**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED JL6007983 05/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE **BRIAOF CAHOKIA** CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PRÉFIX (EACH CORRECTIVE ACTION SHOUL DIBE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 **Initial Comments** S 000 Annual Licensure and Certification Survey S9999 Final Observations S9999 Statement of Licensure Violations I of II: 300.610 a) 300.1210 b) 300.1210 d)2)3)5) 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 needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Attachment A
Statement of Licensure Violations

(X6) DATE

<u> Illinois [</u>	Department of Public	Health	12	ž.,	PORIV	IAPPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6007983	B. WING		05/	04/2000
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			A, IL 62206			
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S9999	Continued From page	ge 1	S9999		,	
	administered as ord 3) Objective ob resident's condition, emotional changes, determining care re- further medical eval- made by nursing sta- resident's medical re- 5) A regular pro- pressure sores, hea- breakdown shall be seven-day-a-week b- enters the facility wit- develop pressure so- clinical condition der sores were unavoida pressure sores shall services to promote and prevent new pre-	pasis: Its and procedures shall be lered by the physician. Its servations of changes in a lincluding mental and lincluding and treat for lincluding and treatment shall be lincluded and treatment shall be lincluded in the lecord. lincluded in				
	Based on record revifailed to timely identifitreat as ordered to prof 3 residents (R89) in a sample of 61. The developing a facility appressure ulcer/injury required surgical deb Findings include:  1. On 5/2/22 at 2:05 I	which became infected ridement.  PM, R89 stated that he did				
	not have the pressure tuberosity when he w	e ulcer on his right ischial as admitted to the facility. it while he was here. He				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6007983 B. WING 05/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE BRIAOF CAHOKIA CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 stated that the Certified Nurses Assistants (CNAs) won't turn him at night. He stated that he will put his call light on, and the CNA will come and turn it off without asking what he needs. He also stated that he may not get his dressing changed for 2 or 3 days. R89's Admission Record, print date of 5/3/22, documents that R89 was admitted to the facility on 2/11/22, and has diagnoses of Paraplegia, unspecified, and Pressure ulcer of Sacral Region. Stage 2. R89's Minimum Data Set (MDS), dated 3/8/22, documents R89 is cognitively intact. R89's MDs documents he requires extensive assistance of two plus person physical assist for bed mobility, transfers, and toilet use. R89's Care Plan, dated 2/14/22, documents R89 is at risk for skin complications related to (r/t) paraplegia weakness and reduced bed mobility related to (r/t) chronic ulcers of Bilateral lower extremities (BLE). The Care Plan documents "(R89) is non-complaint with turning and re-positioning while in bed and in chair. He is able to control motorized wheelchair (w/c) to re-position himself but at times refuses to." R89's Care plan documents "3/1/22-Re-admitted with Stage 3 to coccyx; Coccyx and BLE resolved, 3/28/22-Unstageable to Right ischial tuberosity. and 4/30/22-re-admitted from hospital with new area to scrotum." R89's Initial Skin Screen, dated 2/14/22 at 11:29 AM, documents that upon his admission to the facility, R89 had an area to his Coccyx with pink scar tissue noted, right lower leg (rear) 3-centimeter (cm) by (x) 5cm x 0.0 treatment in place, and Left lower leg (rear) 3cm x 3cm x

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preforming wound care to another area on R89

