

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/24/2017
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NAME OF PROVIDER OR SUPPLIER  APERION CARE BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701
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S 000	Initial Comments  Complaint #1764902/IL#96160  Complaint #1764935/IL#96188  Complaint #1765052/IL#96329	S 000		
S9999	Final Observations  STATEMENT OF LICENSURE VIOLATIONS:  300.610a) 300.1210b) 300.1210d)1)2)3) 300.1220b)2) 300.2040b) 300.2040d) 300.2040e) 300.2070a) 300.2070b) 300.3220f) 300.3240a)  Section 300.610 Resident Care Policies  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	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 09/18/17
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S9999	<p>Continued From page 1 and dated minutes of the meeting.</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>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</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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>Section 300.2040 Diet Orders</p> <p>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.</p> <p>d) The resident shall be observed to determine acceptance of the diet, and these observations shall be recorded in the medical record.</p> <p>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).</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>Section 300.2070 Scheduling Meals</p> <p>a) A minimum of three meals or their equivalent shall be served daily at regular times with no more than a 14 hour span between a substantial evening meal and breakfast. The 14 hour span shall not apply to facilities using the "four or five meal-a-day" plan, provided the evening meal is substantial and includes, but is not limited to, a good quality protein, bread or bread substitute, butter or margarine, a dessert and a nourishing beverage.</p> <p>b) Bedtime snacks of nourishing quality shall be offered. Snacks of nourishing quality shall be offered between meals when there is a time span of four or more hours between the ending of one meal and the serving of the next, or as otherwise indicated in the resident's plan of care.</p> <p>Section 300.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>Section 300.3240 Abuse and Neglect</p> <p>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>	S9999		

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S9999	<p>Continued From page 4</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on record review and interview the facility neglected to provide services that aligned with physician's orders for one of three residents (R8) reviewed for improper nursing care in the sample of 10. R8 was not given breakfast daily prior to dialysis, not given bedtime snacks, not given insulin as ordered, not given medications for treatment of Osteomyelitis as ordered, not given a renal diet as ordered, did not have blood glucose monitored as ordered, and not given a fluid restriction with daily weights as ordered by the physician. The facility failed to provide nutritional and nursing assessments. These failures resulted in R8 being hospitalized for confusion, Encephalopathy, fluid overload, hypoglycemia, and hypothermia.</p> <p>The facility's Abuse Prevention Program dated 2012 documents, "Neglect is the failure to provide necessary and adequate medical, personal, or psychological care. Neglect is the failure to care for a person in a manner which would avoid harm and pain, or the failure to react to a situation which may be harmful. The facility must make a commitment to prevent abusive and/or neglectful actions towards residents."</p> <p>R8's Physician's Orders dated 8-14-17 (date of admission) to 8-18-17 (date of discharge) documents R8 has the Diagnoses of End Stage Renal Disease (ESRD), Congestive Heart Failure (CHF), and Type II Diabetes Mellitus Without Complications. These same admitting orders document the following orders: Dialysis every</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>Tuesday, Thursday, and Saturday for the treatment of End Stage Renal Disease. Controlled Hi Protein Renal Diet. Fluid Restriction of 800 ml (milliliters) every shift for ESRD. Weight Daily. Accucheck's and Insulin Lispro 100 units per ml inject per sliding scale subcutaneous before meals and at bedtime (Blood Sugar 201-250=2 units, 251-300=3 units, 301-350=4 units, 401-1000= 6 units). Insulin Glargine 100 units per ml inject as per sliding scale at bedtime (Blood sugar 0-150 =0 units, 151-200=12 units, 201-1000 =25 units). Augmentin 500-125 mg daily for Wound on the right foot due to Osteomyelitis.</p> <p>R8's Medication Administration Records from 8-14-17 to 8-18-17, indicate R8's blood sugars were not obtained along with sliding scale insulin as ordered on 8-15-17 at 11:00 a.m., 8-16-17 at 7:30 a.m. and 11:00 a.m., and 8-17-17 at 11:00 a.m. These same records indicate R8 never received the scheduled Augmentin for Osteomyelitis.