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S 000	Initial Comments Complaint Investigation 2523375/IL190491	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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 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	S9999		

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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)

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.

These regulations were not met as evidenced by:

Based on record review and interview, the facility failed to check the temperature of a hot beverage before serving and failed to assist and supervise a resident dependent with eating for one of three residents (R1) reviewed for quality of care in the sample of three. These failures resulted in R1

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spilling hot chocolate on herself and sustaining a second degree burn on her left hip/thigh causing R1 pain.

Findings include:

The Safety and Supervision of Residents policy dated 11/5/19 documents "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation Facility-Oriented Approach to Safety 1. Our facility-oriented approach to safety addresses risks for groups of residents. 4. Employees shall be trained and in-serviced on potential accident hazards and how to identify and report accident hazards and try to prevent avoidable accidents. Resident-Oriented Approach to Safety 1. Our resident-oriented approach to safety addresses safety and accident hazards for individual residents 2. Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS (Minimum Data Set assessment). Systems Approach to Safety 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. Resident Risk and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include h. Water Temperatures."

The Serving Food policy dated 11/5/19

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documents "Food shall be prepared and served in a manner that meets the individual needs of each resident. Policy interpretation and implementation 2. Residents Requiring Full Assistance c. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. 3. Dining Room Residents: c. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity."

R1's electronic Medical Record documents R1 was admitted to the facility on 6/12/24 with the following, but not limited to, diagnoses: Unspecified Sequelae of Cerebral Infarction, Schizophrenia, Bipolar Disorder, Other Disorders of Physiological Development, Unspecified Focal Traumatic Brain Injury without Loss of Consciousness, Sequela, Heart Failure, Other Pulmonary Embolism without Acute or Cor Pulmonale, Pulmonary Hypertension, and Muscle Weakness (generalized). R1 was admitted to Hospice Care on 12/19/24 due to terminal diagnosis Unspecified Sequelae of Cerebral Infarction.

R1's Minimum Data Set (MDS) assessment dated 2/24/25 documents R1 had a Brief Interview for Mental Status/BIMS of 4 (severe cognitive impairment). R1 is Dependent on staff for eating. "Helper does All of the effort. Resident does none of the effort to complete the activity."

R1's current Care Plan documents R1 is dependent on staff for meeting emotional, intellectual, physical, and social needs related to Schizophrenia, Traumatic Brain Injury, Bipolar Disorder, Developmental Delay, Cognitive Deficits. Date Initiated 5/20/24. R1 has self-care deficit and needs supervision and/or assist to complete quality care and or poorly motivated to

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complete activities of daily living. Related to poor motivation, poor regard for personal hygiene, and impaired mobility. Interventions: Assist with hands on feeding if R1 is unable or unwilling to complete the task. Date Initiated 5/20/24. R1 has risk factors that require monitoring and intervention to reduce potential for self-injury. R1 will follow safety suggestions and limitations with supervision and verbal reminders for better control of risk factors. Intervention: "Remind of safety precautions and limitations as necessary." Date Initiated 5/20/24. Interventions: R1 will have all drinks covered with a lid. Date initiated 3/17/25. R1 has reddened area from spilled hot chocolate noted to left hip with blistering. R1 to be served tepid, not hot drinks. Date Initiated 3/17/25. R1 currently has an infection due to wound infection of left hip. Date Initiated 3/28/25. R1's current diet is Regular, Dysphasia mechanical texture, regular thin liquids. Interventions: "I (R1) will be fed by staff since I am unable to feed myself." Date Initiated 2/25/25.

The Hospice Plan of Care signed by V10/Hospice Nurse dated 3/12/25 at 8:20 AM documents Interventions: Feed (R1) if visit is during a meal. Goals: "Absence of injury, as evidenced by safe environment maintained to accommodate neurological deficits." "(R1) will maintain a pain score of 4 (four) or less, per patient/family preference, on a scale of 0 (zero)-10."

R1's Nursing Note written by V8/Licensed Practical Nurse/LPN dated 3/16/25 at 9:35 AM documents "Observed (R1) in (high back wheelchair) with water pitcher tipped over on lap. (R1) stating that it was burning her. Water pitcher had hot chocolate in it. (R1) taken to room and skin assessment was complete. Writer (V8) noted red area to left hip. Area not raised or blistered at

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this time."

The Accident statement of V14/Cook taken by V15/Dietary Manager not dated documents that on Sunday 3/16/25 a CNA/Certified Nursing Assistant requested hot chocolate for R1. V14 asked the nurse if it was OK, and the nurse said yes. V14 made the hot chocolate, put it in a cup, and put the lid on it. V14 set the drink on the counter but the CNA was no longer there so V14 took the drink to (R1) and set it on the table.

R1's Nursing Note written by V2/Director of Nursing dated 3/17/25 at 9:54 AM documents "Red areas with slight blistering noted to (R1's) left waist area and left upper thigh area." V11/R1's Primary Care Physician was notified of R1's blistering and Silvadene or alternate cream was requested to apply to R1.

The Weekly Wound Log dated 3/17/25 documents there were four burn wounds to R1's left hip from spilled hot chocolate on 3/16/25. The wounds measured length 2.5 cm (centimeters) by width 0.5 cm, length 4.0 cm by width 3.0 cm, length 2.0 cm by width 1.0 cm, and length 15 cm by 3 cm. Pain was documented as "slight discomfort."

