Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002265	A. BUILDING: ______ B. WING ______	C 12/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF CRESTWOOD	14255 SOUTH CICERO AVENUE CRESTWOOD, IL 60445

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S 000	Initial Comments Complaint Investigations: #2091067/IL120014 #2094319/IL123524 #2094591/IL123818 #2097715/IL127274 #2098071/IL127656 #2098637/IL128271 #2091551/IL120557 #2091574/IL120576	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.610 a) 300.1210 b) 300.1210 d)5) 300.3240 a) 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	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on interviews and record reviews, the facility failed to consistently and accurately assess and monitor a resident's clinical condition, implement interventions that are consistent with a resident's needs, goals, and professional standards of practice, and evaluate the effectiveness of the interventions to prevent a sacral pressure ulcer from worsening for one	S9999		

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S9999	Continued From page 2 resident (R11) in a sample of 9 reviewed for pressure ulcers. This failure resulted in R11 developing a stage 4 sacral pressure ulcer requiring surgical debridement. R11 was also found to have osteomyelitis (bone infection) of the sacrum and coccyx. Findings include: Review of R11's medical record notes R11 with diagnoses including: sepsis, heart failure, diabetes, chronic kidney disease, peripheral vascular disease, atrial fibrillation, coronary artery disease, high blood pressure, seizures, and stroke with right dominant side. Review of R11's hospital record, dated 10/19/20 - 10/28/20, the Wound Physician notes R11's sacral wound is just excoriations, measuring 6cm (centimeters) x 7cm, at this time that are superficial will dress with a medicated cream and a large foam dressing. R11 needs a stage 4 mattress and should turn every two hours. Review of R11's re-admission clinical evaluation, dated 10/28/20, V35, LPN,(Licensed Practical Nurse) noted R11's skin observation: coccyx full thickness skin loss with grey yellow slough; right buttock partial thickness skin loss; and left buttock partial thickness skin loss. Review of R11's Braden score, dated 10/28/20, notes R11's score is 11; score notes R11 is at high risk for skin breakdown. Review of R11's POS (Physician Order Sheet), dated 10/28/2020, notes an order for daily skin check, if any skin issues are identified please complete the skin event form daily x 3 days. On 10/29/2020, an order notes daily skin check. A	S9999		

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Braden score of 13-18 requires daily skin check two times a week. If a skin issue is identified complete the risk management, which will trigger a skin event form every night shift on Mondays and Thursdays.

Review of R11's medical record from re-admission on 10/29 until re-hospitalization on 11/10 does not note any documentation regarding R11's sacral/buttocks ulcers.

Review of R11's MDS (Minimum Data Set), dated 11/5/2020, notes R11 is totally dependent on two staff members for bed mobility; R11 requires extensive assistance of one staff member for eating, toileting, dressing, hygiene, and bathing.

Review of R11's hospital record, dated 11/10/20 - 11/21/20, notes R11 with a sacral pressure ulcer which is more demarcating and necrotic (dead tissue). R11 underwent debridement on 11/16 and found to have osteomyelitis of the sacrum and coccyx. Sacral ulcer measures 10cm x 12cm, exposed bone, with some excoriations around the edges.

On 12/9/2020 at 1:40 PM, V43 (family member) stated V43 was not aware R11 had a sacral pressure ulcer. V43 stated when R11 went to the hospital in November, the nurse at the hospital informed V43 of the sacral pressure ulcer R11 was admitted with.

On 12/15/2020 at 10:12 AM, V4 (Wound Care Coordinator) stated the Braden scale is used to determine a resident's risk for skin breakdown. V4 stated R11 is high risk for skin breakdown. V4 stated residents at high risk should have skin assessed daily. V4 stated upon R11's re-admission to this facility on 11/23/20, R11 was

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noted to have a stage 4 sacral pressure ulcer. V4 denied being informed R11 had skin breakdown on sacrum upon re-admission on 10/28/20. V4 stated prior to 11/23/20, R11 was only being seen for bilateral heel wounds due to peripheral arterial disease.