</p> <p>R8's Nutritional Intake Report dated 8-14-17 to 8-18-17 does not include R8's intake for breakfast on any of these days. The facility's Bedtime snack list does not include R8. R8's Weight Record and Electronic Medical Record dated 8-14-17 to 8-18-17, does not include monitoring of R8's daily weight or fluid intake. R8's Medical Record from 8-14-17 to 8-18-17 does not include a nursing assessment of R8's condition or a nutritional assessment.</p> <p>R8's Hospital History and Physical dated 8-18-17 documents, "(R8) presented to the ER (Emergency Department) today with complaints of confusion that started earlier today. (R8's) blood sugar was very low. Since arriving to the</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>ER, (R8) has been very tired and sleeping much of the time." (R8) temperature upon arrival 96 degrees Fahrenheit. "Admitting problem Diagnoses of Acute Encephalopathy, Fluid Overload, Hypoglycemia, Chronic Osteomyelitis, and Hypothermia." R8's Hospital History and Physical dated 8-18-17 documents, "(R8) is suppose to be receiving Augmentin for Osteomyelitis, but it seems he wasn't receiving it at the nursing home according to the medication list."</p> <p>R8's Nursing Home Progress Notes and Assessments do not include any documentation of R8 being discharged from the facility or R8 being sent to the ED for a condition change.</p> <p>On 8-23-17 at 9:15 a.m., E25 (Dietary Manager) stated, "The cook gets to the facility at 5:30 a.m. The cook would send a tray to (R8) around 6:00 a.m., but it would always come back to the kitchen untouched. According to the intake logs, (R8) would already be gone to dialysis before receiving his breakfast. It would be too difficult to get (R8) a hot breakfast that early in the morning. We (the facility) could have sent a cold sack breakfast had we known that (R8) was leaving early for dialysis. Diabetic residents need breakfast to prevent low blood sugars, which could result in fainting or even a coma. I was not aware that (R8) was on a fluid restriction." E25 (Dietary Manager) confirmed that R8 did not receive breakfast on dialysis days, did not receive a fluid restriction as ordered, did not receive a renal high protein diet as ordered, and did not receive bedtime snacks.</p> <p>On 8-23-17 at 10:10 a.m., Z15 (Dialysis Clinic Nurse Manager) stated, "(R8) did not have breakfast or any snacks on the days (8-15-17 and</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>8-17-17) he came to dialysis. Breakfast is very important for diabetics to prevent blood sugars from dropping."</p> <p>On 8-23-17 at 10:55 a.m., E27 (Certified Nursing Assistant) stated, "(R8) did not get a breakfast tray on the days he had dialysis." E27 also confirmed that R8 would get big pitchers of water and that the staff was unaware of R8 being on a fluid restriction..</p> <p>On 8-23-17 at 2:00 p.m., E29 (Cook) stated, "I never received a diet order for (R8). I always gave (R8) a regular diet. I never packed (R8) a lunch on the days of dialysis. I gave the nursing staff a breakfast tray on Thursday (8-17-17), but the tray was returned 15 minutes later untouched. (R8) had already left for dialysis and did not get a breakfast tray. Bedtime snacks are only offered to residents with physician's orders. I was not aware that (R8) needed a renal diet. I could not provide (R8) with a hot breakfast because I am not here soon enough to cook it."</p> <p>On 8-23-17 at 2:30 p.m., E28 (Dietary Aide) stated, "I prepare the bedtime snacks for residents who only have physician's orders for a snack. (R8) never got a bedtime snack as he was not on the bedtime snack list."</p> <p>On 8-23-17 at 2:10 p.m., E11 (Registered Nurse) stated, "The morning of 8-18-17 (E27/Certified Nursing Assistant) reported to be around 6:00 a.m. that (R8) was aggressive and spitting everywhere. I went down to (R8's) room and he was pushing me, spitting at me, and trying to crawl under the bed. I called 911 and send (R8) to the ED. The paramedics checked (R8's) blood sugar and it was only 23. I did not do an assessment progress note or a risk management</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>assessment. I forgot."</p> <p>On 8-23-17 at 11:10 a.m., R8 stated, "I never got my morning or noon medications, including my insulin, while I was at the facility. I never got breakfast when I would go to dialysis. The night before I went to the hospital I went to bed and next thing I know I woke up in the hospital. My sugar count was 23. My body temperature was low. I could feel my blood sugars dropping and was hungry from missing breakfast, and sometimes lunch. My blood sugars were never checked on the days I had dialysis. That facility is very neglectful. I will never go back." "I did not get my antibiotic for my foot infection. The nurses never checked on me or assessed me."