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| S9999 | Final Observations<br><br>STATEMENT OF LICENSURE VIOLATIONS<br><br>300.610a)<br>300.1210b)<br>300.1210d)3)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><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 | S9999 | | |

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and shall be practiced on a 24-hour, seven-day-a-week basis:

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on record review, interview and observation the facility failed to provide nursing services by not performing ongoing thorough and accurate pain evaluations of one resident's (R1) continued complaints of pain, failed to follow their own policy and procedure on assessing pain and failed to have a plan of care in place to manage the pain for one of 3 residents for complaints of worsening pain following a fall. The facility also failed to renew an antidepressant for one resident (R1) with a long standing history of depression, upon return from the hospital.

These failures contributed to R1 experiencing pain ranging from 3-10 on a scale of 10 for 26 days following a fall from a lift on 10/18/13 and contributed to R1 displaying increased signs and symptoms of depression.

The finding includes:

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| S9999 | Continued From page 2<br><br>A Final (Investigation) Report dated November 18, 2013 states during a mechanical body lift transfer on October 18, 2013 the double straps on the lift tore, resulting in R1 (83 years old) falling to the floor and sustaining a left humeral neck fracture. (Per Minimum data Set dated 8/15/13, R1 weighs 152 pounds.)The report states R1 was noted to have persistent swelling and complaints of pain to the left knee following the fall to the ground on October 18, 2013. The (left) leg, upon initial event of 10/18/13, noted with swelling and foot rotation. On November 15, 2013 R1 underwent surgical repair for an acute left tibial metaphysis fracture with anterior displacement. This report states R1 has extensive history of osteoporosis, osteoarthritis, osteopenia and previous fractures of this area. Also per this report, R1 is receiving a medication "to assist with bone turnover again noting severe risk for fracture." An H & P (history and physical) exam dated 11/13/13 from the hospital states R1 "had a left femur fracture in 10/2012, treated with an intramedullary rod. She went on to have 2 fractures in her left upper extremity a few months ago." This report indicates the facility was aware that R1 was at high risk for fractures.<br><br>E1 (administrator) stated on 11/16/13 at 10:15 am via phone that the lift straps on the hoyer sling separated. When R1 came back from the hospital on 10/18/13, she had a fractured humerus and left swollen knee. E1 stated the rotation of the left leg seemed to be increasing and she complained of pain upon transfer in addition to all over body pain. E1 said staff wanted to keep R1 in bed but she wanted to get up. It wasn't until R1 went to the hospital on 11/13/13 that the fracture to the left leg was diagnosed. | S9999 | | |

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E6 (certified nurses aide) stated on 11/16/13 at 12:45pm she (E6) was the one transferring R1 on 10/18/13 when R1 fell from the lift. E6 said R1 was very particular about who could help her but R1 liked E 6 and she (E6) was one of R1's regular cnas. E6 said R1 didn't complain of pain that much before the fall, just in her shoulder sometimes. E6 said after R1 came back from the hospital after the fall on 10/18/13, she (R1) complained of pain to the left leg during transferring. And when R1 was in bed, she complained of pain when being repositioned or turned, R1 said that hurt too. E6 said "the more you moved her as the days went on she had more pain in bed." E6 stated R1's "left leg was swollen and red in the knee area and the calf." E6 said R1 even started to refuse to get up in the morning and that wasn't like her because she loved to be up in her wheelchair for breakfast.

Following R1's return from the ER visit after the fall on 10/18/13, there is random documentation in the nurses notes of R1 experiencing increasing pain in the left leg upon movement until 11/13/13, when R1 was discharged to the hospital for further evaluation.

The NP (nurse practioner) E3, documented on 10/18/13 after the fall, that R1 had left proximal tibia swelling/tenderness and extreme pain to the left upper and lower extremities. To ER for evaluation. The NP note from 10/21/13 identifies the internal rotation of the left lower extremity and ankle.