On 12/15/2020 at 2:50 PM, V24 NP (Nurse Practitioner) stated after reviewing R11's progress notes, R11 did have ulcers on both heels in October. V24 stated V24 is unable to find documentation of sacral pressure ulcer prior to R11's re-admission on 11/21/2020. V24 stated V24 would expect the Nurse Practitioner to order wound care treatments if she had been made aware of sacral wound when R11 was re-admitted to this facility on 10/28/2020.

On 12/16/2020 at 11:50 AM, V2, DON (Director of Nursing), stated the nurse documents skin events in risk management in the resident's electronic medical record. V2 stated V2 did not note any documentation in risk management related to skin events noted upon re-admission to this facility on 10/28/20 or 11/21/2020.

On 12/17/2020 at 9:00 AM, V10, LPN (Licensed Practical Nurse), stated after reviewing R11's re-admission clinical evaluation, dated 10/28/20, V35, LPN, should have alerted the wound care team of new wounds identified on R11's sacrum/buttocks. V10 stated the wound care team would have measured and staged R11's wounds, received treatment orders from the wound care physician, notified R11's family member, and updated R11's care plan.

Review of this facility's skin care prevention policy, revised 12/2019, notes the Wound Care Coordinator will review all new admissions to put

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a plan in place for prevention based on the resident's activity level, comorbidities, mental status, risk assessment, and other pertinent information. All resident will be observed daily for changes in their skin condition. Residents will be assessed during care for any changes in skin condition including redness or any other alteration in skin integrity, and this will be reported to the nurse.

Review of this facility's wound evaluation and documentation policy, reviewed 12/2020, notes wounds will be evaluated and the following areas documented every 7 days: location, classification/stage, size, depth, presence and location of any undermining, drainage, pain, wound bed color and type of tissue, description of wound edges and surrounding tissue. If a wound is present, the resident and/or resident representative and physician will be notified. The licensed staff will notify the wound care team in a timely manner upon identification of skin impairment. The licensed staff should document the open area, risk management, skin event form, and pain evaluation. Notify the physician for treatment orders. When the wound care team assesses the resident, they will complete braden scale, measure the wound, review physician orders, and update any notes and care plans as appropriate. A member of the wound care team will complete braden scale, wound characteristics and appropriate notes within 24 hours of admission

(A)

2 of 3

300.610 a)
300.1210 b)

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300.1210 d)6)
300.1220 b)3)
300.3240 a)

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. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care
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.

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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.

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to follow the plan of care for high risk for falls; failed to implement individualized safety interventions and interventions consistent with a resident's needs, goals, care plan, and current professional standards of practice to reduce the risk of a fall; failed to analyze the resident's fall to determine the root cause, and develop interventions to reduce the potential for further falls; and failed to provide adequate supervision. These failures resulted in R6 falling forward out the wheelchair, sustaining a laceration to the head. R6 was sent to the hospital and received 7

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sutures.

Findings Include:

1.R6 physician order sheet and care plan show diagnosis of HISTORY OF FALLING UNSPECIFIEDCATARACT and poor trunk control, anemia, chronic pain, hypertension.

R6 plan of care, with initial date of 4/18/2013 and target date of 7/3/2020, shows R6 is high risk for falls related to unaware of safety need. R6 noted with fall incident. Goals will be for R6 not to sustain serious injury through the next review date. Interventions are to have floor mat on the side of the bed while in the bed. Educate the family about safety reminders and what to do if fall occurs. R6 bed in lowest position. Resident transfer to an acute facility for further evaluation. Soft helmet on at all times, may remove during meals, continue to re-educate husband with the risks and benefits of helmet use, Husband continue to remove helmet when he is arourld despite education. Staff to ensure resident is in high visualized are for monitoring when not in bed. The resident has a chair/ bed alarm and motion pad alarm on bed, ensure the device is in place as needed. The resident will have helmet on while ambulating, per family request to prevent head injuries. Therapy department to screen for appropriate ambulatory assistive device.