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6007983 B. WING 05/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE BRIAOF CAHOKIA CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 on 3/28/22. She stated that she cleansed the area and placed a dry dressing to it. She stated that she waited until (Wound Consultant) came in to do wound treatments and she notified the Wound Consultants when they came in to make rounds on Wednesday 03/30/22. R89's Physician's Order (PO), with start date of 3/31/22, documents "Calcium Alginate Miscellaneous, apply to R (right) ischium topically every day shift for/to promote wound healing, cleanse with w/c (wound/cleanser) apply Santyl. calcium alginate and foam pad, Q (every) day and PRN (as needed)." R89's PO, with start date of 3/31/22, documents "Santyl Ointment, 250 unit/GM (gram), (Collagenase), apply to R ischium topically every day shift for/to promote wound healing cleanse with w/c apply Santyl, calcium alginate, and foam dressing Q day and PRN." R89's March 2022 Treatment Administration Record (TAR), documents R89 did not receive treatment for his R ischial tuberosity pressure ulcer on 3/28/22, 03/29/22, and 3/30/22, R89's TAR documented on 3/31/22, R89 received the Calcium Alginate; however, the TAR did not document the Santyl ointment was administered. R89's Skin and Wound evaluation, dated 4/5/22, documents that R89's Stage 2 pressure ulcer to his Right Ischial Tuberosity measured 2.7 cm x 1.8 cm x 0.2 cm. The Evaluation documented the pressure ulcer had 50% granulation, 50% eschar. and moderate exudate. R89's TAR documented on 4/10 and 4/11/22, R89 was out to the hospital.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ IL6007983 B. WING 05/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE **BRIAOF CAHOKIA** CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 5 S9999 R89's Skin and Wound evaluation, effective date of 4/14/22, documents that the stage 2 pressure ulcer to R89's Right Ischial Tuberosity measured 2.2cm x 1.6cm x 0.3 cm. It further documents that the pressure ulcer now had 100% eschar, with moderate exudate, and seropurulent (consisting of a mixture of serum and pus) drainage. R89's Skin and Wound evaluation, dated 4/18/22. documents that the wound to R89's Right Ischial Tuberosity is now unstageable, and is measuring 3.0cm x 2.2cm x 0.3cm. It further documents that there is 10% granulation, 90% eschar, moderate exudate, serosanguineous drainage, and faint odor noted. There was no documentation R89's pressure treatment was changed at that time. R89's Skin and Wound evaluation, dated 4/25/22. documents that the wound to R89's Right Ischial Tuberosity is unstageable due to slough and/or eschar. The wound is measures 4.0cm x 2.8cm x 0.5cm. It has 20% granulation, 80% slough. moderate exudate, serosanguineous drainage. and no odor. R89's April 2022 TAR document that R89 did not receive the Calcium Alginate treatment to his right ischium because he was on leave of absence with medications. There was no documentation he received this treatment on 4/5 and 4/7/22. From 4/12/22 through 4/27/22, there is not documentation on this TAR that R89 received this treatment to his right ischial pressure ulcer. R89's Hospital Internal Medicine Report, with admission date of 4/27/22, documented he present on 4/27/22 "with a worsening right buttock decubitus ulcer".

R89's Hospital Progress Note, dated 4/28/22.

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admissions/readmissions to put a plan in place

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PRINTED: 05/25/2022 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6007983 B. WING 05/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE **BRIAOF CAHOKIA** CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 7 S9999 for prevention based on the resident's activity level, comorbidities, mental status, risk assessment and other pertinent information. 2. Dependent residents will be assessed during care for any changes in skin condition including redness (non-blanching erythema), and this will be reported to the nurse. The nurse is responsible for alerting the Health Care Provider. 3. All residents will be evaluated for changes in their skin condition." It further documents "5. All residents unable to reposition themselves will be repositioned as needed, based on a person-centered approach (minimum of every 2 hours)." It also documents "Educate the resident and resident representative regarding pressure ulcer prevention and treatment as appropriate." "A". Statement of Licensure Violations II of II: 300.610 a) 300.1210 b) 300.1210 d)1) 300.1610 a)1) 300.1630 d) 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

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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

PRINTED: 05/25/2022 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6007983 B. WING 05/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE **BRIAOF CAHOKIA** CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 8 S9999 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 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1610 Medication Policies and Procedures 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.

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Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed

prescriber shall be notified as soon as is

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dose. The 4/10/22 9:00 AM dose was left blank