Nurses notes (NN) 10/18/13: R1 returned from the hospital at 10:45pm. Diagnosis of humerus fracture, minor head injury and abrasion. Leg remains swollen and R1 was medicated for pain. (There was no mention of the left leg having been

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evaluated.) The NP ordered for an orthopedic appointment. The 10/19/13 NN document complaints of left leg pain, swelling and the left foot turned inward.

E5, wound nurse, documernted on the Skin Alteration Assessment dated 10/30/13 that R1 was noted with bruising to (left) foot with pitting edema.

On 11/16/13 at 12:00pm E3 (assistant director of nurses) provided copies of the xrays taken after R1's fall on 10/18/13 and confirmed the left lower extremity had not been xrayed in the ER. POS dated 10/19/13 orders an xray for increased pain and swelling. E2 provided a portable xray (in the facility at bedside) report taken 11/20/13 stating there is a long intramedullary rod stabilizing an old distal femur fracture. Left total knee replacement. Old deformity to left distal tibia. No new fracture is seen. NN continue to document complaints of pain to the left lower extremity and on 10/20/13 state R1 is moaning when turning and changing diaper. This NN states twice that the pain is upon movement. Nurses note document on 11/5/13 at 3 am, R1 rated her pain at 10/10 when being moved for a dressing change. Review of nurses notes through the end of October and up until November 13, show R1 continues to have increasing complaints of pain.

R1's October 2013 MAR (medication administration record) shows R1 had been receiving 1000 mg Tylenol Extra Strength every 12 hours prior to her fall on 10/18/13. On 11/16/13 at 11:45am, E4 (adon) stated R1 was administered this medication for complaints of general body pain from her arthritis and pain to her left arm from a fracture sustained several months ago. This was the only medication for

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pain R1 was administered prior to the fall on 10/18/13. This MAR shows that R1 had a new order for Norco 5/325 one tab by mouth every 6 hours as needed that began on the day of the fall, 10/18/13. Review of R1's October and November MAR and her Controlled Drug Record for the Norco shows R1 received the Norco at least 29 times between 10/18/13 and 10/31/13 and 33 times from 11/1/13 through 11/13/13, when R1 was a direct admit to the hospital for evaluation of the ongoing pain in the left leg and subsequent surgery. E2 stated 11/20/13 at 10:40am she could not locate the Controlled Drug Record for 10/18/13 through 10/23/13, indicating how many times Norco had been signed out for R1 on those days.

A facility Pain Evaluation performed on the day R1 was dropped from the lift, 10/18/13, is non-specific to R1's complaints of pain. It consists of 10 generalized categories (such as mental status, communication, etc) and the responses are numeric based with no further instructions or analysis. R1's quarterly pain assessment dated 11/7/13 is the pain assessment for non-verbal/cognitively impaired residents, neither of which R1 is based on R1's interview of 11/20/13. In addition, the information is incorrect, stating R1's routine pain meds are effective and she (R1) has not had any recent accident that may be causing pain. The facility's Pain Management policy and procedure has not been followed which states to utilize non-verbal pain evaluation on residents who are unable to respond or have a cognitive deficit. When asked for a comprehensive pain assessment that documents and identifies specific risk factors for fractures, location of pain, pain type and characteristics and effects of the pain on activities of daily living, E4 stated the MAR reflects R1's

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pain level every shift. E4 also stated there is no nursing documentation showing the staff was monitoring the circumference, color, edema or inward rotation of the left leg following the incident on 10/18/13. E4 stated R1's pain assessments are the daily levels of pain (scale of 1 -10) found on the MAR and on the back side of the MAR. The reasons documented by nursing on the back of the MARs vary from generalized discomfort to left arm pain with no mention of left leg pain as the reason for pain medication. In addition, not all the instances in which R1 was administered Norco are documented on the back of the MAR.

In addition to receiving Tylenol 1000 mg twice a day and Norco 5/325 one tab by mouth every 6 hours as needed during this time period (10/18/13 - 11/13/13), R1 was prescribed additional Tylenol 500 mg twice a day as needed on 11/1/13 per nurses notes dated same. Xanax .25 mg at bedtime was prescribed on 10/22/13, per physician order sheet.

