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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED STANDARD SURVEY for Complaints CA00876221 and CA00878093. Inspection was limited to the Abbreviated Standard Survey and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor # 31424, Health Facilities Evaluator Nurse. TWO DEFICIENCIES WERE ISSUED FOR Complaint CA00876221. NO DEFICIENCY was issued for Complaint CA00878093.	F 000		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 resident (Resident 1) in a census of 86 residents received adequate pain management consistent with nursing standards of practice, the resident's individualized care plan, the resident's preferences, and facility policy. Resident 1 described his pain as severe and stated it was #5-9 (moderate to severe) on the pain scale (Pain Scale: a tool health care	F 697		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nicole Foreman | TITLE: Administrator | (X6) DATE: 3/12/2024

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.

POC accepted by HFEN 31424 on 4/15/2024.

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F 697	Continued From page 1 professionals utilize to help assess a person's pain; the pain scale is from 0 to 10, where 0 is no pain, and 10 is the worst pain imaginable) and his physician ordered him to receive Hydromorphone (also know as Dilaudid; a narcotic pain medication) 4 mg (milligrams) every 4 hours on a scheduled basis. Licensed nurses did not administer Hydromorphone as ordered by the physician because the facility "ran out" of the medication; nurses did not consistently access and administer Hydromorphone from the emergency medication supply (known as an e-kit); nursing staff did not notify Resident 1's physician (Physician J) when they were unable to administer his pain medication for a period of 24 hours and intermittently thereafter; the pharmacy did not deliver the medication timely; and nursing staff did not develop, and revise when needed, a person-centered care plan addressing pain for Resident 1. These failures: 1) Caused Resident 1 to experience increased pain, 2) Caused Resident 1 to feel suicidal, hopeless, out of control, angry and depressed, 3) Caused Resident 1 to experience symptoms of narcotic withdrawal, and 4) Prevented Physician J from being aware of the ongoing issues related to Resident 1's Hydromorphone delivery and administration and therefore, potentially prevented him from evaluating and addressing the issue. (Online review of the Mayo Clinic website revealed a pain scale provides a standardized means of measuring pain intensity and severity. Their pain scale follows: ..."Pain Free = 0; Mild Pain = 1-3 (nagging or annoying but doesn't interfere with daily activities)...Moderate Pain =	F 697		

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F 697	Continued From page 2 4-6 (interferes with daily activities)... Sever Pain = 7-10 (disabling or unable to carry out normal daily activities) Ranges from "impacts your social relationships, or sleep" to "being bedridden or even delirious.") [https://connect.mayoclinic.org/blog/adult-pain-medicine/newsfeed-post/what-to-expect-at-my-pain-medicine-appointment] Findings: During a confidential telephone interview on 1/5/24 at 1:54 p.m., Confidential Family Member (CF) stated the facility did not give Resident 1 his pain medication as ordered. CF stated Resident 1's physician ordered he receive Dilaudid for his pain but staff withheld it and the pharmacy sometimes did not deliver it to the facility. Review of Resident 1's medical record revealed his physician diagnosed him with Diabetes Mellitus (commonly known as diabetes; disease characterized by sustained high blood sugar levels), paraplegia (paralysis that mainly affects the legs- though it can sometimes affect the lower body), amputation (surgical removal) of his left leg below the knee, phantom limb syndrome with pain (syndrome where an individual continues to feel sensations like pain, itching, or movement, in a limb that has been amputated) and chronic pain syndrome. A physician order, dated 9/20/2023, indicated Resident 1 was to receive Hydromorphone (Dilaudid) 4 mg (milligrams), "...give 1 tablet by mouth every 4 hours for chronic pain." An additional physician order, dated 10/31/2023, indicated Resident 1 was to receive Hydromorphone 2 mg, "...give 2 tablet (sic) [for a total of 4 mg] by mouth every 4	F 697		

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F 697	Continued From page 3 hours for chronic pain." Review of Resident 1's electronic medical record revealed nursing staff documented his pain in the MAR (medication administration report). In October 2023, nursing staff documented Resident 1's pain ranged from approximately zero (no pain) to 7 (severe pain). In November 2023, nursing staff documented on his MAR that his pain ranged from approximately zero to 8 (severe). In December 2023, nursing staff documented on his MAR that Resident 1's pain ranged from approximately 2 (mild pain) to 8 (severe). Review of Resident 1's electronic medical record revealed a nursing care plan (document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes) for pain was not located in his medical record. Review of facility policy titled, "Pain Assessment and Management," subtitled, "General Guidelines" (revised October 2022) indicated, "1. the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, (and) the comprehensive care plan..." Review of Resident 1's medical record revealed the October 2023 MAR that indicated from 10/28/23 through 10/29/23, nursing staff did not give Resident 1 approximately six doses of his scheduled Hydromorphone (representing a time period of approximately twenty-four hours). The following doses were documented as not given: 4	F 697		

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a.m.; the nurse documented, "...waiting for supplies...," 8 a.m. the nurse documented, "...await for delivery...," 12 noon the nurse documented, "...on order...," 4 p.m. the nurse documented, "...waiting for supplies...," 8 p.m. the nurse documented, "...waiting for supplies...," at midnight the nurse documented the medication was not given and at 3 a.m.. documented, "...waiting for supplies."

Review of Resident 1's medical record revealed the November MAR indicated on 11/8/2023, the midnight dose was not given and the nurse documented #9 (no side effects) and #2 (Resident not available).