</p> <p>On 8-24-17 at 9:30 a.m., E2 (Director Of Nursing) stated, "We (the facility) do not serve snacks at bedtime. Diabetic residents should always have a bedtime snack. (R8) did not receive a bedtime snack. On Thursday (8-17-17) (R8) was suppose to get a breakfast tray before dialysis, but did not. I did not know until yesterday that (R8) was on a fluid restriction and neither did the dietary manager. (R8) should have been monitored closely here since he was diabetic. (R8) did not get his scheduled blood sugars with sliding scale insulin on 8-15-17 at 11:00 a.m., 8-16-17 at 7:30 a.m. or 11:00 a.m., or 8-17-17 at 11:00 a.m. That could have prevented (R8's)hospitalization, hypoglycemia, change in mental status, and fluid overload. (R8's) daily weights were not done, either." E2 also verified that R8 did not have a nursing assessment or nutritional assessment done since admitted and should have.</p> <p>On 8-24-17 at 11:25 a.m., Z4 (Nurse Practitioner) stated, "If (R8) was on Glargine insulin then (R8)</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>should get a bedtime snack. The facility should have been getting (R8's) blood sugars four times daily with the sliding scale insulin. (R8) should receive breakfast daily. They (the facility) should monitor (R8's) fluid restriction as ordered and document. They should have obtained daily weights due to (R8) having CHF and Dialysis. If (R8) was not getting bedtime snacks and blood sugars monitored, that could have contributed to the hypoglycemia. If they were not monitoring for fluid intake and daily weights that would have caused fluid overload. These failures and poor follow through were neglectful." "(R8) should have been receiving the Augmentin for chronic Osteomyelitis as ordered."</p> <p>The facility's undated Diabetes Mellitus Routine Care policy documents, "Objective of policy is to provide care that will enable the person to achieve and or maintain control of diabetes and to function safely in his natural environment. A focused assessment is performed by a licensed nurse within 24 hours of admission which includes skin, sensory, extremities, appetite, thirst, urination, condition of feet, and other common problems. A registered dietician is to conduct an assessment and education once the diagnosis of Diabetes is made which will be documented in the nurse's notes. Goal of the person with diabetes is to consume a therapeutic diet. Residents with diabetes maybe on replacement and bedtime snacks."</p> <p>The facility's undated Fluid Restriction policy documents, "The nursing department and the dietary department will ensure that the resident receives the prescribed amount of fluid. All water pitchers will be removed from the bedside to ensure compliance from the resident, family, and facility staff during the fluid restriction.</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>(A)</p> <hr/> <p>300.610a) 300.1210a) 300.1210b) 300.1210d)1)3) 1220b)2) 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. 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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p>	S9999		
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S9999	<p>Continued From page 11</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>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>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>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>Section 300.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to assess pain, provide pain relieving interventions, and control pain for one of three residents (R4) reviewed for pain in the sample of ten. These failures resulted in R4 experiencing an acute exacerbation of unrelieved chronic pain resulting in hospitalization for the exacerbation of pain, which also resulted in an elevated blood pressure.</p> <p>The facility's Pain Management Program policy dated 1-1-2014 documents, "It is the policy of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity, and facilitate life involvement. The purpose of this policy is to accomplish that goal through an effective pain management program. The pain management program with include performing assessments, accurate and complete documentation of pain assessments and monitoring, and a schedule of frequent assessments. A pain assessment protocol will be initiated when the Minimum Data Set triggers an indication of pain, receives routine pain medication and the pain is not controlled, and a change in pain occurs. Documentation of assessments and the resident's response to the pain management plan will be made with each assessment. Pain control will be assessed with medication pass."</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>R4's current Physician's Order Sheet (POS) documents R4 has diagnoses of Chronic Pain Syndrome and Pain in Leg. This same POS documents R4 receives Methadone HCL (Hydrochloride) 10 mg (milligrams) two tablets three times daily for pain, and Oxycodone IR (Immediate Release) HCL (Narcotic Pain Reliever) 5 mg one to two capsules as needed every four hours for moderate to severe pain.</p> <p>R4's Minimum Data Set (MDS) Section J Pain Management dated 7-3-2017, documents R4's Pain is almost constant, makes it hard for R4 to sleep at night, and limits R4's day to day activities. This section also indicates R4's pain is a "10" on a 0-10 scale with a 10 meaning it is the worse pain R4 can imagine.</p> <p>R4's Minimum Date Set dated 7-3-17 documents R4's BIMS (Brief Interview of Mental Status) score is an 11 indicating R4 is interviewable.</p> <p>R4's Pain Screen Assessment dated 7-12-17, documents R4 has moderate pain and a pain score of five. This same assessment documents that a score of five or greater indicates a comprehensive assessment is needed. R4's Medical Record does not include a comprehensive pain assessment after 7-12-17.</p> <p>R4's Transcription Note dated 7-25-17 and signed by Z4 (Nurse Practitioner) documents R4 is having more pain, R4's left leg and lower back are getting worse, and R4 feels like she needs more pain medications. This same note documents a order referral to Z5 (Pain Specialist) has been filled out.</p> <p>R4's current Chronic Pain Syndrome Care Plan documents R4 will be free of any discomfort and interventions for pain control include the following:</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>Administer analgesic medication as ordered by a physician. Review every shift for pain medication efficacy by assessing whether pain intensity is acceptable to R4. Anticipate R4's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions every shift and as needed for compliance. Review for alleviation of symptoms, dosing schedules and resident satisfaction with results, and impact on functional ability and cognition.</p> <p>R4's Medication Administration Record (MAR) dated 8-1-17 to 8-14-17, documents R4 receives Oxycodone two tablets on five occasions within this time frame. This same MAR documents the Oxycodone was ineffective on 8-5-17 and 8-12-17.</p> <p>R4's Controlled Drug Record documents R4 received Oxycodone 5 mg two tablets on 8-12-17 at 3 p.m. and 9 p.m., and on 8-13-17 at 1:15 a.m. R4's MAR and Nursing Progress Notes dated 8-12-17 and 8-13-17 do not include documentation of R4 receiving these doses of Oxycodone, the severity of R4's pain, the location of R4's pain, or the effectiveness of the Oxycodone.</p> <p>R4's Nursing Progress Notes dated 8-13-17, document Z1 (R4's Family Member) called the facility and requested R4 be sent to the emergency room for pain control. This same note documents R4 was sent to the emergency room.</p> <p>R4's Emergency Room Note dated 8-13-17 and signed by Z6 (Emergency Department Physician), documents R4 presents to the ED (Emergency Department) from the nursing home with</p>	S9999		
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S9999	<p>Continued From page 16</p> <p>complaints of increased pain in the left leg which has been chronic for sometime, and an elevated blood pressure of 223/123 with complaints of pain to the right leg. This same note documents R4 will be admitted for hospital services for intractable pain and high blood pressure related to the pain with a plan to obtain a doppler ultrasound, start hydromorphone one mg IV (Intravenously) every hour (in addition to the Oxycodone as needed and Methadone three times daily), and start blood pressure regimen medications.</p> <p>R4's Toxicology Urine Screen dated 8-13-17 at 10:39 a.m., documents R4 is negative for urine opiates.</p> <p>R4's Consultation dated 8-13-17 and signed by Z7 (Medical Doctor/Pain Specialist), documents R4 is admitted to the hospital for uncontrolled pain that is a continuously sharp pain to the left leg and right leg. This same consult documents R4's Plan for the chronic pain is to continue Methadone 20 mg three times daily, continue Oxycodone five to ten mg every four hours as needed, and add IV Dilaudid one to two mg every two hours for severe pain.</p> <p>R4's Hospital Progress Note dated 8-13-17 and signed by Z3 (Hospital Social Service) and Z5 (Emergency Room Physician), documents Z11 (Registered Nurse) and Z5 (Emergency Room Physician) are concerned that there is no indication that R4 was receiving R4's pain medication of oxycodone due to R4's negative urine opiate screen. This same note documents Z1 (R4's Family Member) is concerned that nursing home staff is stealing R4's pain medication.</p>	S9999		