R1 went to an ortho appointment on 10/22/13. The report from this consultation dated 10/22/13 shows the physician did not examine the left leg, only the left arm where a fracture to the humerus had been confirmed. There is a statement in this report that R1 has chronic left leg pain, however there was no documentation in the medical record or mention of such obtained during staff and family interviews supporting that R1 had chronic left leg pain prior to the fall on 10/18/13. Following R1's return from this ortho appointment, nurses note on 10/22/13 state R1 is transported via stretcher, "(no) complaints of pain but yells out to movement/transfer."

E4 provided R1's entire care plan on 11/16/13 and there was no plan of care identifying

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interventions or their effectiveness to address R2's pain based on a resident-specific assessment for R1's pain post fall, 10/18/13. The facility's pain policy also directs staff to develop the care plan based on the evaluation regarding pain and pain relief. E4 confirmed on 11/16/13 at 3:10pm there was no such plan of care for R1.

R1 had a second bedside portable xray performed on 10/30/13 of the left tibia, fibula and ankle. It states "Examination reveals some soft tissue swelling with some demineralization and arthritic changes and an old fracture deformity of proximal and distal tibia with vascular calcifications. There is revision total knee replacement prosthesis with some flexion deformity of the knee. Clinical correlation is requested." E4 was asked if the clinical correlation had been completed as suggested in this report and E4 provided a progress note done by R1's attending physician (and facility's medical director) dated 11/1/13 does not indicate R1's left leg was examined, only that the xray shows an old fracture.

Z1 (R1's orthopedic surgeon) stated on 11/21/13 at 5:35pm that he (Z1) would have sent R1 back to the ER for evaluation for complaints of the on-going pain even though the portable xrays were negative. Z1 stated portable xays are not as good as the ones in the hospital and the people taking the xrays are usually not as skilled as the technicians in the hospital. Z1 said R1's left leg was swollen and contracted and that clinical assessment based on a portable xray would be difficult due to R1's underlying contractures. Z1 stated there was a screw navigating from a previous surgery that was in the knee. Z1 said the fracture could have started as a stress fracture when R1 was dropped and that the contractures,

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osteoporosis and fall all worked together to cause the fracture.

Z3 (family member ) stated on 11/21/13 at 7:30pm he saw R1 the day after the fall, 10/19/13, and noticed her left leg was pointed inward at about a 45 degree angle. Z3 said "I tried to get her to move it and she no, it's sore." Z3 said that several days later, maybe about a week, R1 complained of throbbing and burning pain to the left lower leg. Staff thought it might be a blood clot but the test was negative. All the while her foot was turned inward. Z3 said she was in a lot of pain when being transferred saying, 'Ow ow, it hurts." Z3 said that when Z2 (POA and family member) arrived (11/8/13) they both began asking staff including E2, why R1's foot was turned so far inward. Z3 said R1 couldn't straighten her leg because of contractures. Z3 said he and Z2 wondered how the facility could have gotten an accurate xray because R1 could not have been positioned well. Z3 said all the facility kept doing was to give her more pain medication until we (Z2 and Z3) finally insisted she (R1) be sent back to the hospital for more evaluation.

Z2 (POA and family member) stated on 11/20/13 at 10:10am R1 began complaining of pain to her left leg immediately after the fall on 10/18/13 over the phone. (Z2 lives out of state.) Z2 stated she was on the phone multiple times with E2 from 10/19/13 until she arrived 11/8/13, telling E2 about R1's continued complaints of pain to the left leg. Z2 stated R1's left leg and foot were huge when she saw it on 11/8/13. Z2 said she told the NP (E3) over the phone starting a day or two after the fall that R1 does not stop complaining of pain to the left leg. Z2 said she (Z2) watched staff transfer R1 to bed (upon

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arrival on 11/8/13) and every inch they moved her, R1 would cringe and cry, Z2 couldn't even watch. "It was incredible pain for her," said Z2. Z2 stated she sat in on R1's care plan conference on 11/12/13 and insisted R1 go to the hospital, that this level of pain is not normal. "I asked them why are we still monitoring the pain, there is something wrong." Z2 was told there would be a palliative care evaluation and that a Fentanyl patch for pain was going to be tried. Z2 stated on 11/12/13 she insisted to E2 that R1 be sent to the ER and E2 talked her into waiting until the next day, 11/13/13, until after the hospice or palliative evaluation.