Review of Resident 1's medical record revealed the December MAR that indicated multiple doses of Hydromorphone were not given between 12/11/2023 to 12/14/2023. On 12/11/2023 at 4 p.m., the nurse documented Resident 1's pain scale was #7 (severe) and the rationale for not administering the medication was "other". On 12/12/23 at 4 a.m., the nurse documented Resident 1's pain as #7 (severe), Hydromorphone was not given, and the nurse documented at 6:21 a.m. that they were, "...waiting for supplies..." On 12/13/23, the nurse documented the midnight and 4 a.m. doses were not given due to, "Hold med, see progress notes". At 05:55 a.m., the nurse documented that they were, "...waiting for supplies..." On 12/14/23, the nurse documented the midnight dose was not given; at 00:40 a.m. (forty minutes past midnight), the nurse documented, "...Previous LN (licensed nurse) shared... that resident was out of Dilaudid, refill will be process (sic), and supply will be deliver(ed) by midnight. However, no delivery has

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F 697	Continued From page 5 been made. Contacted pharmacy and spoke with (name), stated that refill has not been processed yet but she will process and will be delivered to the facility by 445am (sic). Per pharmacist, she was unable to give me authorization from the e-kit (emergency medication supply) since the prescription is different..." At 1:23 a.m., the nurse documented, "...Contacted pharmacy...Refill is (sic) yet to be processed..." At 4:20 a.m., the nurse documented, "Unable to get any (Hydromorphone) from the e-kit per pharmacy since prescription is different. waiting for delivery..." , During an interview on 1/30/2024 at 2 p.m., Licensed Nurse C (LN C) stated the pharmacy delivered medication to the facility daily at approximately 6 a.m., 4:30 p.m., and 10 p.m. but it was sometimes hard getting medications from the pharmacy. She stated if a resident's medication was missing, nursing staff had to call the pharmacy. She stated she had had to make multiple calls (to request the medication) in the past and it occurred on all three shifts (day, evening, and night shifts). When asked why staff needed to make multiple calls, LN C stated she did not know. LN C stated she remembered Resident 1, he had an amputation of he left leg below his knee, he had a heel wound, and he would describe his pain as being, "everywhere." She stated Resident 1 was receiving his Dilaudid every four hours but the pharmacy had not delivered it, she had called pharmacy (to request the medication), but it was not delivered. She stated she had to call pharmacy to get a one-time code for access to the e-kit and she was then able to administer the medication. (The e-kit required a pharmacy-provided code in order to	F 697		

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F 697	Continued From page 6 access narcotics like Hydromorphone/Dilaudid). During the same interview on 1/30/2024 at 2 p.m., LN C stated other resident's medication were similarly impacted. She stated she had had to call pharmacy for other residents whose medications were missing but the pharmacy failed to deliver them. LN C stated when she called the pharmacy, she spoke directly with a pharmacist (versus general pharmacy staff) because she was more likely to get the medication delivered if she did so. During a telephone interview and concurrent review of email correspondence (from Pharmacist F) on 2/12/24 at 11:20 a.m., Pharmacist F (Pharm F) stated the facility requested Resident 1's Hydromorphone be refilled on 10/27/23 (the day prior to his not receiving Hydromorphone for twenty-four hours), the medication was not delivered until 10/29/23 at 2:30 a.m., and the pharmacy was only able to provide a "small supply" of ten tablets (the Hydromorphone was on backorder). When asked why the medication was not delivered on 10/28/23, Pharmacist F stated they attempted to fill the full order (versus the ten tablets) and the pharmacy sent out the medication on 10/28/23 at approximately midnight. When asked why nursing staff did not get the Hydromorphone from the e-kit (on 10/28/23), Pharmacist F stated Resident 1's order was for 4 m.g. dose tablets and the ekit had only 2 m.g. tablets. He stated the nurse could have called the physician for a one-time order (physician order for one dose of medication, versus a scheduled dose) of Hydromorphone (in order to access the e-kit medication) and stated this was "common"	F 697		

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(practice). When asked why nursing staff did not get a new one-time order, Pharmacist F stated he did not know and stated that should have happened.

During the same telephone interview and concurrent review of email correspondence on 2/12/24 at 11:20 a.m., Pharm F was asked why the nurse did not give the Hydromorphone on 11/8/23 dose at midnight. Pharm F stated he believed the nurses did not have the medication.

During the same telephone interview and concurrent review of email correspondence on 2/12/24 at 11:20 a.m., Pharmacist F was asked about nurses intermittent failures to administer Hydromorphone to Resident 1 from 12/11/2023 to 12/13/2023. Pharm F stated he did not know why nurses did not administer Hydromorphone during this time. He stated the Hydromorphone order was changed to 2 m.g. tablets (nurses would give two, 2 mg tablets) in November and was filled and delivered on 11/20/23 and 11/29/23. When asked how many tablets were delivered on 11/29/23, Pharm F stated 118 pills were delivered. When asked how many doses that represented, Pharm F stated about ten days worth and the medication would have run out on 12/11/20 (when nursing staff began documenting that the medication was missing). He stated the facility requested a refill on 12/9/23 and 12/13/23 but the pharmacy had to send a notice to the facility and provider (doctor) on both occasions; the notice indicated no refills remained and another physician order was needed. Pharm F stated the next order the pharmacy saw requested was on 12/14/23 around 12:53 a.m.; the Hydromorphone went out (with a quantity of

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fifty tablets) and was delivered at 6:30 a.m. on the same day.

During a telephone interview on 2/12/2024 at 3:30 p.m., Resident 1 and CF were asked what it was like not receiving his Dilaudid, especially during the 24-hour period on 10/28/23. Resident 1 stated he had lots of pain, had the sweats, felt itchy, and felt like he had hives. He stated he had withdrawal (from his Dilaudid) on top of his pain. Resident 1 stated his pain was always above a 7 (severe), occasionally at a 9, but not below a 5 (moderate). Resident 1 stated missing his Dilaudid doses caused his pain to increase and made him feel like it was a "hopeless situation." Resident 1 stated not receiving his pain medication made him feel angry and depressed. He stated he felt out of control and stated, "I was at their whim and at their mercy." CF stated Resident 1 talked about suicide due to not getting his pain medication and the resulting increased pain.

