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| F9999 | FINAL OBSERVATIONS<br><br>FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br>300.1210a)<br>300.1210b)<br>300.1210d)1)3)<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)<br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each | F9999 | | |

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| F9999 | Continued From page 48<br>resident to meet the total nursing and personal care needs of the resident.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These Regulations were not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to effectively manage pain control for R4, 1 of 1 sampled resident who verbalized complaints of pain in the sample of 13.<br><br>Findings include:<br><br>According to the medical record R4 is an 81 year old non-ambulatory female with diagnoses including: Insulin Dependent Diabetes, Right AKA | F9999 | | |

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| F9999 | Continued From page 49<br>(Above the Knee Amputation), Morbid Obesity, Hypertension, Peripheral Neuropathy and history of Back Pain.<br>he MDS (Minimum Data Set) Annual Assessment dated 05/07/12 noted in Section C (cognitive patterns) R4 had a summary score of 11 (moderately impaired) and a zero under Acute Mental Status Change (no evidence of acute mental status change from baseline.)<br>R4 was first observed on 07/17/12 at approximately 10:00 AM. in her room. R4 was sitting in an adaptive wheelchair next to her bed. R4 stated at this time she would like someone to put her back in her bed. She also stated she had been up in her chair all morning and her back was really hurting.<br>R4 was observed again on 07/19/12 at approximately 11:30 AM. in her room, lying in bed. R4 was asked about her general care at the facility and she stated she is always in pain. "It goes all the way up my right side. When I'm in the chair it hurts my back." R4 also stated when she is in bed she can stretch out and she doesn't have as much pain. R4 was asked if she gets any medication for pain and she stated she thought she gets Motrin but it doesn't help. When asked to rate her pain when it occurs on a scale of 1-10, R4 rated the pain as a "9". R4 further described her pain, "my back feels like a needle is sticking me. My tailbone, it feels like a cancer, what they give me don't help. I don't like to complain."<br>E7, RN (Registered Nurse) was interviewed at the nurses station at approximately 11:40 AM. E7 was asked if R4 had any pain medication ordered. E7 looked in R4's medical record then stated that R4 was getting Tylenol but she said it wasn't helping so we got an order for her | F9999 | | |

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Gabapentin to be increased. At 11:45 AM two nurses aides were observed transferring R4 from her bed to her wheelchair using a mechanical lift. When staff rolled her on her left and right sides to place the sling under her, R4 moaned. When asked about the location of her pain she stated the pain goes up her right side and continues all the way up.

Further review of the medical record noted on 06/28/12 R4 became unresponsive and was sent by ambulance to the hospital. R4 returned to the facility on 06/28/12 with a diagnosis of 1.) Syncope and 2.) Lumbar Radiculopathy. The second diagnosis was explained on the discharge instructions and described as a disease to the nerve root, usually referring to the spinal nerves. These go from high in the neck to the low back. The pain produced by this condition usually starts at the site of the problem and radiates outward and downward towards the arms or legs. An order for Tramadol HCL/ Acetaminophen (Ultracet Tablet) 1 tab, orally every 4-6 hours as needed. #10, (10 tablets) was written. The physician's order sheet for Ultracet from the hospital was located in R4's record with no refills ordered. Facility medication records indicate that R4 was administered Ultracet one time on 07/10/12 and once on 07/19/12. The reason listed by the nurse on 07/10/12 states c/o "pain" and the result was documented as "observe." The 07/19/12 administration lists "c/o leg pain" with no results documented.
R4's most current care plan dated 05/07/12 was reviewed and there was no update to the plan after R4's hospital visit of 06/28/12. One of the interventions listed in the care plan is to evaluate effectiveness of neurontin/Vicodin for phantom