R6 care plan, with initiated dated of 11/13/2017, shows R6 had an actual fall on 11/13/17 r/t (related to) poor safety awareness / impulsiveness, pt (patient). was sent to ER for an evaluation. Goals are to decrease incident of fall through the next review. Interventions: Resident not to be alone in the room while sitting on the chair unsupervised due to poor trunk control.

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Mattress on the floor for safety. Place call light within reach.

R6 Plan of care, with initiated date of 5/15/2020, shows R24 has potential for falls, resident at risk for injury from falls Poor Balance, and Poor safety awareness/impulsiveness. Goals: The facility will reduce the likelihood of the resident experiencing an injury related to a fall through next review target date 07/03/2020. Interventions are to maintain bed in the lowest position, lock wheels to prevent the bed from moving. Check on resident frequently and place resident in visible view of staff when up in chair as resident will allow. PT/OT evaluation and treat per MD order. Call light within resident's reach when in room.

R6 facility incident report, dated 5/15/2020 at 8:15 AM, shows incident location, resident's room. Incident description observed resident laying on the floor. Leaf huddle called nursing staff responded. Resident assisted from floor put to bed per mechanical lift. Noted laceration of forehead with small amount of bleeding pressure dressing applied bleeding stopped. Neuro checks initiated no change in LOC. Full body check done no visible injuries or bruises noted PROM within normal limits. Resident's nonverbal no s/s - (signs/symptoms) of pain noted, no facial grimacing noted. Resident unable to give description. Assessed by nurse. Resident assisted from the floor to the bed per mechanical lift x2 staff members. Noted laceration to forehead with small amount of bleeding pressure dressing applied bleeding stopped. Neuro checks initiated no change in LOC. Full body check done no visible injuries or bruises noted PROM within normal limits. Resident's nonverbal no s/s of pain noted, no facial grimacing noted. Head to toes check done, vital signs taken, pressure dressing

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S9999	Continued From page 10 applied, neuro checks initiated, scheduled pain medication given. Resident sent to hospital. N. injury type, laceration injury location, face. Level of pain "0". Mental status unable to determine. Injuries report post incident, no injuries observed post incident. Predisposing environmental factors, other. Predisposing physiological factors, gait imbalance. Predisposing situation factors, leaning. Witness V20 (Nurse) fall unwitnessed. V37, CNA-(Certified Nursing Assistant) informed me that she got the resident up and stepped away to get her tray. Resident leaned forward and fell. She was unable to catch her in time. Patient had a laceration to her forehead. V37 witness statement shows I got the resident up as usual. I stepped away to get her tray and she fell I could not reach her in time to prevent her fall. Agencies / People notified. Nurse Practitioner at 5/15/2020 at 1:42 PM and Family member on 5/15/2020 at 8:40 AM. Notes RCA (Root Cause Analysis): poor sitting balance r/t weakness. Resident left facility via stretcher accompanied two attendants. Gauze dressing to forehead dry no change in status. Neuro checks pearl, no decrease in LOC. Resident transported to ER for evaluation. Resident left facility via stretcher accompanied two attendants. Gauze dressing to forehead dry no change in status. Neuro checks pearl, no decrease in LOC. Resident transported to ER for evaluation. 83-year-old female here for long term care. Past medical history hypertension, gastroesophageal reflux disease, dysphagia, hyperlipidemia, Alzheimer's, dementia, chronic anemia, chronic rhinitis, ulcerative colitis/ chron's disease, chronic obstructive pulmonary disease. Patient was observed on the floor with laceration to forehead and small amount of bleeding. Pressure dressing applied bleeding stopped. Neuro checks initiated no change in LOC. Full body check done no visible injuries or bruises	S9999		

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noted PROM within normal limits. Residents' nonverbal no s/s of pain noted, no facial grimacing noted. Resident transported to ER for Evaluation. Resident left facility via stretcher accompanied two attendants. Gauze dressing to forehead dry no change in status. Neuro checks pearl, no decrease in LOC. Returned to facility with sutures to forehead.