During the same telephone interview on 2/12/2024 at 3:30 p.m., CF stated she had told the prior DON and Administrator (both no longer at the facility) about Resident 1's suicidal thoughts. She stated she was not sure who they were (their names) as the facility had had multiple DON's over the past month and a temporary Administrator.

Online review of the Mayo Clinic website indicated, "...Do not...suddenly stop taking opioids (Hydromorphone) ...Opioids withdrawal can be dangerous, and symptoms can be severe....stop opioids slowly, called a taper. Tapering means slowly lowering over time the

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amount of opioid medicine you take until you stop completely...Symptoms of opioid withdrawal may include...mood changes such as sadness and depression... Increased pain...Goose bumps on the skin... sweating...Thoughts of suicide..."

(https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/tapering-off-opioids-when-and-how/art-20386036).

During an interview on 2/13/24 at 11:55 a.m., Licensed Nurse H (LN H) stated she remembered Resident 1 well. She stated he used to take his Dilaudid for pain prn (as needed, not scheduled). He took it so frequently that staff called his physician and got the order changed to scheduled Dilaudid (nursing brought him his Dilaudid every four hours versus waiting for him to request it). LN H stated Resident 1's family member (CF) would sometimes call her to tell her Resident 1 was in pain. When asked if she was aware Resident 1 had felt suicidal when his medication was withheld, she stated she was not aware.

During the same interview on 2/13/24 at 11:55 a.m., LN H stated pharmacy medication delivery was an "ongoing" issue at the facility. She stated nursing staff had to call the pharmacy multiple times for missing medications or refills, especially for narcotics (like Hydromorphone). She stated she would keep calling, they would say they would deliver the medication, but the medication would not come. LN H stated she did not know why they didn't process and send the medication. She stated sometimes the did does not message the pharmacy back (after pharmacy reached out to them). LN H stated she worked at another

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facility and they had a process where nurses could request a "rush med," where a driver would pick up the medication and deliver it within two hours. She stated it would be nice if this facility had such a backup system.

During the same interview on 2/13/24 at 11:55 a.m., LN H stated if a resident was out of a medication, nursing could call the pharmacy and access the e-kit (pharmacy would provide a code to access the e-kit). When asked why a nurse might not get a code from the pharmacy, she stated the prescription for the medication may be old and/or the resident needed a new prescription. LN H stated on day shift, a nurse could call the physician and ask for a new order. LN H stated the facility had a lot of registry nurses (provided by a contract service) and they did not always ask for help (if they had an issue) and they did not go the extra length (for their residents).

During a telephone interview and concurrent medical record review on 2/14/2024 at 9 a.m., the Director of Nursing (DON) was asked about Resident 1 not being administered his Hydromorphone on 10/28/23. The DON stated Resident 1 missed a total of seven doses of Hydromorphone on 10/28/23 and nursing staff documented he had no pain (on the MAR during that time). She confirmed Resident 1's medical record contained no documentation that he was suicidal, no social service note addressing his being suicidal, and no nursing care plan to address his chronic pain. When asked what should have happened, the DON stated staff should have faxed pharmacy a request a refill, called the pharmacy and documented an

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estimated time of medication arrival. If the medication was not delivered, staff should have called pharmacy a second time and "bumped it up," (notified) the DON or the Administrator, and documented in the record that the physician was notified. The DON stated nursing should have gotten a code to access the e-kit (and get the medication) and she stated there was no reason to go seven dosed without pain medication.

During the same telephone interview and concurrent medical record review on 2/14/2024 at 9 a.m., the DON stated there was no progress note (nursing note) from nursing staff documenting why his midnight dose of Hydromorphone was not given on 11/8/23. She stated nursing should have documented the reason.

During the same telephone interview and concurrent medical record review on 2/14/2024 at 9 a.m., the DON confirmed Resident 1 did not receive his 12/11/23 Hydromorphone scheduled for 6 p.m. and that nursing documented his pain was #7/10 (severe) at the time. She confirmed he did not receive his Hydromorphone on 12/12/23 at 4 a.m., nursing documented they were waiting for supplies, and his pain was #7 (severe). The DON confirmed Resident 1's Hydromorphone was not given on 12/13/23 at 4 a.m. The DON confirmed on 12/14/23, Resident 1 did not receive his Hydromorphone at midnight and 4 a.m.. The DON stated her expectation was that nurses needed to do what they needed to do to get the medication and they should "bump it up" (to leadership for assistance).

During the same telephone interview and

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concurrent medical record review on 2/14/2024 at 9 a.m., the DON was asked if she was aware nursing staff had reported pharmacy deliveries were an ongoing problem at the facility and she stated she did not know (this). When asked if the issue with pharmacy was not resolved in October and continued into December 2023 for Resident 1, the DON stated it was a "safe assumption" and it appeared the issue had not been resolved.

During a telephone interview on 2/21/24 4:30 p.m. and 6:00 p.m., Pharmacist G (Pharm G) stated he was the consulting pharmacist at the facility, dealt primarily with clinical issues, and delivery issues were dealt with on the dispensing side (at the dispensing pharmacy, where Pharm F was located). Pharm G confirmed Resident 1 was not given Hydromorphone for twenty-four hours on 10/28/23 and stated it was an, "unfortunate situation" that he missed his scheduled medication. When asked what nursing should have done in this situation, he stated that they should have notified the physician, who could have then contacted the pharmacy.