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| F9999 | Continued From page 51<br>leg pain. There was no dosage listed for the neurontin nor was it updated after the neurontin was increased. There was no current order at all for the Vicodin listed. Another intervention listed was to monitor resident for pain other than phantom pain but there was no other pain listed on the care plan. R4's pain assessment tool completed on 07/05/12 does not document any instances of pain or updates in pain medication administration or pain management. R4's diagnosis of Radiculopathy is not addressed in the pain assessment nor is the administration of Ultracet included the assessment. Medication Administration Records (MARs) for April through July, 2012 include an order to evaluate for pain every shift. (+) = yes, (-) = no. However, the majority of entries were staff initialing each shift and not documenting presence or absence of pain as the order is written. Also R4's care plan notes to use the face scale when assessing for pain. This conflicts with the pain documentation order placed on the MAR.<br>On 07/1912 the facility notified the physician of R4's complaints of pain and a new order for scheduled pain medication was initiated.<br>(B)<br><br>300.1210a)<br>300.1210b)<br>300.1210d)1)<br>300.2040b)<br>300.2040e)<br>300.3240a) | F9999 | | |

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| F9999 | Continued From page 52<br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)<br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. | F9999 | | |

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| F9999 | Continued From page 53<br>Section 300.2040 Diet Orders<br><br>b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.<br>e) A therapeutic diet means a diet ordered by the physician as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These Regulations were not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to properly assess, monitor and intervene for 1 of 1 resident (R6) with a history of aspiration pneumonia in a sample of 13. This put R6 at risk for further complications related to aspiration pneumonia. The facility failed to maintain acceptable parameters of nutritional status for 1 of 1 resident (R6) with observed swallowing difficulties and poor oral intake in a sample of 13. This resulted in a significant weight loss of 16 pounds (10%) in 38 days.The facility failed to provide necessary services related to diabetic | F9999 | | |

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| F9999 | Continued From page 54<br>management.<br><br>Findings include:<br><br>R6 is an 82 year old male admitted to the facility on 6/11/2012 with a diagnosis which includes diabetes mellitus, history of pneumonia, vitamin D deficiency and gastroesophageal reflux disease. R6 has no diagnosis related to swallowing difficulty. R6 does have most of his natural teeth. R6 is on a mechanical soft diet with low concentrated sweets per physicians order dated 6/11/12<br><br>During observation on 7/17/2012 at 12:05 PM R6 received a lunch tray with a submarine sandwich , whole potato chips, cucumber salad and juice of thin liquid consistency. Staff cut the sandwich in four pieces and left the table to assist another resident. R6 began to eat at 12:07 PM using a fork to attempt to spear the potato chips. R6 then used the fork to put a large piece of sandwich in his mouth. Without chewing the first large bite R6 put another large bite of sandwich in his mouth. At 12:10 PM R6 began coughing and letting large pieces of lunch meat, lettuce and tomato fall out of his mouth. R6 continued to hold some food in his mouth. R6 had clear nasal drainage in moderate amounts coming from his nose while coughing. R6 then took a drink of juice. R6 finished the juice of thin liquid consistency but continued to cough. E14 (Business director and CNA) told R6 to stop eating since he was coughing. R6 refused to eat any more of his lunch meal. E14 also stated that R6 feeds himself. | F9999 | | |

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| F9999 | Continued From page 55<br><br>On 7/17/2012 at 2:15 PM E6 (dietary supervisor) stated the mechanical soft diet for lunch was a submarine sandwich with whole potato chips, lettuce leaf and tomato slices on the sandwich with cookies and juice.<br><br>On 7/18/2012 at 10:00 AM, E4 (Registered Dietitian) stated the the mechanical soft diet for lunch on 7/17/2012 should have consisted of potato chips in nickel sized pieces, a submarine sandwich with thin sliced tomato and shredded lettuce and shredded thin sliced lunch meat. E4 agreed that lettuce leaves nor whole potato chips should be given as a mechanical soft diet.<br><br>On 7/18/2012 at 5:45 PM, R6 ate 2 bites of tuna casserole and one sip of thickened milk which staff assisted by feeding R 6. R 6 held the tuna casserole in his mouth and began coughing. R6 again had clear nasal drainage in moderate amounts coming from his nose. R6 then spit out the tuna casserole and the one sip of thickened milk . R 6 refused to eat or drink anything else.<br><br>On 7/18/2012 at 5:50 PM , E15 (CNA) stated R6 usually eats better than this for supper, but R6 doesn't like this meal. Staff did not offer a substitute. E15 also stated that R6 frequently coughs at meal time.<br><br>Nurses notes dated 6/11/2012 -7/18/2012 were reviewed and there were no nursing notes documenting that R6 had a poor appetite or was coughing during meals. The physician was not notified of a poor appetite or coughing during meals for this time either. | F9999 | | |