A hospice provider assessment dated 11/13/13 states R1 fell 10/18/13 "and after fall left leg has been causing (R1) pain. (R1) describes pain as burning over the entire leg and she rates pain a 5-7/10 on the numeric scale. (R1) states pain comes and goes and hurts more with movement of extremity. On Norco 5/325mg. Per (R1) Norco not helping with pain control. Radiology reports of left leg negative to date and time. Being sent to hospital this afternoon for further evaluation of LLE (left lower extremity)." On November 15, 2013 R1 underwent surgical repair for an acute left tibial metaphysis fracture with anterior displacement.

On November 20, 2013 at 4:35 pm R1 was observed in the hospital to be lying in bed. R1 was lying on her right side with her left leg contracted at a right angle. R1 stated she is unable to straighten her leg any further and that it's been like that for years. R1 began to cry stating that it took the staff at the facility "more than 3 weeks to figure out which bone in my leg was broke. My leg and foot were so swollen. It was such horrible pain when I moved. I couldn't

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sleep for more than 1 or 2 hours at a time. It kept getting worse and worse. I wanted to stay in bed and they made me get up."

R1's Medical Administration Record (MAR) for February 1 - 8 th (date of discharge to hospital) 2013 shows R1 had been receiving Celexa 30 mg at bedtime while in the facility. Review of MAR for Feb. 14, 2013 (date of readmission) shows R1's Celexa was not renewed upon return from the hospital. E4 stated on 11/16/13 at 2:50pm R1's Celexa was renewed on 6/4/13,
3 1/2 months after readmission from the hospital. E4 did not reply when asked why the medication was not prescribed upon readmission from the hospital on 2/14/13.

E2 provided a typed statement dated 12/3/13 noting that R1 has a long history of being on antidepressants and that upon return from the hospital, R1's physician (and facility medical director), Z4, discontinued the antidepressant when in the hospital for abdominal surgery. When asked for documentation as to why Z4 felt R1 no longer needed the medication upon readmission, E2 stated there is no such documentation, only the medication was not prescribed upon readmission on 2/14/13.

A geriatric psych consult dated 6/28/13 states that R1 "appears flat, sad looking, causually groomed and tense. Her speech is monotonal. ... Demeanor is sad. Body posture and attitude convey an underlying depressed mood. Slowness of physical movement helps reveal depressed mood." Diagnosis: Major Depressive Disorder, Recurrent Moderate and Anxiety disorder.

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| S9999 | Continued From page 11<br><br>E2 stated on 12/4/13 at 12:10pm she could not locate any previous psychiatric evals prior to R's hospitalization on 2/8/13-2/14/13.<br><br>Social Service note dated 2/28/13 states R1 "voiced out feeling tired and trouble sleeping at times" displays...mild depressive symptoms. Social service note dated 5/23/13 states R1 has sad affect at times and voices little energy and trouble sleeping at times. Identified mild depressive symptoms.<br><br>Z2 stated on 11/20/13 at 10:10am that R1 has had a long history of depression and has been on antidepressants for years. Z2 said she (Z2) began suspecting R1 was becoming depressed in March and it seemed to be getting worse. May and June were very hard for R1 said Z2, R1 was very weepy and not engaging in her usual daily patterns. That's when Z2 began asking about R1's antidepressant and was told R1 had not been receiving it.<br><br>Physician telephone order shows that Lexapro 10 mg every day was ordered for R1 on 6/4/13 and then increased to 20mg every day on 6/14/13. E2 stated on 12/5/13 that R1's Lexapro had been discontinued while in the hospital for abdominal surgery in February 2013 and was not renewed until June 4, 2013. E2 gave no expalnation given as to why the antidepressant was not renewed until 3 1/2 months later other than the physician did not reorder it.<br><br>(B) | S9999 | | |