STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055833	A. BUILDING _____ B. WING _____	**03/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FULTON GARDENS POST ACUTE, LLC	**537 E. FULTON STREET STOCKTON, CA 95204**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their pain management policy to notify the physician of an acute new onset severe pain in a timely manner for one of 3 sampled residents (Resident 1) following a fall. This failure had the risk potential for Resident 1's severe pain not to be managed properly as well as result in delay of treatment options following a fall. Findings: According to the 'Admission Record' the facility admitted Resident 1 over 4 years ago with multiple [DIAGNOSES REDACTED]. During an observation and concurrent interview with Resident 1 on 1/17/20, at 11:25 a.m., she stated she had fallen over two weeks ago and had broken her left leg and left arm. Resident 1 stated she did not sleep all night after the fall due to pain from her left leg and left arm and she had to go to the hospital to be checked the following day. Resident 1 stated the pain from her left leg and arm was new and was pretty bad. Resident 1's clinical record was reviewed as follows: A 'Progress Note' dated 1/1/20 indicated a Certified Nursing Assistant (CNA), . saw resident sitting on the floor against her nightstand on the right side of her bed. A 'Change of Condition Progress Note' dated 1/1/20 indicated, Resident alert, awake, verbally responsive, coherent and oriented to person, place, time and situation. The 'Medication Administration Record (MAR) printed on 1/17/20 indicated that a pain of 7 to 10 on a scale of zero to 10 was considered 'Severe Pain.' The pain documented on the MAR for the night shift on the day she fell dated 1/1/20 was 9 out of 10. A 'Progress Note' dated 1/2/20 (night of 1/1/20) and timed at 6:57 a.m., indicated she was on her first day post fall and had complained of pain rated at 8 out of 10 and as needed pain medication was given. The note did not indicate where the location of the pain was or if it was of new and/or acute nature. A 'Progress Note' populated from the electronic MARs dated 1/2/20 (night of 1/1/20) and timed at 2:02 a.m., indicated she received pain medication for breakthrough pain. The location of the pain was not documented. A 'Progress Note' dated 1/2/20 and documented by the day shift nurse indicated, At 0900 (9 a.m.) nurse was unable to arouse pt (patient), pt stated that she was in too much pain and has not slept last night due to pain. During assessment, pts left wrist was swollen and pt c/o (complained of) pain on the left wrist and left hip. During an interview with a Licensed Nurse (LN) 3 on 1/17/20, at 12:10 p.m., she stated Resident 1 had a [DIAGNOSES REDACTED]. During an interview and concurrent Resident 1's record review with the Assistant Director of Nursing (ADON) on 1/17/20, at 12:27 p.m., she stated the night shift nurse should have assessed Resident 1 when she complained of severe pain and documented the location of pain on the MAR and progress note. The ADON further stated the night nurse should have notified the physician if the severe pain was of new onset. The ADON stated Resident 1 was sent to the hospital the following day after x-rays indicated she had fractured her left thigh and left upper arm bones from the fall. A review of the facility's 'Pain Management' policy dated 10/1/19 indicated, To ensure accurate assessment and management of the resident's pain. If there is a new onset of pain . the Licensed Nurse will notify the Attending Physician . Acute pain should be assessed every 30-60 minutes after the onset of pain . document resident's pain and response to interventions in the medical record . There was no documented evidence in Resident 1's clinical record, the pain was assessed every 30-60 minutes after the acute onset. Additionally, the physician was not notified of the acute onset of pain until the following day.
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 observation, interview and record review, the facility failed to assess pain in a manner consistent with professional standards of practice and follow their pain management policy, when the location of an acute episode of severe pain was not assessed and documented prior to administration of pain medication following a fall, for one of 3 sampled residents (Resident 1). This failure had potential risk for Resident 1's location of severe pain not to be identified and managed, as well as result in delay of treatment options following a fall. Findings: According to the 'Admission Record' the facility admitted Resident 1 over 4 years ago with multiple [DIAGNOSES REDACTED]. During an observation and concurrent interview with Resident 1 on 1/17/20, at 11:25 a.m., she stated she had fallen over two weeks ago and had broken her left leg and left arm. Resident 1 stated she did not sleep all night after the fall due to pain from her left leg and left arm and she had to go to the hospital to be checked the following day. Resident 1 stated the pain from her left leg and arm was new and was pretty bad. Resident 1's clinical record was reviewed as follows: A 'Progress Note' dated 1/1/20 indicated a Certified Nursing Assistant (CNA), . saw resident sitting on the floor against her nightstand on the right side of her bed. A 'Change of Condition Progress Note' dated 1/1/20 indicated, Resident alert, awake, verbally responsive, coherent and oriented to person, place, time and situation. The 'Medication Administration Record (MAR) printed on 1/17/20 indicated that a pain of 7 to 10 on a scale of zero to 10 was considered 'Severe Pain.' The pain documented on the MAR for the night shift on the day she fell dated 1/1/20 was 9 out of 10. A 'Progress Note' dated 1/2/20 (night of 1/1/20) and timed at 6:57 a.m., indicated she was on her first day post fall and had complained of pain rated at 8 out of 10 and as needed pain medication was given. The note did not indicate where the location of the pain was. A 'Progress Note' populated from the electronic MARs dated 1/2/20 (night of 1/1/20) and timed at 2:02 a.m., indicated she received pain medication for breakthrough pain. The location of the pain was not documented. A 'Progress Note' dated 1/2/20 and documented by the day shift nurse indicated, At 0900 (9 a.m.) nurse was unable to arouse pt (patient), pt stated that she was in too much pain and has not slept last night due to pain. During assessment, pts left wrist was swollen and pt c/o (complained of) pain on the left wrist and left hip. During an interview with a Licensed Nurse (LN) 3 on 1/17/20, at 12:10 p.m., she stated Resident 1 had a [DIAGNOSES REDACTED]. During an interview and concurrent Resident 1's record review with the Assistant Director of Nursing (ADON) on 1/17/20, at 12:27 p.m., she stated the night shift nurse should have assessed Resident 1 when she complained of severe pain and documented the location of pain on the MAR and progress note. The ADON further stated the night nurse should have notified the physician if the severe pain was of new onset. The ADON stated Resident 1 was sent to the hospital the following day after x-rays indicated she had fractured her left thigh and left upper arm bones from the fall. A review of the facility's 'Pain Management' policy dated 10/1/19 indicated, To ensure accurate assessment and management of the resident's pain. If there is a new onset of pain . the Licensed Nurse will notify the Attending Physician . Acute pain should be assessed every 30-60 minutes after the onset of pain . document resident's pain and response to interventions in the medical record . There was no documented evidence in Resident 1's clinical record, the pain was assessed every 30-60 minutes after the acute onset. Additionally, the physician was not notified of the acute onset of pain until the following day.

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

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.