACTED]. The first dose was not given until 8/22/20 at 9:12 a.m. During an interview with the Director of Nursing (DON) on 9/2/20, at 10:30 a.m., the DON acknowledged that the resident was admitted to the facility at 6:30 p.m. on 8/21/20 with an order for [REDACTED]. The DON stated it is a pharmacy policy. During an interview on 9/2/20 at 2:15pm, with a licensed nurse (LN2), LN2 stated Resident 1 told LN2 on Saturday, 8/22/20 that she (Resident 1) had been in pain throughout the night and had been asking for pain medication, but did not receive any [MEDICATION NAME] through the night. At 6:28 a.m., Resident 1 had received Tylenol. The LN2 stated that the pharmacy has to have a signed order by the MD or NP, or a phone call from the MD or NP in order to release the med from the ADC to be given to the resident. The LN2 stated that the floor nurse will generally contact the MD or the NP so the pharmacy can be notified to release the medication. The LN2 stated she is not sure where the breakdown happened. During an interview on 9/2/20 at 2:30 p.m. with a licensed nurse (LN3), the LN3 stated they had worked the night shift 8/21/20 into 8/22/20. The LN3 stated Resident 1 had complained of pain throughout the night, to the point where LN3 called the pharmacist (RPH) at 12am and 4am. The LN3 stated the RPH told them the MD and NP were not answering calls. The LN3 stated in the past, they have been told by the RPH that there is a list of doctors on a, Do not call list that they're not supposed to call at night. LN3 indicated this has been a problem in the past, and the DON is aware of it. During an interview on 9/2/20 at 3:30 p.m., the RPH reported being unable to supply a code for the nurse to get the narcotics from the ADC without the physician's verification. The RPH reported trying several times to reach the MD and NP, but was unable. The RPH stated they had not contacted the SNF to ask for help to reach the MD. The RPH indicated a, Do not call list for physicians who do not wish to be contacted at night does exist. During an interview on 9/2/20 at 3:45 p.m. with the admitting nurse (LN1), The LN1 stated that they had verified the resident's medication orders with MD and faxed them to the pharmacy at 7:30 p.m. The LN1 stated they were not aware the order was never validated between the RPH and the MD because the LN1 was just in the facility to perform the admission, and left the facility at 8:30 p.m. The LN1 stated, This has happened in the past, and when it does, the nurse will call the MD and ask the MD to call the pharmacy. During an interview on 9/3/20 at 3:15 p.m., the MD stated if the RPH cannot reach MD, the RPH should telephone the facility so staff can attempt to reach MD, versus allowing the resident to stay in pain for an extended period of time. The MD indicated if the MD who wrote the orders is not available, staff has the ability to call the Medical Director. The MD stated, I know she was in a great deal of pain, because a total knee replacement is a painful surgery. (Resident 1) should not have had to wait until the morning for pain medications. During a review of the facility's policy and procedure titled, Pain Management, dated 04/2012, the policy indicated in part, The facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by .developing and implementing a plan, using pharmacologic and/or non-pharmacologic interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE