

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005177</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/10/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKE SHORE HLTHCARE &amp;REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626</b>
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>300.610a) 300.1010h) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1610a)1) 300.1630a) 300.1630e) 300.3220f) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1010 Medical Care Policies</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including,</p>	S9999		

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

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S9999	<p>Continued From page 1</p> <p>but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.1610 Medication Policies and Procedures</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.</p> <p>Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.</p> <p>Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to administer Furosemide/Lasix (a diuretic medication) ordered for an intravenous (IV) push according to the manufacturer's specification and as outlined in the state's nurse practice act for two residents (R31 and R32) and did not provide the correct doses of a subcutaneous medication administered to one resident (R7).</p> <p>The facility allowed a non-qualified nursing staff to repeatedly administer an intravenous push medication (Furosemide) for R31 and failed to use calibrated equipment for monitoring R31 blood pressure. These failures put R31 a risk for serious side effects and adverse reactions from the improper administration of a strong diuretic.</p> <p>Findings include:</p> <p>1. During the medication pass on December 17, 2013 at 10:00 am on the second floor, E15 (Licensed Practical Nurse/LPN) was administering medications to R31. E15 took R31's Furosemide vial labeled "Furosemide 10 mg/ml (milligram/millimeter) , 4 ml (40 mg) per IV Q 12 hours." E15 withdrew 4 ml of this medication via a syringe from the vial. E15 also withdrew 5 ml of saline solution via a syringe stating, "I don't have an order for it at this time but I usually flush the line with 5 ml saline before and</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>5 ml after administering of medication."</p> <p>At 10:05 am, E15 took R31's blood pressure before administration of the medications, and recorded a result of 128/62 mmHg. E15 stated that blood pressure should be taken before the administration of the medication to check if it is safe for the patient to have it.</p> <p>E15 flushed the intravenous access line with 5 ml of saline solution for 30 seconds. Then E15 administered a total of 4ml of Furosemide within 30 seconds and flushed the intravenous access with 5 ml after the medication for 30 seconds.</p> <p>The blood pressure machine used by E15 to take R31's blood pressure was not calibrated; the pointer on the dial of the machine was at 300. E3 (Assistant Director of Nursing/ADON) and Z4 (Nurse Consultant) did not respond when asked who and how often the facility check the medical equipment and did not provide any additional information about the subject. The facility failed to identify and ensure that the equipment is properly calibrated.</p> <p>-R31's December 2013 Physician order sheet included the following: "12/4/13 : Lasix 40 mg IV (4ml) every 12 hours" "12/17/13: Flush IV line with 5 ml saline before and after medication"</p> <p>R31's December 2013 Medication Administration Record documents that "IV Lasix" has been administered to R31 since December 4, 2013. On December 18, 2013 at 11:00 am, E15 confirmed that she had administered the medication as evidenced by E15's initials on the following dates: December 4, 5, 6, 9, 10, 11, 12, 14, 15, 16,</p>	S9999		

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S9999	<p>Continued From page 5 17,2013.</p> <p>R31's care plan which was updated on December 19, 2013 documents, "RN is responsible to administer IV medications per manufacturer's instructions. Monitor side effects." -On December 18, 2013 at 10:00 am on the second floor, E15 (Licensed Practical Nurse) stated that the intravenous push medication should be given slowly for 3 minutes. E15 confirmed that she has been administering the intravenous push medication for R31 for 2 weeks. E15 stated that LPNs are allowed to give the intravenous push medication if the Registered Nurse is present. On December 18, 2013 at 11:00 am on the second floor, E15 was preparing to administer R31's medications. E15 took R31's Furosemide vial labeled "Furosemide 10 mg/ml, 4 ml (40 mg) per IV Q 12 hours." E15 withdrew 4 ml of the medication via a syringe from the vial. E15 also withdrew 5 ml of saline solution via a syringe. E15 stated that R31's blood pressure was 128/65 mmHg. E15 used the same blood pressure machine that was not properly calibrated. E3 (ADON) was with E15 in R31's room during the administration of the intravenous push. E3 was looking at the watch and coaching E15 until 4ml of intravenous push medication was given completely for 5 minutes. E15 then flushed the intravenous access with 5 ml saline solution. On December 18, 2013 at 11:00 am on the second floor, E3 stated that the intravenous push medication should be given slowly for 5 minutes. E3 added that Licensed Practical Nurses are allowed to administer the intravenous push medication when they are physically supervised by a Registered Nurse (RN). At 11:15 am, E15 stated that "I did not call an RN yesterday because they are busy." At 1:20 pm, E27 (RN-</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>Supervisor) also stated that RNs should be physically present when an LPN gives the intravenous medication; it is for RNs to supervise and make sure that the LPNs follow the guidelines.</p> <p>-The facility's policy on "Administering Medications by IV Push" documents under "Preparation: 3. The licensed nurse responsible for IV medications shall be knowledgeable of 1. Indications for use; b. appropriate routes of administration, doses and diluents; c. side effects; 4. A Registered Nurse may be supervised a Licensed Practical Nurse performs IV push." According to the Illinois Department of Financial and Professional Regulation memorandum entitled " Important Notice regarding the administration of IV Medications by LPNs " document that, " the administration of chemotherapeutic agents via intravenous routes, starting or adding blood or blood components, administration of medication via intravenous push and adding medication to existing intravenous infusions including heparin in heparin locks, is not allowed. "</p> <p>On 12-18-13 at 4:25pm, E45 Licensed Practical Nurse (LPN) during interview stated a Registered Nurse (RN) must supervise a (LPN) when giving intravenous push (IVP) medication. E45 stated the facility policy states it is okay for a LPN to give IVP medication. E45 stated LPN educational training states an LPN should not give IVP medication. E45 stated she has given IVP medication with RN supervision.</p> <p>On 12-18-13 at 4:35pm, E46 (LPN) stated IVP medication can be given by an LPN under RN supervision. E46 stated LPN educational training states IVP medication should always be given by an RN.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>On 12-18-13 at 4:40pm, E47 (LPN) stated IVP medication can be given by the LPN with RN supervision. E47 stated she has given IVP medication with RN supervision.</p> <p>-On December 18, 2013 at 3:00 pm, the manufacturer's medication insert for Furosemide was supplied by Z4 (Nurse Consultant) who stated that the document came from the pharmacy and "it should be given slowly for 1-2 minutes and not for 5 minutes." It documents that, " Dosage and Administration: Parenteral therapy with Furosemide injection, should be used only in patients unable to take oral medication or in emergency situations and should be replaced with oral therapy as soon as practical. The intravenous dose should be given slowly (1-2 minutes). The manufacturer's insert for Furosemide also documents that, "Cases of tinnitus and reversible or irreversible hearing impairment and deafness have been reported. Reports usually indicate that Furosemide toxicity is associated with rapid injection..."</p> <p>2. On December 18, 2013 at 3:00 pm, E3 (ADON) stated that "I told you that only R31 has an IV push but R32 also has an intravenous medication push." R32's December 2013 Physician order sheets, document the following order: "Lasix (diuretic) 20 mg Intravenous every 8 hours" R32's December 2013 Medication Administration Record document that Lasix was administered intravenously every 8 hours (6am, 2pm, 10 pm) beginning December 13, 2013. According to the facility's "Nursing Department Schedule" no Registered Nurse was physically present during the 11-7 shift on December 14,</p>	S9999		



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S9999	<p>Continued From page 8</p> <p>2013.</p> <p>3. On 12-18-13 at 4:25pm, E45 Licensed Practical Nurse (LPN) stated a Registered Nurse (RN) must supervise a (LPN) when giving intravenous push (IVP) medication. E45 stated the facility policy states it is okay for a LPN to give IVP medication. E45 stated LPN educational training states an LPN should not give IVP medication. E45 stated she has given IVP medication with RN supervision.</p> <p>On 12-18-13 at 4:35pm, E46 (LPN) stated IVP medication can be given by an LPN under RN supervision. E46 stated LPN educational training states IVP medication should always be given by an RN.</p> <p>On 12-18-13 at 4:40pm, E47 (LPN) stated IVP medication can be given by the LPN with RN supervision. E47 stated she has given IVP medication with RN supervision.</p> <p>3. R7 is an 81 year old male admitted with diagnoses that included: chronic venous stasis, coronary artery disease, hypertension, congestive heart failure, cardiomyopathy, dementia, and sub-acute chronic subdural hematoma. R7's physician order sheet dated 12/11/13 indicates an initial order for Heparin 5000 units/milliliter, inject 5000 units under the skin every 12 hours that was crossed out with a line and a new order for Heparin 5000 units/milliliter, inject 0.5 milliliters every 12 hours was written. R7's medication administration record from 12/12/13 to 12/17/13 indicates documentation of 12 administered medication doses of 5000 units/milliliter, inject 5000 units, as evidenced by</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>documentation of various nurse staff's initials. On 12/17/13 at 6:19 PM, E34 (Registered Nurse/Nurse Supervisor) presented a plastic bag with a pharmacy label attached that contained one open vial of heparin injection. E34 stated " We have been giving the patient 5000 units. "</p> <p>The pharmacy label contained the following documentation: R7's name, dispense date of 12/11/13, Heparin sodium 5000 units/milliliter vial, and inject 1 milliliter (5000 units) subcutaneously every 12 hours.</p> <p>The facility's Medication Administration: General Procedures policy, with a 3/2012 revision date depicts the following: Medication Administration Procedure Section: 10. If the physician order cannot be followed for any reason, the physician should be notified in a timely manner (depending on the situation), and a note should reflect the situation in the resident chart.</p> <p>R7's nurse notes from 12/11/13 to 12/19/13 did not contain any documentation regarding the facility staff notifying the physician of the fact that the 12/11/13 2nd heparin order for heparin 5000 units/milliliter, inject 0.5 milliliters every 12 hours could not be followed.</p> <p>The facility' s Subcutaneous Injections policy depicts the following in the preparation section:</p> <ol style="list-style-type: none"> <li>1. Verify that there is a physician's medication order for this procedure. Verify the order for resident ' s name, drug name, dose, time, and route of administration.</li> </ol> <p>(B)</p> <p>300.610a) 300.1010h)</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>300.1210a) 300.1210b) 300.1210c) 300.1210d)1) 300.1210d)3) 300.1220b)2) 300.1220b)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1010 Medical Care Policies</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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)</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER  <b>LAKE SHORE HLTHCARE &amp; REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626</b>
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S9999	<p>Continued From page 12</p> <p>nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>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)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to timely and accurately assess and treat the presence of pain for 3 residents (R1, R20, R44) reviewed for pain. This failure resulted in lack of pain control for 3 residents (R1, R20, R44), which impacts the quality of life and care of the resident.</p> <p>Findings include:</p> <p>1. R44 could be heard moaning and groaning from the hallway outside her room on 12/16/13 at approximately 1:30pm. Surveyor entered R44's room to find R44 sitting up in bed, complaining of back pain and thirst. R44 stated she gets back pains on a daily basis. The room was dark and R44 was tearful. R44 appeared thin and frail and</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>stated that she has been trying to get staff attention but nobody has come into her room. R44's call light was not within her reach. When asked what she has done to get staff attention, R44 stated she has been hitting her plastic drinking cup on the bedside table.</p> <p>At approximately 1:33pm, E10 (Nurse) entered R44's room stating "your back is hurting? I'll be right back". Approximately 2 minutes later E10 returned and offered R44 a pill which R44 swallowed. When asked, E10 told surveyor that she gave R44 "a norco". E10 then asked R44 several times how severe the pain is on a 1-10 scale. Each time R44 responded "it really hurts", not numerically rating her pain.</p> <p>Review of R44's Physician's Order Sheet (POS) dated 12/1/13 through 12/31/13 shows an order for pain assessment every shift and Hydrocodone-Acetaminophen 5-325, 1 tablet every 6 hours as needed for pain. R44's diagnoses included Arthritis and Left Upper Chest Pacemaker.</p> <p>R44's pain flow sheet documentation dated 12/16/13, 12:30pm, shows a pain intensity of "8", however R44 did not give a numerical rating during the 1:30pm observation.. Medication Administration Record (MAR) shows a "0" pain rating for that same hour that R44 was medicated. Also, the MAR shows a "0" rating on 12/18/13 on the 7-3 shift, however the pain flow sheet shows R44 was medicated for pain of "7" intensity on that shift. Pain Flow Sheet shows consistently that movement is the aggravating factor for R44's pain.</p> <p>E10 presented a comprehensive pain assessment for R44 dated 12/18/13. There was no evidence of a comprehensive pain</p>	S9999		

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S9999	<p>Continued From page 15</p> <p>assessment having been done prior to this date. The assessment states R44 experiences sharp pain frequently and at no specific time of day. MAR for period 12/1/13 through 12/18/13 shows R44 was experiencing pain at "4" on 12/11/13 and at "6" on 12/13/13. There is no documentation of pain medications being administered on those two occasions. No evidence that pain characteristics was assessed. An undated Care Plan states nursing staff to assess R44's pain at regular intervals, noting predisposing factors.</p> <p>2. R20 has a diagnosis of Cerebrovascular Accident with bilateral hand contractures. During the initial tour on 12/16/13 at approximately 9:45 am, R20 was observed in her room, in bed, alert, with bilateral hand contracture. R20 stated that she had a stroke 18 months prior, has limited movement in both hands and not able to raise her left leg. R20 went on to say that she hasn't had any exercises to her hands for more than one week. There were no positioning nor splinting devices in place. On 12/18/13 at approximately 1:45pm, R20 was sitting in the dining room with bilateral hand splints in place. R20 stated that the splints are causing pain in both hands. R20 stated she received pain medication earlier in the day when she told the nurse that she was in pain. R20 stated that the nurse did not assess her pain for severity nor returned to assess effectiveness of the medication. R20 described the current pain as excruciating at a "10" on the pain scale, and radiating into her thumbs. R20 stated that when she has splints in place, she receives pain medication at least 3 times daily and needs to be medicated more often than that because the pain is not usually controlled. At 2:10pm, E28 (Nurse) stated that she last gave R20 her prescribed pain medication at 10am. E28 stated that she did not</p>	S9999		



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S9999	<p>Continued From page 16</p> <p>assess the intensity of R20's pain and said that she gives the pain medication whenever R20 asks for it. E28 was made aware that R20 continues to complain of pain. At 2:45pm, E28 stated that she contacted R20's physician regarding R20's recurrent pain and received an order to administer pain medication every 4 hours instead of previous schedule of every 6 hours to achieve better pain control. R20's restorative assessment dated 12/18/13 states R20 complains of pain during passive range of motion exercises and refuses the application of splints at times due to pain.</p> <p>Facility's Pain Protocol dated October, 2010, states that pain is to be assessed when there is onset of new or worsening pain. This assessment is to include characteristics and severity of pain. The Protocol also states that the nurse will identify situations or interventions where an increase in pain may be anticipated such as wound care, ambulation, or repositioning. The Protocol also states that pain medications should be selected based on pertinent treatment guidelines.</p> <p>3. R1 is a 71 year old female admitted to the facility with diagnoses that include: sacral ulcer, peripheral vascular disease, diabetes, hypertension, hyperlipidemia, and anemia. On 12/18/13 at 9:52 AM, during pressure ulcer dressings to the left hip and sacrum, R1 moaned when E24 (Wound Care Nurse) removed the old dressings from R1's left hip and sacral wounds, R1 moaned again when E24 touched the sacral wound while cleansing the wound with a gauze pad soaked in a wound cleanser and R1 moaned</p>	S9999		

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S9999	<p>Continued From page 17</p> <p>a third time when E24 touched the left hip wound while cleansing the wound with a 0.9% normal saline soaked gauze pad. R1 said " ouch " and moaned a 4th time, when E24 wiped the wound cleanser off of the left hip wound. E11 (Wound Care Nurse) assisted E24 with the pressure ulcer dressing changes.</p> <p>On 12/18/13 at 9:58 AM, E11 asked R1 if the wounds hurt and R1 stated " yes ". On 12/18/13 at 9:59 AM, E11 asked R1 if she was in pain. R1 said that she had pain in her butt when it was touched. E24 continued the dressing change to R1' s sacral wound and R1 continued to moan throughout the rest of the dressing change as the sacral wound was touched. On 12/18/13 at 10:03 AM, after the dressing changes were completed, E24 asked R1 for her pain score. R1 said her pain score was an 8 out of 10. On 12/18/13 at 10:10 AM, R1 stated: " The staff come to change the pressure ulcer dressings once a day. "</p> <p>R1' s physician order sheet dated 10/11/13 indicates a current prescription order for hydrocodone/acetaminophen (5milligrams/325 milligrams) one tablet per gastrostomy tube every four hours as needed. Controlled Substance Disposition Record dated 11/11/13 indicates that R1 received one dose of the medication on 12/18/13 at 8:40 AM.</p> <p>R1' s physician order sheet dated 12/9/13 indicates the following orders: sacrum/coccyx: cleanse with wound cleanser, apply medicated gauze to wound, lightly/loosely pack wound with saline moist gauze, apply dry gauze and tape, and change daily; left hip: cleanse with normal saline solution, pat dry, apply medicated cream to wound, apply protective dressing, change every 3 days if loose or soiled.</p> <p>R1's care plan dated 10/13/13, for the sacral and left hip pressure ulcers documents: assess for</p>	S9999		

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S9999	<p>Continued From page 18</p> <p>discomfort/notify nursing staff for intervention as an approach. R1' s care plan dated 10/14/13, for pain documents: report resident complaints of pain to the nurse immediately. Observe signs/symptoms of pain. Report signs/symptoms of pain such as: persistent yelling or calling out; restlessness/agitation; crying/screaming/moaning. And listen to concerns and notify appropriate staff as approaches. E11 and E24 failed to reassess R1's pain before starting the pressure ulcer dressing changes. E24 asked R1 about her pain during the dressing changes, but did not initiate and implement any interventions to address R1's pain. E11 and E24 did not leave R1's room to report any complaints of pain to R1' s assigned nurse during the dressing changes.</p> <p>The facility's Pain Clinical Protocol depicts the following: 4. the nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, or repositioning.</p> <p>(B)</p> <p>300.625 f) 3) A)</p> <p>300.625 f) 3) A) Identified Offenders</p>	S9999		

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S9999	<p>Continued From page 19</p> <p>f). If identified offenders are residents of a facility, the facility shall comply with all of the following requirements:</p> <p>3). Every licensed facility shall provide to every prospective and current resident and resident's guardian and to every facility employee, a written notice, prescribed by the department, advising the resident, guardian, or employee of his right to ask whether any residents of the facility are identified offenders. The facility shall confirm whether identified offenders are residing in the facility.</p> <p>A) The notice shall also be prominently posted within every licensed facility.</p> <p>This regulation was not met as evidenced by the following:</p> <p>Based on observation, interview and record review the facility failed to post a notice of identified offenders in the facility. This has the potential to affect all 248 residents.</p> <p>Findings Include:</p> <p>On 12-17-13 at 10:00am, there were no identified offender notices observed in the lobby area.</p> <p>On 12-19-13 at 5:25pm, with E2 (Assistant Administrator), there were no identified offender notices observed throughout the facility.</p> <p>On 12-19-13 at 5:40pm E2, stated that were no identified offender notices posted within the facility.</p> <p>The facility has documented 11 identified offenders.</p>	S9999		

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