During the same telephone interview on 2/21/24 4:30 p.m. and 6:00 p.m., Pharmacist G was asked about nursing staff not accessing the e-kit for Resident 1's Hydromorphone. He stated nursing can access the e-kit twenty-four hours a day and it requires a one-time code. He stated this necessitated a physician prescription which could be a verbal order, followed by a written copy (of the order) within seven days. The pharmacy could call the physician for emergency pharmacy needs. Pharm G confirmed Resident 1's issues with Hydromorphone (delivery) in October were still present in December

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(approximately two months later). When asked if he was aware of issues with accessing the e-kit, Pharm G stated, "no." When asked if he was aware of ongoing delivery issues at the facility, Pharm D stated he was aware, but not of any specific issues. He stated there was "turnover at the top" (leadership at the facility) and that can happen with leadership issues.

During a telephone interview on 2/27/2024 at 9:43 a.m., Physician J was asked if he was aware Resident 1 experienced pharmacy delivery issues with his Dilaudid (Hydromorphone). He stated he was aware it happened one time but did not know it was a routine issue. When asked if he was aware nursing staff had not administered Resident 1 his scheduled Dilaudid for approximately twenty-four hours on 10/28/23, Physician J stated the patient (Resident 1) shared the information with him, but nursing staff had not. When asked if nursing staff should have informed him of this, he stated, "of course." Physician J stated nurses lost track of narcotic counts and they called when they ran out (of medication). Physician J was asked if Resident 1's symptoms of sweating, itching, and feeling like he had hives were consistent with narcotic withdrawal symptoms and he confirmed that they were, and stated Resident 1 was dependent on Dilaudid. Physician J was informed nursing staff did not document that they were monitoring for signs of withdrawal during that time and he stated nursing staff should have documented the issue and, "escalated it up." Physician J stated if he was not available, they (his group) had an on-call (physician available to take a call) physician and staff could have escalated it up to them (for assistance). When asked if he was

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aware Resident 1 had felt suicidal at the time, Physician J stated, "no." He stated Resident 1 had expressed to him that he was upset and uncomfortable (due to pain). Physician J was informed that Resident 1 and CF stated they had informed the previous DON and Administrator about Resident 1's suicidal ideation's and he stated, "I believe them." When asked what his expectation was regarding leadership's knowledge of Resident 1's suicidal ideation, he stated the DON should call pharmacy to uncover the problem. He stated the DON should have called pharmacy when Resident 1 ran out of medications on other occasions as well. Physician J was informed Resident 1 missed multiple dosed of Dilaudid from 12/11/23 through 12/14/23. Physician J stated nursing staff should have used the Dilaudid located in the E-kit.

Review of facility policy titled, "Pain Assessment and Management," subtitled, "Implementing Pain Management Strategies" (revised October 2022) indicated, "... 4. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects... 5. The following are considered when establishing the medication regimen: ...b. Administering medications around the clock... 6. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider (doctor) when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications..." Under subtitle, "Monitoring and Modifying Approaches," the policy indicated, "... 4. If the resident is prescribed opioid analgesics (pain medication), monitor for the following side

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F 697	Continued From page 15 effects: ... b. Physical dependence which causes symptoms of withdrawal when opioid medication is stopped, or a dose is held or missed..." Review of facility policy titled, "Administering Medication," subtitled, "Policy Statement" (Revised April 2019) indicated, "Medications are administered in a... timely manner, and as prescribed." Under subtitle, "Policy Interpretation and Implementation," the policy indicated, "...4. Medications are administered in accordance with prescribe orders, including and required time frame..." Review of facility policy titled, Provider Pharmacy Requirements," subtitled "Policy" (dated April 2008) indicated, "Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies..." Under subtitle, "Procedures," the policy indicated, "...D. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to: ...2) Accurately dispensing prescriptions based on authorized prescribe orders....6) Providing routine and timely pharmacy service seven days per week and emergency pharmacy service 24 hours per day, seven days per week...b. Medications which should be promptly available such as... drugs used to treat problems including severe pain... or other severe discomfort are available within 4 hours.	F 697		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		

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F 755	Continued From page 16 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's pharmacy failed to provide 1 resident (Resident 1) in a census of 86 residents with his routine pain medication (Hydromorphone, also known as Dilaudid) timely and failed to ensure nursing staff had access to the Hydromorphone	F 755		

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F 755	Continued From page 17 located in the facility's e-kit (container with emergency medication storage). These failures contributed to Resident 1 to missing his Hydromorphone doses for approximately 24 hours on 10/28/2023 and missing his pain medication again multiple times from 12/11/23 through 12/14/23 which in turn: 1) Caused Resident 1 to experience increased pain, 2) Caused Resident 1 to feel suicidal, hopeless, out of control, angry and depressed, 3) Caused Resident 1 to experience symptoms of narcotic withdrawal, and 4) Prevented Physician J from being aware of the ongoing issues related to Resident 1's Hydromorphone delivery and administration and therefore, prevented him from evaluating and addressing the issue.(Online review of the Mayo Clinic website revealed a pain scale provides a standardized means of measuring pain intensity and severity. Their pain scale follows: ..."Pain Free = 0; Mild Pain = 1-3 (nagging or annoying but doesn't interfere with daily activities)...Moderate Pain = 4-6 (interferes with daily activities)... Sever Pain = 7-10 (disabling or unable to carry out normal daily activities) Ranges from "impacts your social relationships, or sleep" to "being bedridden or even delirious.") [https://connect.mayoclinic.org/blog/adult-pain-medicine/newsfeed-post/what-to-expect-at-my-pain-medicine-appointment] Findings: During a confidential telephone interview on 1/5/24 at 1:54 p.m., Confidential Family Member (CF) stated the facility did not give Resident 1 his pain medication as ordered. CF stated Resident	F 755		