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Illinois Department of Public Health **FORM APPROVED** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED IL6007983 05/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE **BRIAOF CAHOKIA** CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 11 S9999 that the first dose of was administered on 4/19/22. On 4/26/22 at 10:30 AM, R48 stated that the facility runs out of his pain medication, and it takes a couple of days for the medication to come in R48 stated that he does take other medication that helps with his pain. R48 stated that during the time of not receiving his pain medication his pain is increased. R48 stated that he had a lower leg amputation and at times the pain is unbearable. R48 stated that he depends on the medication to assist with his daily functions. On 4/28/22 at 10:21 AM, V9 (Licensed Practical Nurse/LPN), stated that R48 is alert and oriented. V9 stated that there have been problems with getting R48 pain pills at times. V9 stated that R48 has ran out of pain medication and she ordered it and it comes in by the next day. On 4/28/22 at 11:45 AM, V2 (Director of Nursing/DON), stated that she would expect the nurses to order the medication prior to the resident being out. V2 stated that if the medication were not here, she would expect the nurse to notify the physician and follow the physician's direction. V2 stated that if the medication is available in the convenience box, she would expect the nurse to access it and administer from there. On 5/4/22 at 12:12 PM, V9 stated that if a resident received routine medication and the medication ran out, he would experience increased pain. 2. R53's POS documents 3/4/22 Oxycodone HCl Capsule 5 MG \*Controlled Drug\* Give 1 capsule by mouth every 4 hours as needed (PRN) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6007983  NAME OF PROVIDER OR SUPPLIER  STREET AD		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:  B. WING			(X3) DATE SURVEY COMPLETED	
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BRIAOF	CAHOKIA		ROME LANE	, =:: 5552			
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\$9999	Continued From pa	ge 12	S9999				
- 1	moderate to severe pain.						
		pant.				1	
- 1	R53's Progress Not	es, dated 3/5/22 at 12:12 PM,					
	documents "Nurses	Notes Note Text: Returned	1				
Į	from dialysis. Resid	ent had c/o (complaint of) not				1	
	having a cane and s	stated that he left his					
	somewhere and nee	eded a cane. Informed					
9	resident that we dor	n't have canes, but I would	1 1			}	
- 1	threatened to sell at	Therapy) office had any. He	1			1	
	for him. He also old	ate stating we have to provide that he needed a tray and I	1 1	*			
	let him know trave a	re coming out soon Lineble					
- 1	let him know trays are coming out soon. Unable to give narcotic pain med at this time and PRN		1				
- 1	(as needed) Tylenol	given."	f I			1	
						1	
i i	R53's Controlled Dru	ug Receipt					
- 1	Record/Disposition f	orm, dated 3/7/22	1 1		Ÿ		
	Documents Oxycodone Cap 5 mg first dose		1 1				
	administered 3/8/22.						
	On 4/27/22 at 11:00	AM, R53 stated that he has a	i l				
1	broken finger and ne	ed pain medication for it.					
	R53 stated that he ha	as had problem with getting					
	his pain medication a	and that the facility runs out	-				
	of his medication. Re	33 stated that it took a long					
	time to get the medic	ation when it was first					
	ordered, and he was	in a lot of pain.					
	On 4/20/22 at 40:04 f	MANO state Life A Total State					
	on 4/20/22 at 10:21/ have problems with a	M V9 stated that R53 did					
	was filonieilis mitil č	getting his medication and state that			23		
	R53 did not have a se	cript (prescription) when he					
i	first came, and the of	hysician had to be notified to					
9	get the script. V9 stat	ed that once the script was			13		
r	eceived the pharmad	by was notified and the		2			
r	nedication was recei	ved.					
	7n //28/22 at 2:44 Ft	U 1/4 /Administration					
1	יון 4/20/22 at 3:11 Pl hat R53 left the facilit	M, V1 (Administrator) stated					
ء ا	naci too lett tile (acii)) advice), and his medi	ty AMA (against medical cation was destroyed. V1					
	ent of Public Health	outon was desiroyed. VI					

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PRINTED: 05/25/2022 Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6007983 B. WING 05/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE **BRIAOF CAHOKIA** CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 13 S9999 stated that R53 came back to the facility and was readmitted. V1 stated that when readmitted R53 had orders but did not have scripts for his narcotics. 3. R116's Admission Record, not dated, list Chronic Pancreatitis and low back pain as diagnosis for R116. R116's Care Plan, dated initiated 4/22/22, documents "PAIN: (R116) Requires pain monitoring and management r/t his history of Bladder Cancer and Chronic Pancreatitis. It also documents "Administer pain meds and treatments as ordered, monitor and record." R116's MDS documents that R116 is cognitively intact. R116's POS, dated April 22, documents "Oxycodone HCL ER Tablet ER 12-hour Abuse Deterrent 10 mg give 1 tablet by mouth every 12 hours for moderate to severe pain". On 4/27/22 at 11:15 AM, R116 stated that the facility runs out of his medication. R116 stated that he had bladder cancer and has had hernias due to repair and has frequent pain. R116 stated that the pain is bad. R116 stated that sometimes it doesn't do any good to tell them you are in pain when they don't have the medication to give to you or won't give it to you. The facility's Pain Management Policy, review

llinois Department of Public Health

date 12/2021, documents "To facilitate and provide guidance on pain observations and

independence, promote resident comfort and

management. To facilitate resident

preserve resident dignity. This will be accomplished through an effective pain

	Department of Public	Health			FOR	RM APPROVED			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	TE SURVEY			
o <sup>®</sup> .	I DENTI ION TON HOMBER		A. BUILDING:			MPLETED			
		IL6007983	B. WING_		0	EIN AIGNAG			
NAME OF PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY, STATE, ZIP CODE			5/04/2022			
BRIAOF CAHOKIA 3354 JEROME LANE									
(X4) ID	CAHOKIA, IL 62206  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORPERTION								
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRO PRIATE DEFICIENCY)		(X5) COMPLETE DATE			
\$9999	Continued From pa	ge 14	\$9999						
: 29	independence and e involvement." It also is defined as whatever says it is and exists does." It continues as a process of alley level that is acceptal	am, providing our residents sary comfort, exercise greater enhance dignity and life documents "Guideline: Pain ver the experiencing person whenever he or she says it Pain Management is defined viating the resident's pain to a ble to the resident and is clinical condition and nt goals."			a Vē				
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