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On 7/19/2012 at 12:20 PM R6 was fed by E2 (DON) in his bed. The head of the bed was at 90 degrees. R6 ate 2 bites of mashed potatoes, but began coughing after the first bite. R6 was also given a 1 inch cube of pork chop which he chewed for approximately 2 minutes never swallowing. E2 asked R6 if he would like to spit the meat out. R6 shook his head yes and spit the partially chewed meat in a napkin.
R6 then refused to eat or drink any other part of the meal.

E2's nurses note of 07/19/12 documents that the family was then notified of R6's swallowing difficulties. Family informed E2 that R6 has had 2 previous hospitalizations for aspiration pneumonia and that is why he is on a mechanical soft diet.

Review of R6's clinical record from 6/11/12-7/18/12 shows no speech evaluation for holding food in mouth, coughing at meals, or poor oral intake. There were also no documented swallow evaluations in the record. Review of the Nutritional Assessment dated 7/15/12 stated : R6 is able to feed self, had difficulty swallowing thin liquids 7/5/12 at breakfast, recommend trying thickened liquids, but did not tolerate so continue thin liquids, R6 has a fair oral intake.

The only intervention by the facility after 07/19/12 was to obtain a physician's order for a swallow evaluation by the speech therapist.

R6's careplan dated 06/21/12 for Nutrition notes that he has a potential for altered nutritional status related to current mechanical soft diet. The careplan further states that R6 will show no signs

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of aspiration. The only interventions in the plan are to 1) provide diet as ordered, 2) Encourage self feeding, 3) Honor food preferences. There were no specific interventions to address R6's swallowing difficulties or for monitoring specific signs and symptoms of aspiration. No updates were initiated to the careplan after 06/21/12.

Review of Medication Administration Record (MAR) dated 6/12/2012 - 6/30/2012 for R6 showed he is a type II diabetic and the physician had ordered blood glucose testing four times a day with sliding scale insulin coverage.

An interview with E2 (DON) on 7/19/2012 at 11:20 AM stated that R6 was a stable diabetic at the facility since 6/11/2012 admission. E2 also stated that the hospital had problems with R6's blood sugar being unstable prior to R6's admission to the facility.

Review of the physicians order dated 6/11/2012 for R6 shows an order to administer insulin using the following scale based on blood sugar levels:
140 - 180 milligrams/deciliter (mg/dl) = 1 unit
180 - 220 mg/dl = 2 units
221-260 mg/dl = 3 units
261- 300 mg/dl = 4 units
300 mg/dl = 5 units
over 400 mg/dl call the physician.

No parameters were given which would have provided nursing with the necessary interventions if R6's blood sugar level fell below the acceptable range (70 - 130 mg/dl per the "Standards of Medical Care in Diabetes - 2010" Volume 3, Supplement 1, January 2010).

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| F9999 | Continued From page 58<br>Review of the MAR for 6/11/2012 - 6/30/2012 shows R6 did not receive sliding scale insulin on 6 different days at 8 PM per orders. Blood sugars on the following dates required sliding scale coverage:6/12/2012 level 265, 6/13/2012 level 147, 6/14/2012 level 176, 6/26/2012 level 210, 6/27/2012 level 204.<br><br>Interview with E2 on 7/19/2012 at 11:20 AM confirmed no sliding scale insulin was given during the month of June 2012 at 8 PM. E2 also confirmed that insulin was given during the month of July 2012 at 8 PM. E2 also confirmed the sliding scale insulin order was not clear as to the frequency R6 was to receive sliding scale insulin.<br><br>(B) | F9999 | | |