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F 755	Continued From page 18 1's physician ordered he receive Dilaudid for his pain but staff withheld it and the pharmacy sometimes did not deliver it to the facility. Review of Resident 1's medical record revealed his physician diagnosed him with Diabetes Mellitus (commonly known as diabetes; disease characterized by sustained high blood sugar levels), paraplegia (paralysis that mainly affects the legs- though it can sometimes affect the lower body), amputation (surgical removal) of his left leg below the knee, phantom limb syndrome with pain (syndrome where an individual continues to feel sensations like pain, itching, or movement, in a limb that has been amputated) and chronic pain syndrome. A physician order, dated 9/20/2023, indicated Resident 1 was to receive Hydromorphone (Dilaudid) 4 mg (milligrams), "...give 1 tablet by mouth every 4 hours for chronic pain." An additional physician order, dated 10/31/2023, indicated Resident 1 was to receive Hydromorphone 2 mg, "...give 2 tablet (sic) [for a total of 4 mg] by mouth every 4 hours for chronic pain." Review of Resident 1's electronic medical record revealed nursing staff documented his pain in the MAR (medication administration report). In October 2023, nursing staff documented Resident 1's pain ranged from approximately zero (no pain) to 7 (severe pain). In November 2023, nursing staff documented on his MAR that his pain ranged from approximately zero to 8 (severe). In December 2023, nursing staff documented on his MAR that Resident 1's pain ranged from approximately 2 (mild pain) to 8 (severe).	F 755		

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Review of Resident 1's electronic medical record revealed a nursing care plan (document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes) for pain was not located in his medical record.

Review of facility policy titled, "Pain Assessment and Management," subtitled, "General Guidelines" (revised October 2022) indicated, "1. the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, (and) the comprehensive care plan..."

Review of Resident 1's medical record revealed the October 2023 MAR that indicated from 10/28/23 through 10/29/23, nursing staff did not give Resident 1 approximately six doses of his scheduled Hydromorphone (representing a time period of approximately twenty-four hours). The following doses were documented as not given: 4 a.m.; the nurse documented, "...waiting for supplies...," 8 a.m. the nurse documented, "...await for delivery...," 12 noon the nurse documented, "...on order...," 4 p.m. the nurse documented, "...waiting for supplies...," 8 p.m. the nurse documented, "...waiting for supplies...," at midnight the nurse documented the medication was not given and at 3 a.m.. documented, "...waiting for supplies."

Review of Resident 1's medical record revealed the November MAR indicated on 11/8/2023, the midnight dose was not given and the nurse documented #9 (no side effects) and #2 (Resident not available).

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F 755	Continued From page 20 Review of Resident 1's medical record revealed the December MAR that indicated multiple doses of Hydromorphone were not given between 12/11/2023 to 12/14/2023. On 12/11/2023 at 4 p.m., the nurse documented Resident 1's pain scale was #7 (severe) and the rationale for not administering the medication was "other". On 12/12/23 at 4 a.m., the nurse documented Resident 1's pain as #7 (severe), Hydromorphone was not given, and the nurse documented at 6:21 a.m. that they were, "...waiting for supplies..." On 12/13/23, the nurse documented the midnight and 4 a.m. doses were not given due to, "Hold med, see progress notes". At 05:55 a.m., the nurse documented that they were, "...waiting for supplies..." On 12/14/23, the nurse documented the midnight dose was not given; at 00:40 a.m. (forty minutes past midnight), the nurse documented, "...Previous LN (licensed nurse) shared... that resident was out of Dilaudid, refill will be process (sic), and supply will be deliver(ed) by midnight. However, no delivery has been made. Contacted pharmacy and spoke with (name), stated that refill has not been processed yet but she will process and will be delivered to the facility by 445am (sic). Per pharmacist, she was unable to give me authorization from the e-kit (emergency medication supply) since the prescription is different..." At 1:23 a.m., the nurse documented, "...Contacted pharmacy...Refill is (sic) yet to be processed..." At 4:20 a.m., the nurse documented, "Unable to get any (Hydromorphone) from the e-kit per pharmacy since prescription is different. waiting for delivery..." , During an interview on 1/30/2024 at 2 p.m.,	F 755		

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Licensed Nurse C (LN C) stated the pharmacy delivered medication to the facility daily at approximately 6 a.m., 4:30 p.m., and 10 p.m. but it was sometimes hard getting medications from the pharmacy. She stated if a resident's medication was missing, nursing staff had to call the pharmacy. She stated she had had to make multiple calls (to request the medication) in the past and it occurred on all three shifts (day, evening, and night shifts). When asked why staff needed to make multiple calls, LN C stated she did not know. LN C stated she remembered Resident 1, he had an amputation of he left leg below his knee, he had a heel wound, and he would describe his pain as being, "everywhere." She stated Resident 1 was receiving his Dilaudid every four hours but the pharmacy had not delivered it, she had called pharmacy (to request the medication), but it was not delivered. She stated she had to call pharmacy to get a one-time code for access to the e-kit and she was then able to administer the medication. (The e-kit required a pharmacy-provided code in order to access narcotics like Hydromorphone/Dilaudid).

During the same interview on 1/30/2024 at 2 p.m., LN C stated other resident's medication were similarly impacted. She stated she had had to call pharmacy for other residents whose medications were missing but the pharmacy failed to deliver them. LN C stated when she called the pharmacy, she spoke directly with a pharmacist (versus general pharmacy staff) because she was more likely to get the medication delivered if she did so.

During a telephone interview and concurrent review of email correspondence (from

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Pharmacist F) on 2/12/24 at 11:20 a.m., Pharmacist F (Pharm F) stated the facility requested Resident 1's Hydromorphone be refilled on 10/27/23 (the day prior to his not receiving Hydromorphone for twenty-four hours), the medication was not delivered until 10/29/23 at 2:30 a.m., and the pharmacy was only able to provide a "small supply" of ten tablets (the Hydromorphone was on backorder). When asked why the medication was not delivered on 10/28/23, Pharmacist F stated they attempted to fill the full order (versus the ten tablets) and the pharmacy sent out the medication on 10/28/23 at approximately midnight. When asked why nursing staff did not get the Hydromorphone from the e-kit (on 10/28/23), Pharmacist F stated Resident 1's order was for 4 m.g. dose tablets and the ekit had only 2 m.g. tablets. He stated the nurse could have called the physician for a one-time order (physician order for one dose of medication, versus a scheduled dose) of Hydromorphone (in order to access the e-kit medication) and stated this was "common" (practice). When asked why nursing staff did not get a new one-time order, Pharmacist F stated he did not know and stated that should have happened.

