**Final Observations**

**Statement of Licensure Violations:**
1 of 2 Findings

- 300.610a)
- 300.1210b)
- 300.1210d(2)(3)
- 300.1610a(1)
- 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 and dated minutes of the meeting.

**Section 300.1210  General Requirements for Nursing and Personal Care**

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.
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<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>S9999</td>
<td>Continued From page 1 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.</td>
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<td>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:</td>
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<td>2) All treatments and procedures shall be administered as ordered by the physician.</td>
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<td>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.</td>
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<td>Section 300.1610 Medication Policies and Procedures</td>
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<td></td>
<td>a) Development of Medication Policies</td>
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<td></td>
<td>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</td>
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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.

Section 300.3240 Abuse and Neglect

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

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to provide a policy on reordering medication and failed to administer Morphine Sulfate for 1 of 3 R5 residents reviewed for administration and availability of pain medication. This failure resulted in R5 being without opiate pain medication for 2 days resulting in R5 being transferred to the local hospital and being admitted and treated for opiate withdrawal.

Findings include:

A review of R5's clinical record physician order sheet documents MS Contin 15mg tablet extended release (Morphine Sulfate Controlled Release) 1 tablet as needed every 6 hours.

According to the controlled drug receipt/disposition form documents R5 had an order for Morphine sulfate 15 mg every 6 hours
Continued From page 3

as needed for pain. The form also documents that this is a high alert medication, and was last dispensed to the facility on 10/31/2017. According to the disposition form and the medication administration record R5 received the last dose of MS Contin on 11/9/17 at 10:50pm.

On 11/27/17 at 4:30pm E2 (Director of Nursing) said that her expectation and facility practice is to re-order medication prior to running out of the said medication. During this interview E2 said that the nursing staff should re-order medication 3 to 4 days prior to the medication runs out.

According to the facility policy documents the facility should notify the pharmacy by when reordering is necessary.

According to the clinical record progress note dated 11/11/2017 8:03pm R5 experienced a change in condition consisting of vomiting and coffee ground emesis and was sent to the local hospital for evaluation.

According to the local hospital record dated 11/11/2017 R5 presented to the emergency room with chronic wide spread pain and nausea vomiting, and a history of opioid addiction. According to record R5 was admitted to the local hospital and treated for vomiting and opioid withdrawal.

According to MS Contin package insert MS Contin classification is defined as an opioid/narcotic pain medication. MS Contin extended-release tablets are a strong prescription pain medicine used to treat moderate to severe pain that requires around-the-clock, long-term treatment. When the patient no longer requires therapy with MS Contin tablets, use a gradual
Continued from page 4

downward titration of the dose to prevent signs and symptoms of withdrawal in the physically-dependent patient. Do not abruptly discontinue MS Contin.

(B)

300.120a)
300.120b)
300.120d)(6)
300.1220b)(3)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

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)
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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.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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
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.

Section 300.3240 Abuse and Neglect

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

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to develop a plan of care to prevent a potential tripping hazard of an extended length oxygen tubing for 1 of 3 residents R1 reviewed for fall risk and fall prevention interventions. This failure resulted in R1 getting out of bed walking to the bathroom with her nasal cannula and oxygen tubing connected, falling to the floor sustaining a large hematoma and laceration to the head requiring a repair with staples.

Findings include:

According to R1's clinical record 9-13-17 3:45am E5 (Certified nurse aide) noticed the call light was on and upon entering R1's room R1 was on the floor and called out for the nurse The note
Continued From page 7

documents that R1 was face down on the floor, and that R1 was unable to state what happened and denies pain or loss of consciousness, R1 attempted to get up but was encouraged to lay still.

On 11/27/17 at 9:30am E17 (nurse) said that on 9-13-17 around 3:30am she heard E5 (Certified nurse aide) call out from R1’s room. E17 said she ran to the room and observed R1 lying face down on the floor near the bathroom with a moderate amount of blood on the floor. E17 said because R1 is a dialysis patient she checked the fistula site first. E17 said that she noticed that R1 had matted blood on the side of her head and blood coming from the head. E17 said that she applied ice and pressure, and had asked E4 (nurse) to call 911. E17 said that R1 was slow to respond but eventually did respond and was noted to be alert and oriented. E17 said that she noticed that R1’s oxygen tubing was alongside of R1. E17 said that R1 was not tangled in the tubing but it was right alongside of her. E17 said that the tubing was very long so that R1 could go from her bed to the bathroom.

On 11/27/17 at 10:00am E5 (Certified Nurse aide) said that on 9-13-17 around 3:15am she left R1 in the bed asleep, and made rounds to other residents rooms. E5 said that around 5 or 10 minutes later she noticed the call light on in R1’s room. E5 said that when she went to answer the call light she observed R1 on the floor face down with blood on the floor. E5 said that she called out for help. E5 said that she assisted E17 with R1 who was observed to be alert. E5 said that R1 was unable to say what happened. E5 said that R1 was not tangled up in the oxygen tubing, however said that the oxygen tubing was lying right alongside of R1. E5 said that R1’s oxygen
Continued From page 8

Tubing was very long, E5 said it allowed R1 to move around the room and go to the bathroom while leaving the oxygen tank at the bedside. E5 said that she can't recall if R1 was wearing the oxygen at the time of the fall, however E5 said that R1 has on the oxygen tubing most of the time. E5 said that R1 didn't pull the call light, but R1's roommate (R6) pulled the call light.

On 11/27/17 at 10:20am E4 (Nurse) said on 9/13/17 around 3:30am E5 called out for help and she went into R1's room and observed R1 on the floor face down with blood on the floor. E4 said that E17 and E5 assisted R1. E4 said that R1 was observed to be alert. E4 said that R1 said she didn't know what happened. E4 said that R1 was not tangled in the oxygen tubing, but said that R1 was still wearing her oxygen tubing. E4 said that the nasal cannula was still in R1's nose. E4 said that R1 had very long oxygen tubing which allowed her to go to the bathroom while being able to keep the oxygen tank at the bedside. E4 said that R1 had a large liquid oxygen tank.

According to the physical therapy evaluation dated 8/24/17, R1's functional deficits as balance while standing requires handhold support, unable to maintain balance while turning head/trunk. R1 is also documented as requiring contact guard assist for transfer from sitting to standing position, and from standing to seated position. The evaluation also includes noted fall precautions, low endurance, safety precautions, safety awareness; oxygen 2 liter per nasal cannula. R1 is also noted to be high risk for falls.

On 11/14/17 at 11:30am E9 (Physical therapy) said that contact guard assist is defined as placing a hand on the back or shoulder to assist
Continued From page 9

with balance while standing or ambulating. E9 also said that because R1 wore oxygen that R1 required someone behind pulling the oxygen tank so that the oxygen tubing doesn't become a tripping hazard.

According to R1's clinical record for fall prevention R1 is at risk for falls/accidents related to medical complexities, impaired mobility, and uses a wheelchair for mobility. The plan of care interventions does not include interventions of ensuring R1's oxygen tubing as a potential tripping hazard.

According to the falling star initiative policy and procedure dated 4/2017 documents a plan of care will be initiated utilizing fall prevention strategies to reduce or eliminate each residents fall risk.

According to the hospital record dated 9/13/17 R1 indicates that R1 said that she was getting up to use the restroom and fell from standing. The record documents that R1 has a large hematoma over the crown on the right side of her head, and treated for a laceration to the left parietal scalp repaired with staples.