R6 progress note, dated 5/15/2020 at 1:33 PM, completed by V20 (Nurse) shows "Writer called to this resident room per assigned CNA noted resident laying on the floor face down. Leaf huddle called nursing staff responded. Resident R6 assisted from the floor put to bed per mechanical lift. Noted laceration to forehead with small amount of bleeding pressure dressing applied bleeding stopped. Neuro checks initiated no change in LOC- loss of consciousness. Full body check done no visible injuries or bruises noted. PROM (Passive Range of motion) within normal limits. Resident nonverbal no s/s (signs/symptoms) of pain noted no facial grimace noted. NP (Nurse Practitioner) notified states I will be in the facility by 10 am to see her. Daughter notified."

R6 hospital records, dated 5/15/2020 at 12:00 PM, shows in part history of present illness, the patient presents with head injury. The onset was just prior to arrival. Type of injury fall with laceration. The course /duration of symptoms is improving. The location of incident occurred was at the nursing home. Risk factors consist of Alzheimer's. Prior episodes: none. Therapy today. Associated symptoms: denies vomiting. Diagnosis show fall, blunt head trauma and facial laceration. Laceration repair shows in part 3 cm in length, irregular shape depth multiple layers, anesthesia 5ml 2% lidocaine, skin closure 5-0

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nylon (7 sutures) simple technique. Complexity 2 layers.

On 12/11/2020 at 3:28 PM, V20 (Nurse) said she was notified by the aide that R6 had a fall on 5/15/2020. V20 said when she went to R6's room to complete her assessment, R6 was on the floor face down in front of her wheelchair. V20 said R6 was noted with a laceration to her forehead. V20 said she observed R6 high back wheelchair was in the upright position. V20 said she rendered first aide and applied a gauze dressing to the area. V20 said the aide told her she stepped away from R6 to get something, V20 said she wasn't sure. Facility incident report reviewed with V20. V20 said the documentation showing no visible injuries or bruises noted was typed in error, R6 did sustain and injury from the fall. V20 said R6 was sent to the hospital and received sutures to her forehead. V20 said she was unable to determine R6 mental status because R6 was nonverbal. V20 said although she checked the box for predisposing environmental factors, there were no predisposing environmental factors related to R6 fall. V20 said R6 had predisposing physiological factors that contributed to her fall of gait balance. V20said R6 could not come to a standing position independently, she required assist. V20 said R6 had predisposing situational factors of leaning that contributed to her fall. V20 said R6 had poor trunk control which caused her to lean from side to side. V20 said R6 should not be left sitting in high back wheelchair in an upright position alone. V20 said the staff should not step away too far from the resident who has poor trunk control a couple steps are okay. V20 said she does not know how far or how long V20 stepped away from R6. V20 said R6 did not need her helmet on the day of the fall. V20 said if she documented that the fall occurred in R6 room

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then that's where the fall occurred.

On 12/15/2020 at 2:45 PM, V2 (Director of Nursing) said she conducted the fall investigation for R6 for the fall on 5/15/2020. V2 said although both witness statements show V20's name, one statement is from V20 and the other statement is from V37. V2 said that's why she specifically put V37's name in the statement so that it could be recognized as V37 statement. V2 said the program did not have V37 name listed and she had to list any name in order to document the interview. V2 said the root cause for R6 fall was poor sitting balance. V2 said if R6 plan of care intervention show that R6 should have a soft helmet on at all times and may remove during meals then R6 should have had a helmet on the day of the fall. V2 said the helmet is used to prevent head injuries in the event of a fall or seizure. V2 said R6 plan of care shows R6 should not be alone in the room while sitting up on the wheelchair unsupervised due to poor trunk control. V2 said R6 could potentially fall from the chair when she is unsupervised due to poor trunk control, R6 did not have the ability to maintain a proper sitting balance. V2 said R6 should have not been left sitting in the high back wheelchair while V37 stepped away to retrieve the food tray. V2 said R6 sustained a laceration to the forehead and was sent to the hospital where she received sutures.

Several calls were made to interview V37, no answer.

Care Plan policy, dated 10/03 with last review date of 9/20, shows each resident will have a care plan that is current, individualized, and consistent with their medical regimen. Care plan consist of the flowing problems identified by

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reviewing the medical records and discussion with the resident and /or significant others. Goals are set in conjunction with the family and resident. Goals are realistic, measurable, behaviorally stated and may be longer or shorter term. Goals should prevent decline or maintain resident function if realistic and appropriate based on the diagnosis. Interventions are actions taken to achieve the goals. These interventions should build on the resident's strengths, be realistic and identify those responsible for the interventions. Evaluation of the care plan should occur at least every90 days or with a significate change of the resident. If the goal is continued, a new date of completion should be identified. If the goal has been achieved it should be discontinued and a new goal, if appropriate, written. If the goal is now unachievable, it should be discontinued, and a care plan update as to why.

Fall Management and Prevention Program policy, dated 9/2020, shows in-part, it is the intent of this facility to provide residents with assistance and supervision to minimize the risk of falls and falls related to injuries. A comprehensive care plan will be implemented based on fall risk screen score with an individual goal and interventions specific to each patient.

2. Review of R2's medical record notes R2 was admitted on 12/31/2019 with diagnoses including: seizure disorder, chronic respiratory failure with hypoxia, diabetes, chronic obstructive pulmonary disease, generalized muscle weakness, abnormalities of gait and mobility, anemia, heart failure, pulmonary hypertension, dependence on oxygen, high blood pressure, and end stage renal disease.

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Review of R2's fall risk screen, dated 12/31/2019, notes R2 is at high risk for falls.

Review of R2's falls care plan, dated 12/31/2019, notes R2 is at risk for injury from falls. Interventions identified include: provide adequate lighting, check on R2 frequently and place in visible view of staff when up in chair, toilet in a timely manner, encourage R2 to transfer and change position slowly, and orient to environment. R2's care plan was not updated after a fall on 1/6/2020.

Review of R2's PT (Physical Therapy) evaluation, dated 1/1/2020, R2's functional assessment notes R2 requires maximum assistance of two staff for bed mobility, rolling, and supine to sitting position. R2 requires total assistance with transfers. Assessment summary notes R2 demonstrates decreased bilateral lower extremity muscle strength/muscle performance, impaired balance and functional activity tolerance, all of which impact R2's safety and independence with functional activity tolerance and requires skilled PT services in order to help R2 reach R2's prior level of functioning with increased safety awareness.

Review of R2's nurse practitioner's progress note, dated 1/6/2020, notes reason for visit: fall and pain. R2 alert and oriented x 3. R2 seen today for report of fall over night as well as pain associated from the fall. R2 reported R2 was being transferred from bed to dialysis chair when R2 fell. R2 reported R2's legs went behind R2. R2 reported pain in lower back, left hip, and left leg. X-rays ordered of left hip, left leg, and lower back; results showed no acute injury. As needed narcotic analgesics and Lidoderm patch to lower back ordered. R2 with significant muscle

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weakness. Fall precautions, safety awareness discussed with nursing and R2. R2 instructed R2 must be transferred with a mechanical lift device.

There is no documentation found in R2's medical record noting the fall event on 1/6/2020, or that the interdisciplinary team met to determine the root cause of R2's fall and develop interventions to prevent future falls from occurring.

Review of R2's BIMS (Brief Interview of Mental Status), dated 1/7/2020, notes R2's score is 15 out of 15. R2 is able to make needs known.

Review of R2's MDS (Minimum Data Set), dated 1/7/2020, notes R2 is totally dependent on two staff persons for bed mobility and transfers.

On 12/11/2020 at 1:00 PM, V12 (Rehabilitation Director) stated R2 was non-ambulatory. V12 stated it was recommend staff use a mechanical lift device for all transfers for R2.

On 12/11/2020 at 1:27 PM, V10, LPN (Licensed Practical Nurse) stated the fall protocol includes: performing a pain assessment, notifying the physician, and completing the fall risk assessment. V10 stated fall screening is completed upon admission and quarterly. V10 stated residents are monitored for 72 hours post fall. V10 stated the IDT (Interdisciplinary Team) meets post fall to determine root cause, review interventions, and document in the resident's care plan. V10 stated the care card at the nurses' station is used to inform CNAs (Certified Nurse Aides) of resident's fall interventions.

On 12/15/2020 at 1:30 PM, V2, DON (Director of Nursing) stated V2 was not made aware R2 had a fall while residing at this facility. V2 stated V2

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S9999	Continued From page 17 reviewed R2's medical record and did not note any fall event documentation by the nurse on duty at the time of the fall. V2 stated nurse expectations include: notify family, physician, and V2; document fall event in risk management; and complete a fall event. V2 stated IDT (Interdisciplinary Team) would meet to determine root cause and high risk, and determine interventions to prevent further falls. Review of this facility's fall management and prevention program, dated 9/2/2020, notes all residents will have a comprehensive fall risk screen on admission and with significant change of condition and appropriate care plan interventions will be implemented and evaluated as indicated by assessment. A comprehensive care plan will be implemented based on fall risk screen score with an individual gal and interventions specific to each resident. The care plan will be reviewed following each fall. Interventions are to be revised as indicated by screen. If a fall occurs, the following actions will be taken: assess resident including neurological checks, pain, range of motion, skin, joints, extremities, vital signs; assess resident each shift for 72 hours; pain will be assessed every shift for 72 hours; notify physician/family member; document assessment, pertinent facts, and incident in risk management; complete a fall event; begin investigation; IDT to determine root cause of fall; update care plan. (B) 3 of 3 300.610 a) 300.1010 h) 300.1210 b)	S9999		

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S9999	Continued From page 18 300.1220 b)2) 300.3240 a) 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 300.1010 Medical Care Policies 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 accident, injury or change in condition at the time of notification. 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. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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resident to meet the total nursing and personal care needs of the resident.

Section 300.1220 Supervision of Nursing Services

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

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to follow their comprehensive pain management protocol and reassess the effectiveness of an administered pain medication; and failed to notify the physician of the ineffectiveness of the current pain management. This failure resulted in R14 complaining of persistent lower back pain for over 3 hours and subsequently standing up to get pain relief, losing her balance, falling to the floor, and being transported to the hospital with complaints of pain and numbness in her bilateral legs and lower back pain. R14 was assessed to have an acute comminuted avulsion fracture of the right ischial tuberosity.

Findings Include:

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R14 admitted in the facility on 8/19/20 with primary admitting diagnosis of Orthopedic after care. R14 has a primary discharge diagnosis from the hospital of status post extension of previous instrumentation in L3-S1 (L-Lumbar and S-Sacral), L3-L4 TILF (Transforaminal Lumbar Interbody Fusion), L3-L4 laminectomy and foraminotomies (surgical procedure).

R14 care plan indicates R14 is at risk for alteration of comfort initiated on 8/19/20 with an intervention that reads: Notify physician if current pain medication management is not effective.

R14 is care plan for potential for falls, at risk for injury from falls, with start date of 8/19/20. Goals: The facility will reduce the likelihood of the resident experiencing a fall through next review, initiated on 8/19/20, with target date of 11/17/20.

Medication Administration Record (MAR) was reviewed. MAR has order for Tramadol 50 mg to give 2 tablets every 6 hours as needed for moderate pain. Tramadol pain medication was given on 8/21/20 at 0150 for a pain level of 8 on a scale of (0-10).

V40's Notes on 8/21/20 at 2:03 AM reads: R14 rang call light, requested pain meds. R14 given 2 tramadol as ordered.

On 8/21/20 at 3:00 AM, V40's note reads: R14 rang call light, stated R14 is still waiting for her Tramadol. Nurse informed R14 she had taken her tramadol an hour ago. R14 stated she don't remember.

On 8/21/20 at 4:00 AM, V40's note reads: R14 rang call light again asking for more pain meds,

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reviewed medication with R14 and what time she could have more tramadol.

On 8/21/20 at 4:27 AM, V40's note reads: rang call light again asking for her pain meds.

On 8/21/20 at 5:05 AM, V40's incident follow up note reads: R14 alert and oriented stated she was in pain and got up to look through her purse in the closet to see if she had stronger pain meds. Stated she lost her balance and fell backward landing on her left side, however she was observed laying on her right side.

On 8/21/20, R14 was sent to hospital and Emergency department Chief Complaint was Back Pain, reads in part: patient states "I had corrective back surgery and I have not been getting anything for pain". Patient alert and oriented x 4, patient states pain of 10/10. R14 states that previously R14's numbness had improved but since the fall, R14's numbness and pain has worsened. X-ray of Pelvis and Bilateral hips with an impression of acute comminuted avulsion fracture of the right ischial tuberosity.

On 12/15/20 at 1 PM, surveyor interviewed V2 (Director of Nursing) who stated, "R14 had a fall. It was on a night shift. R14 had medication that she wanted sooner and that it was not able to be given. Nurse explained that she could not give pain medication to R14 because it was too soon. When V40 told R14 no and did not give medication, R14 called her Neurologist. I cannot remember the details but I know the nurse informed me of the fall. 911 came after the fall. It was R14 that called 911 per her neurologist instruction. R14 was transferred to hospital and she was discharge from the hospital back to R14's home."

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On 12/17/20 at 2 PM, surveyor interviewed V40 (nurse)who stated, "I assessed R14, and checked her for any bruising, for ROM (Range of Motion) and redness. R14 was able to do ROM without impairments. No pain in her extremities when ROM were performed. CNA (certified nursing assistant) and I helped R14 off the floor, but I don't remember if we used the mechanical lift device. No new or intensified pain after the fall."

On 12/17/20 at 2 PM, surveyor interviewed V40 (Nurse) who stated, "R14 is able to reposition herself and resident was repositioning herself. I gave her tramadol as ordered one time and did not do any new interventions from 2am to 5am. R14 was the one who keeps putting her light on and telling me she is still in pain. I told her she already had her medicine. I did not call the doctor and I don't recall why I did not call. Pain is subjective, usually if the pain medication is not working, I would notify the doctor to let them know that resident been complaining of pain and already medicated, maybe get a new order to relieve pain".

On 12/17/20 at 2:15 PM, R14's attending physician (V38) stated, "I do not remember R14, she was only in the facility for a short period of time. R14 gets two tramadol 50mg for pain every 6 hours as needed. I did not receive a call from the nurse, but in general, if the medication is ineffective and resident is still in pain and pain medication is too soon to be given, the nurses sometimes calls and informs me and maybe after our discussion I could order another pain medication".

Per NCBI (National Center for Biotechnology Information) notes: Clinical manifestation, patient

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often present with sudden pain in the pack of the thigh or hip, followed by abnormal gait or inability to walk. Physical examination often reveals the following: swelling of the buttocks, accompanied by ecchymosis, tenderness at the ischial tuberosity when touching the bones, inability to sit, and disorders of hip and knee flexion and extension. If accompanied by nerve damage, it can be expressed as pain in the hips and large hind legs, and the most obvious symptoms is extreme pain of the hip extension, adduction and external rotation.

Pain management policy, with revision date of 7/14, reads in part: To facilitate and provide guidance on pain observation and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence and enhance dignity and life involvement. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Monitoring for effectiveness of interventions. Licensed nursing may notify Health Care Provider of any new development of pain, change in pain, change in condition that could potentially cause pain, for pharmacological interventions based on individual's pain factors. If the pain has not been managed consistent with the resident's goal and needs the interdisciplinary team may need to reconsider current interventions and revise those interventions as needed.

This facility's fall management and prevention

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S9999	Continued From page 24 program, dated 9/2020 reads in part: All residents will have a comprehensive fall risk screen on admission, quarterly and with significant change of condition and appropriate care plan intervention will be complemented and evaluated as indicated by assessment. If a fall occurs, the following action will be taken: Assess resident including neuro checks, pain ROM, skin, extremities, and vital signs (B)	S9999		