During the same telephone interview and concurrent review of email correspondence on 2/12/24 at 11:20 a.m., Pharm F was asked why the nurse did not give the Hydromorphone on 11/8/23 dose at midnight. Pharm F stated he believed the nurses did not have the medication.

During the same telephone interview and concurrent review of email correspondence on 2/12/24 at 11:20 a.m., Pharmacist F was asked

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about nurses intermittent failures to administer Hydromorphone to Resident 1 from 12/11/2023 to 12/13/2023. Pharm F stated he did not know why nurses did not administer Hydromorphone during this time. He stated the Hydromorphone order was changed to 2 m.g. tablets (nurses would give two, 2 mg tablets) in November and was filled and delivered on 11/20/23 and 11/29/23. When asked how many tablets were delivered on 11/29/23, Pharm F stated 118 pills were delivered. When asked how many doses that represented, Pharm F stated about ten days worth and the medication would have run out on 12/11/20 (when nursing staff began documenting that the medication was missing). He stated the facility requested a refill on 12/9/23 and 12/13/23 but the pharmacy had to send a notice to the facility and provider (doctor) on both occasions; the notice indicated no refills remained and another physician order was needed. Pharm F stated the next order the pharmacy saw requested was on 12/14/23 around 12:53 a.m.; the Hydromorphone went out (with a quantity of fifty tablets) and was delivered at 6:30 a.m. on the same day.

During a telephone interview on 2/12/2024 at 3:30 p.m., Resident 1 and CF were asked what it was like not receiving his Dilaudid, especially during the 24-hour period on 10/28/23. Resident 1 stated he had lots of pain, had the sweats, felt itchy, and felt like he had hives. He stated he had withdrawal (from his Dilaudid) on top of his pain. Resident 1 stated his pain was always above a 7 (severe), occasionally at a 9, but not below a 5 (moderate). Resident 1 stated missing his Dilaudid doses caused his pain to increase and made him feel like it was a "hopeless situation."

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Resident 1 stated not receiving his pain medication made him feel angry and depressed. He stated he felt out of control and stated, "I was at their whim and at their mercy." CF stated Resident 1 talked about suicide due to not getting his pain medication and the resulting increased pain.

During the same telephone interview on 2/12/2024 at 3:30 p.m., CF stated she had told the prior DON and Administrator (both no longer at the facility) about Resident 1's suicidal thoughts. She stated she was not sure who they were (their names) as the facility had had multiple DON's over the past month and a temporary Administrator.

Online review of the Mayo Clinic website indicated, "...Do not...suddenly stop taking opioids (Hydromorphone) ...Opioids withdrawal can be dangerous, and symptoms can be severe....stop opioids slowly, called a taper. Tapering means slowly lowering over time the amount of opioid medicine you take until you stop completely...Symptoms of opioid withdrawal may include...mood changes such as sadness and depression... Increased pain...Goose bumps on the skin... sweating...Thoughts of suicide..."

(https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/tapering-off-opioids-when-and-how/art-20386036).

During an interview on 2/13/24 at 11:55 a.m., Licensed Nurse H (LN H) stated she remembered Resident 1 well. She stated he used to take his Dilaudid for pain prn (as needed, not scheduled). He took it so frequently that staff

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	555214	A. BUILDING _____ B. WING _____	C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL POST ACUTE CENTER	81 PROFESSIONAL CENTER PARKWAY SAN RAFAEL, CA 94903

(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
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called his physician and got the order changed to scheduled Dilaudid (nursing brought him his Dilaudid every four hours versus waiting for him to request it). LN H stated Resident 1's family member (CF) would sometimes call her to tell her Resident 1 was in pain. When asked if she was aware Resident 1 had felt suicidal when his medication was withheld, she stated she was not aware.

During the same interview on 2/13/24 at 11:55 a.m., LN H stated pharmacy medication delivery was an "ongoing" issue at the facility. She stated nursing staff had to call the pharmacy multiple times for missing medications or refills, especially for narcotics (like Hydromorphone). She stated she would keep calling, they would say they would deliver the medication, but the medication would not come. LN H stated she did not know why they didn't process and send the medication. She stated sometimes the did does not message the pharmacy back (after pharmacy reached out to them). LN H stated she worked at another facility and they had a process where nurses could request a "rush med," where a driver would pick up the medication and deliver it within two hours. She stated it would be nice if this facility had such a backup system.

During the same interview on 2/13/24 at 11:55 a.m., LN H stated if a resident was out of a medication, nursing could call the pharmacy and access the e-kit (pharmacy would provide a code to access the e-kit). When asked why a nurse might not get a code from the pharmacy, she stated the prescription for the medication may be old and/or the resident needed a new prescription. LN H stated on day shift, a nurse

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could call the physician and ask for a new order. LN H stated the facility had a lot of registry nurses (provided by a contract service) and they did not always ask for help (if they had an issue) and they did not go the extra length (for their residents).

