STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055833	A. BUILDING _____ B. WING _____	C 11/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00924724. The inspection was limited to the specific incidents investigated and does not represent the findings of a full inspection of the facility. The Department substantiated a violation of the regulations for complaint #CA00924724 written under F-658.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to provide care and services according to professional standards of practice and the comprehensive care plan for one of three sampled residents (Resident 1) when a physician ordered pain medication (Tramadol-used to relieve moderate to moderately severe pain) did not arrive from the pharmacy until three days after Resident 1's admission to the facility, and the medication was not administered from the E-kit (an emergency supply of medication) even though it was available. These failures put Resident 1 at risk for increased, uncontrolled pain and had the potential	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/06/24

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.

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F 658	Continued From page 1 to affect her psychosocial wellbeing. Findings: A review or Resident 1's medication administration record (MAR), dated 10/2024, indicated "Start date 10/1/24...Tramadol...50 mg [unit of measure] give one tablet every 12 hours as needed for pain...Monitor level of pain (0-10 scale): Document pain level as follows: 0=None...1-3=Mild Pain...4-6=Moderate Pain...7-10=Severe Pain..." A review of Resident 1's "Pain Level Summary" indicated on 10/2/24, Resident 1's highest level of expressed pain was a "5" (moderate pain). On 10/3/24, Resident 1's highest level of expressed pain was a "5" (moderate pain). A review of Resident 1's pain care plan, initiated 10/2/24, indicated "...The resident [is] at risk of pain...Administer analgesia [pain medication] as per orders..." A review of a nurse progress note, dated 10/2/24 at 8:35 a.m., indicated, "...The resident requesting pain medication PRN [as needed]. Spoke to MD regarding pain medication and ordered Tylenol [used to relieve mild pain] 650 mg q [every] 6 hours PRN..." A review of a nurse progress note, dated 10/2/24 at 10 a.m., indicated, "Called the pharmacy...regarding Tramadol orders. Stated will fax the prescription to [physician/MD]. Called back to pharmacy around 1255 [12:55 p.m.] stated that MD did not reply yet. Resident aware. Called pharmacy staff around 1338 [1:38 p.m.] for follow up regarding tramadol order still in process.	F 658		

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F 658	Continued From page 2 Endorsed to PM nurse for follow up." During a concurrent observation and interview with the Director of Nursing (DON) on 11/12/24, at 11:46 a.m., the E-kits stored at Nurses Station's one and two were observed to have four tablets of 50mg Tramadol in each of the E-kits. During an interview on 11/12/24, at 2:01 p.m., Licensed Nurse (LN) 1 stated when the facility admits a new resident their medication orders are sent to the pharmacy and usually arrive at the facility within 24 hours. LN 1 stated if controlled substances (A drug that is tightly controlled by the government because it may be abused or cause addiction. This includes Tramadol) are part of the new orders, a triplicate (a prescription signed by the doctor) was needed for the pharmacy to fill the prescription. If a triplicate was available, the medication can be removed from the E-kit with a code from a pharmacist prior to the medication being delivered. During an interview on 11/12/24, at 2:13 p.m., LN 2 stated if there was not a triplicate available staff needed to contact the physician. LN 2 stated Tylenol was not adequate for a pain level of "5" and Resident 1 kept asking for the Tramadol. LN 2 stated "I felt sorry for her [Resident 1]." LN 2 stated if a resident's pain was not controlled it could lead to other health concerns like high blood pressure, anxiety, and increased pain. A review of Resident 1's Tramadol prescription indicated the facility physician wrote and signed an order for Resident 1's Tramadol on 10/2/24. A review of a pharmacy "Shipping Manifest," dated 10/3/24, indicated a nurse received, and	F 658		

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F 658	Continued From page 3 signed for, Resident 1's delivery of Tramadol to the facility on 10/4/24 at 1:15 a.m. During an interview on 11/15/24, at 3:54 p.m., the Administrator (ADM) stated the risk of delayed pain medication delivery was the resident would be in pain. The ADM stated it was important to alleviate pain and to follow the physician's orders.	F 658		

	This document will serve as a credible allegation of our intent to correct the deficient practice identified. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement, by the provider, of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907 **F 658** A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 1 was admitted 10/1/24. Resident 1 received pain meds 10/2/24 with follow up pain scale indicating it was effective, 10/3/24 pain meds were administered with follow up pain scale indicating effective. Additional pain management provided 10/4/24, 10/5/24, 10/6/24, 10/7/024, and 10/8/24 with follow up pain scale indicating effective pain management. B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken; Administrator audited all residents pain monitoring reported levels to ensure all resident's were being assessed and administered appropriate pain medications as indicated by their reported pain levels on 11/20/24. No other residents were found to be affected. C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur; The Director of Nursing re-educated licensed nurses on 11/6/24, 11/28/24, and12/6/24

	regarding pain management policy, pain as a 5th vital sign, documentation requirement, non-pharmacological interventions, physician notification of resident's pain and importance of immediate intervention, pain scale, identification of patterns in PRN administration indicating a need for routine pain meds, care plan management and updates, e-kit utilization, and completeness of narcotic prescription. Admission coordinator was in serviced on 12/7/24 to confirm the pharmacy has received an e-script from the acute attending physician to cover the first 3 days of new residents stay. D. How the facility plans to monitor its performance to make sure solutions are sustained; Director of Nursing will review all new admissions to ensure pain management is appropriate and available to residents upon admission. The interdisciplinary team will review the residents pain management regiment during each care conference to ensure accuracy and that the resident's plan of care is appropriate and consistent. The Director of Nursing will report any trends identified to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. Allegation of Compliance Date: December 15, 2024