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S9999	<p>Continued From page 17</p> <p>On 8-15-17 at 12:45 p.m. R4 was sitting on the side of the bed in the hospital. R4 had an I.V. of Dilaudid running. R4 stated, "I never got a pain pill in the middle of the night on 8-13-17." R4 stated, "My entire left leg hurt at the nursing home. When I left the nursing home my pain was at a level ten and was constant. Everytime I would ask the staff for a pain pill they would tell be to walk up to the nurse's desk and ask for it myself. Sometimes I would get a pain pill, but the staff would never check on me to see if it helped with the pain. I was never asked how bad my pain was. The staff never did anything to help my pain. I was always moaning and screaming in pain. I had to call my son to get sent to the hospital. The hospital has helped my pain. I finally have gotten some relief."</p> <p>On 8-15-17 at 2:00 p.m. Z3 (Hospital Social Service Worker) stated, "The emergency room physician was concerned that (R4) was not getting her Oxycodone as needed while at the nursing home. (R4) came to the emergency room with an extremely elevated blood pressure and severe pain. (R4) said she had to call her son at home to get help for the pain."</p> <p>On 8-16-17 at 9:15 a.m., E16 (Certified Nursing Assistant/CNA) stated, "(R4) always complained of pain. (R4's) pain was never relieved."</p> <p>On 8-16-17 at 9:25 a.m., E15 (CNA) stated, "(R4) would complain a lot of pain to her legs. (R4) was constantly moaning in pain. (R4) always complained of pain. (R4's) pain was never relieved. (R4) had chronic pain all of the time. I think the nurses just got use to her moaning and being in pain."</p> <p>On 8-16-17 at 10:10 a.m., E12 (R4's Physician)</p>	S9999		
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S9999	<p>Continued From page 18</p> <p>stated, "I was not aware (R4's) Oxycodone was ineffective. I suggested the facility send (R4) to a pain clinic for (R4's) worsening pain."</p> <p>On 8-16-17 at 1:30 p.m., E9 (Licensed Practical Nurse) stated, "I gave (R4) oxycodone at 3:00 p.m. and 9:00 p.m. on 8-12-17 for back pain. (R4) has had back surgeries and would be in a lot of pain. I did not document on the PRN (As Needed) MAR (Medication Administration Record) sheet or the progress notes that I gave the oxycodone and did not document a pain scale. I was suppose to document on the MAR the pain scale and whether the pain pill was effective or not, but I did not."</p> <p>On 8-16-17 at 12:20 p.m. E10 (Charge Nurse) stated, "I spoke with Z5's (Pain Specialist) office on 7-28-17 about (R4's) pain referral. I have not followed up since then. I would normally follow up daily, but I have been working the floor too much and have had no time to call. (R4) was having chronic pain to the left side and left leg. (R4's) chronic pain is never relieved."</p> <p>On 8-16-17 at 1:20 p.m., E8 (Licensed Practical Nurse) stated, "(R4) complained of pain consistently to the left leg and sometimes to the back. I gave (R4) oxycodone on the 8-5-17 at 7:05 p.m. The pain pill was ineffective, but there is no documentation that the physician was notified that (R4's) pain was ineffective."</p> <p>On 8-16-17 at 11:45 a.m. E2 (Director Of Nursing) stated, "Whenever (R4's) pain pill is given it should be documented on the PRN (as needed) sheet and the narcotic sheet. The nurses should go back to the resident and see if the pain pill was effective or not. If the pain pill was ineffective then the nurses need to look at</p>	S9999		
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S9999	<p>Continued From page 19</p> <p>getting a change in medication. The nurses are not documenting whether (R4's) pain pill is effective or not, and should be. The nurses have not been tracking (R4's) pain and should have been. (R4's) pain assessment should have been done every shift according to (R4's) care plan. (R4's) pain assessment has not been done every shift. (R4's) pain assessment score on 7-12-17 was a five and a comprehensive pain assessment should have been done, but was not. (R4's) pain started to worsen on 7-25-17 and no further pain assessments were done after the pain worsened. No one knew (R4) had a pain clinic order, so no one followed up to ensure the appointment was made." On 8-17-17 at 2:00 p.m. E2 (Director Of Nursing) stated, "The nurses should have been assessing (R4) to figure out her pain. (R4's) oxycodone should have been given more frequently to control her pain and to prevent her hospitalization for chronic pain."</p> <p>On 8-21-17 at 12:15 p.m. Z10 (Pharmacist) stated, "(R4's) urine opiates screen should have most definitely tested positive for oxycodone 5 mg IR (Immediate Release) at least for 24 hours, if not longer. If (R4) was given a dose of oxycodone at 1:15 a.m., then the urine drug screen should have tested positive for opiates. It should have definitely tested positive if (R4) was given three doses within the 24 hours before the urine test."</p> <p>On 8-22-17 at 10:30 a.m., E2 (Director of Nursing) stated, "60 tablets of (R4's) oxycodone is missing and we (the facility) are concerned that the medication had been misappropriated. We have had concerns in the last month of nurses taking narcotic medication for personal use. (R4's) 60 tablets would have had to be taken by someone because they were definitely delivered</p>	S9999		
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