During a telephone interview and concurrent medical record review on 2/14/2024 at 9 a.m., the Director of Nursing (DON) was asked about Resident 1 not being administered his Hydromorphone on 10/28/23. The DON stated Resident 1 missed a total of seven doses of Hydromorphone on 10/28/23 and nursing staff documented he had no pain (on the MAR during that time). She confirmed Resident 1's medical record contained no documentation that he was suicidal, no social service note addressing his being suicidal, and no nursing care plan to address his chronic pain. When asked what should have happened, the DON stated staff should have faxed pharmacy a request a refill, called the pharmacy and documented an estimated time of medication arrival. If the medication was not delivered, staff should have called pharmacy a second time and "bumped it up," (notified) the DON or the Administrator, and documented in the record that the physician was notified. The DON stated nursing should have gotten a code to access the e-kit (and get the medication) and she stated there was no reason to go seven dosed without pain medication.

During the same telephone interview and concurrent medical record review on 2/14/2024 at 9 a.m., the DON stated there was no progress note (nursing note) from nursing staff documenting why his midnight dose of

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Hydromorphone was not given on 11/8/23. She stated nursing should have documented the reason.

During the same telephone interview and concurrent medical record review on 2/14/2024 at 9 a.m., the DON confirmed Resident 1 did not receive his 12/11/23 Hydromorphone scheduled for 6 p.m. and that nursing documented his pain was #7/10 (severe) at the time. She confirmed he did not receive his Hydromorphone on 12/12/23 at 4 a.m., nursing documented they were waiting for supplies, and his pain was #7 (severe). The DON confirmed Resident 1's Hydromorphone was not given on 12/13/23 at 4 a.m. The DON confirmed on 12/14/23, Resident 1 did not receive his Hydromorphone at midnight and 4 a.m.. The DON stated her expectation was that nurses needed to do what they needed to do to get the medication and they should "bump it up" (to leadership for assistance).

During the same telephone interview and concurrent medical record review on 2/14/2024 at 9 a.m., the DON was asked if she was aware nursing staff had reported pharmacy deliveries were an ongoing problem at the facility and she stated she did not know (this). When asked if the issue with pharmacy was not resolved in October and continued into December 2023 for Resident 1, the DON stated it was a "safe assumption" and it appeared the issue had not been resolved.

During a telephone interview on 2/21/24 4:30 p.m. and 6:00 p.m., Pharmacist G (Pharm G) stated he was the consulting pharmacist at the facility, dealt primarily with clinical issues, and delivery issues were dealt with on the dispensing

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side (at the dispensing pharmacy, where Pharm F was located). Pharm G confirmed Resident 1 was not given Hydromorphone for twenty-four hours on 10/28/23 and stated it was an, "unfortunate situation" that he missed his scheduled medication. When asked what nursing should have done in this situation, he stated that they should have notified the physician, who could have then contacted the pharmacy.

During the same telephone interview on 2/21/24 4:30 p.m. and 6:00 p.m., Pharmacist G was asked about nursing staff not accessing the e-kit for Resident 1's Hydromorphone. He stated nursing can access the e-kit twenty-four hours a day and it requires a one-time code. He stated this necessitated a physician prescription which could be a verbal order, followed by a written copy (of the order) within seven days. The pharmacy could call the physician for emergency pharmacy needs. Pharm G confirmed Resident 1's issues with Hydromorphone (delivery) in October were still present in December (approximately two months later). When asked if he was aware of issues with accessing the e-kit, Pharm G stated, "no." When asked if he was aware of ongoing delivery issues at the facility, Pharm D stated he was aware, but not of any specific issues. He stated there was "turnover at the top" (leadership at the facility) and that can happen with leadership issues.

During a telephone interview on 2/27/2024 at 9:43 a.m., Physician J was asked if he was aware Resident 1 experienced pharmacy delivery issues with his Dilaudid (Hydromorphone). He stated he was aware it happened one time but did not know it was a routine issue. When asked

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if he was aware nursing staff had not administered Resident 1 his scheduled Dilaudid for approximately twenty-four hours on 10/28/23, Physician J stated the patient (Resident 1) shared the information with him, but nursing staff had not. When asked if nursing staff should have informed him of this, he stated, "of course." Physician J stated nurses lost track of narcotic counts and they called when they ran out (of medication). Physician J was asked if Resident 1's symptoms of sweating, itching, and feeling like he had hives were consistent with narcotic withdrawal symptoms and he confirmed that they were, and stated Resident 1 was dependent on Dilaudid. Physician J was informed nursing staff did not document that they were monitoring for signs of withdrawal during that time and he stated nursing staff should have documented the issue and, "escalated it up." Physician J stated if he was not available, they (his group) had an on-call (physician available to take a call) physician and staff could have escalated it up to them (for assistance). When asked if he was aware Resident 1 had felt suicidal at the time, Physician J stated, "no." He stated Resident 1 had expressed to him that he was upset and uncomfortable (due to pain). Physician J was informed that Resident 1 and CF stated they had informed the previous DON and Administrator about Resident 1's suicidal ideation's and he stated, "I believe them." When asked what his expectation was regarding leadership's knowledge of Resident 1's suicidal ideation, he stated the DON should call pharmacy to uncover the problem. He stated the DON should have called pharmacy when Resident 1 ran out of medications on other occasions as well. Physician J was informed Resident 1 missed

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multiple dosed of Dilaudid from 12/11/23 through 12/14/23. Physician J stated nursing staff should have used the Dilaudid located in the E-kit.

Review of facility policy titled, "Pain Assessment and Management," subtitled, "Implementing Pain Management Strategies" (revised October 2022) indicated, "... 4. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects... 5. The following are considered when establishing the medication regimen: ...b. Administering medications around the clock... 6. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider (doctor) when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications..." Under subtitle, "Monitoring and Modifying Approaches," the policy indicated, "... 4. If the resident is prescribed opioid analgesics (pain medication), monitor for the following side effects: ... b. Physical dependence which causes symptoms of withdrawal when opioid medication is stopped, or a dose is held or missed..."

Review of facility policy titled, "Administering Medication," subtitled, "Policy Statement" (Revised April 2019) indicated, "Medications are administered in a... timely manner, and as prescribed." Under subtitle, "Policy Interpretation and Implementation," the policy indicated, "...4. Medications are administered in accordance with prescribe orders, including and required time frame..."

Review of facility policy titled, Provider Pharmacy

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F 755	Continued From page 31 Requirements," subtitled "Policy" (dated April 2008) indicated, "Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies..." Under subtitle, "Procedures," the policy indicated, "...D. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to: ...2) Accurately dispensing prescriptions based on authorized prescribe orders.... 6) Providing routine and timely pharmacy service seven days per week and emergency pharmacy service 24 hours per day, seven days per week...b. Medications which should be promptly available such as... drugs used to treat problems including severe pain... or other severe discomfort are available within 4 hours.	F 755		

Professional Post-Acute Center

Professional POC for Pain Management

February 28, 2024

F697

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice

The resident is no longer at the facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

The facility has run the order listing for opioids and each medication cart was checked to ensure an adequate number of medications were on the cart to meet the administration of the physician's order. There were no other residents identified who were identified as having an inadequate supply of medications.

The opioid order listing was also utilized to ensure that each resident had a plan of care for pain. There were no other residents identified.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

Education will be provided to Licensed nurses by the Director of Nursing Services regarding the importance of following a physician's order and having medications on hand to administer per the MD order.

The licensed nurses will be instructed on the importance of reordering medications prior to running out and following up with the pharmacy if the medication has not been delivered prior to running out. If the medication runs out prior to delivery, the nurse will notify the physician so alternative medications can be ordered and utilized out of the e-kit. The nurses will be educated on the proper protocol on utilization of the e-kit and the steps to take to ensure access.

If the ordered medication is in the e-kit, the licensed nurse will notify the pharmacy that access to the e-kit is needed. If the e-kit has the medication but the dose is different, the nurse will call the MD for a one-time order so access can be obtained.

The education also included the need for licensed nurses to be aware of the ramifications of not administering an opioid to a resident who has been routinely receiving it and the signs and symptoms of opioid withdrawal and the importance of updating and revising the care plan with each resident's change of condition.

The licensed nurses are also responsible for accurate documentation in the medical record. If access is not granted to the e-kit and alternative interventions are ineffective and the resident is in unrelieved pain, the nurse shall notify the MD and the Director of Nursing and the request to have the resident sent to the acute will be made to meet the pain goals of the resident.

The facility will also have a registry instruction binder with directions on how to utilize the E-kit and general pharmacy ordering instruction as per the policy. The licensed nurse who are staff members will be instructed on being a resource for any nurse from registry.

How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.

Monitoring shall be ongoing through the daily MAR audit conducted by the Director of Medical Records Monday through Friday except for holidays. The audit will focus on routine pain medications that have not been documented as given and a care plan has been revised to address the resident's potential for pain. The audit will be forwarded to the Director of Nursing for follow-up. Any pain medication that has not been documented as administered will necessitate an assessment of medications on hand, pain assessment of the resident and notification to the MD. In addition, the Director of Nursing will instruct the nurses to monitor for withdrawal if the resident has not received the medication. If the medication was administered, the licensed nurse will be contacted to correct the documentation omission.

Medications not delivered will require pharmacy notification and MD notification and alternative orders will be requested to meet the residents pain goals. In addition to the MD notification, the Administrator and Director of Nursing will be notified so the issue can be escalated to the pharmacy for resolution by the Director of Nursing and/or Administrator. In addition, the Director of Nursing will ensure that the e-kit is utilized when alternative orders have been received or medications need to be accessed from the e-kit.

Monitoring shall be ongoing through a once-a-week audit completed by the Director of Nursing or designee (a nurse manager) by running the opioid order listing and auditing the carts for the required medications to ensure nurses have ordered the medication prior to running out. If a card is found to be low in supply and has not been ordered, the order will be placed, and the Director of Nursing shall monitor the delivery of the medication to ensure medications are available for administration.

Medications not delivered timely will necessitate the Director of Nursing and/or Administrator to reach out to the pharmacy manager to ensure timely delivery of medications ordered for rush medications and routine medications. The assigned consultant pharmacist will also be notified to ensure additional support for medication delivery.

The plan of correction is integrated into the quality assurance system

The Director of Nursing will bring any trends of deliveries from the pharmacy for the monitoring processes to the QAPI committee where the POC may be modified to achieve the threshold of 100% for pain medications. ALL non-compliant finding will be reported to the administrator and added to monthly QAPI for 3 months or until no negative trends are Identified.

Include dates when corrective action will be completed 3/28/2024

F755

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice

The resident is no longer at the facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

The facility has run the order listing for opioids and each medication cart was checked to ensure an adequate number of medications were on the cart to meet the administration of the physician's order. There were no other residents identified who were identified as having an inadequate supply of medications.

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How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.

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Medications not delivered timely will necessitate the Director of Nursing and/or Administrator to reach out to the pharmacy manager to ensure timely delivery of medications ordered for rush medications and routine medications. The assigned consultant pharmacist will also be notified to ensure additional support for medication delivery.

Facility Administrator Notified Pharmacy regarding delivery and timeless of medications, Pharmacy was given education if Medication cannot be delivered in the 4 hour window, the pharmacy will need to notify the facility immediately.

The plan of correction is integrated into the quality assurance system

The Director of Nursing will bring any trends of STAT deliveries from the pharmacy for monitoring processes to the QAPI committee where the POC may be modified to achieve the threshold of 100% for pain medications. ALL non-compliant finding will be reported to the administrator and added to monthly QAPI for 3 months or until no negative trends are Identified.

Include dates when corrective action will be completed: 3/28/2024

LNHA

4/15/2024

POC accepted on 4/10/24. Request made to Admin to sign and date the POC and 2567. Nicole Forman returned POC/2567 to the dept on 4/15/24. Eileen Brooker 4/15/2024