R1's Nursing Note written by V3/LPN dated 3/17/25 at 2:14 PM documents that V10/Hospice Nurse assessed R1, and new orders were given by V20/Hospice Physician for Silvadene two times a day to the blistered area on R1's left hip for seven days.

The Hospice Certification of Terminal Illness signed by V20/Hospice Physician dated 3/17/25 at 3:48 PM documents "(R1) is chair bound, and tends to lean forward, putting herself off balance.

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Speech is limited to a vocabulary of 6 (six) or less words in a conversation." "Staff assist (R1) to eat, as she is unable to manage utensils." "(R1) is totally dependent for bed mobility, dressing, grooming, toileting, eating, and transfers."

The Hospice Visit Note signed by V10/Hospice Nurse dated 3/24/25 at 9:43 AM documents R1 has burns to left hip/thigh causing pain "Soreness, Tender" and pain is an active problem. "Facility nurse called and stated that she believed that (R1's) burns were getting infected. (V10) completed PRN (as needed) visit. Burn areas look to be healing. Spoke with (V20/Hospice Physician) who gave orders to continue Silvadene cream 1% (percent) BID (twice a day) for 7 (seven) days. Cover area with (dressing) and secure with tape. RN (Registered Nurse) also ordered Norco 5/325 (milligrams) give one tab every 4 (four) hours PRN for pain. Discussed with facility nurse (V3/LPN) about giving Norco before dressing changes due to (R1) having pain during dressing change."

R1's Medication Administration Record/MAR dated 3/1/25 - 3/31/25 documents Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligrams) to give one tablet by mouth every four hours as needed for pain related to burn on left hip/thigh. Start date 3/24/25.

R1's Nursing Note written by V18/Registered Nurse/RN dated 3/24/25 at 12:23 AM documents "(R1) has extensive burn to right hip. Order to clean with wound cleanser and apply Silvadene and cover. Areas are red and blistered with open areas covered in slough."

R1's Nursing Note written by V3/LPN dated 3/24/25 at 4:13 PM documents that V10/Hospice

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RN was in to see R1. V20/Hospice Physician gave a new order to continue Silvadene to the burn on R1's left hip/thigh, cover with (dressing) and secure with tape twice a day for seven days. Give Norco 5-325 mg one tab by mouth every four hours as needed for pain related to R1's burn.

The Hospice Skilled Visit Note signed by V10/Hospice Nurse dated 3/25/25 at 11:45 AM documents R1's wound is 18 cm (centimeters) by 9 cm, slough in wound bed with small amount of Serosanguinous drainage and mild odor. Visit Plan: Contacted doctor to obtain new order for antibiotic.

R1's Nursing Note written by V8/LPN dated 3/25/25 at 12:04 PM documents that V10/Hospice Nurse was at the facility today to see R1. New order received for Clindamycin 300 mg twice a day for seven days for left hip wounds.

R1's Nursing Note written by V18/RN dated 3/26/25 at 12:30 AM documents that R1 continues to have extensive burns to her left hip and buttocks. All areas are opaque and covered in slough with small black areas scattered throughout. V18 faxed a request to hospice requesting to change from Silvadene to Medi honey.

R1's Dietary Note written by V21/Registered Dietician dated 3/31/25 at 8:28 AM documents that during an on-site visit on 3/31 V21 was notified that R1 had a skin issue being treated that was caused by a hot liquid spillage. V21 reviewed R1's diet due to R1's burn and weight loss. V21 recommended that all drinks are to have a lid. V21 noted poor intakes. "(R1) needs supervision at meals."

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R1's Medical Record does not include a hot liquid risk assessment.

R1's Medication Administration Record dated 3/1/25 - 3/31/25 documents "Silvadene External Cream 1% (percent) (silver Sulfadiazine) Apply to left hip affected area topically every shift for blistered area." Start date 3/19/25.

R1's Treatment Administration Record dated 3/1/25 - 3/31/25 documents "Apply Silvadene cream BID (twice a day) to affected areas on left hip and cover with non-adherent pads for seven days every shift for blisters on skin. Start date 3/18/25 discontinue 3/23/25.

R1's Treatment Administration Record dated 3/1/25 - 3/31/25 documents "Apply Silvadene cream BID (twice a day) to affected areas on left hip and cover with non-adherent pads for seven days every shift for blisters on skin. Start date 3/24/25 discontinue 3/28/25.

R1's Treatment Administration Record dated 3/1/25 - 3/31/25 documents "Clean area to left hip with wound cleanser; apply Medi honey and cover with (dressing) and secure with tape daily until healed every day shift for wound healing." Start date 3/29/25.

R1's Medication Administration Record dated 3/1/25 - 3/31/25 and 4/1/25 - 4/30/25 documents there is to be a pain assessment every shift on days and nights. Start date 12/8/24. (Pain is based on a 0 -10 scale) Pain was documented as follows; 3/17 both shifts 3 (three), 3/18 days 1 (one), nights 3, 3/22 days 7 (seven), 3/23 both shifts 5 (five), 3/24 both shifts 7, 3/26 both shifts 6 (six), 3/29 both shifts 6, 3/30 days 4 (four), 3/31

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both shifts 5, 4/1 both shifts 4, 4/2 nights 3. (3/4/25 was the only time that pain was documented before the burn incident, and it was rated at a 3)

The Food Temperature Chart for 3/16 to 3/22/25 does not document any temperatures for the Hot Coffee or Hot Tea.

On 4/18/25 at 10:22 AM, V3/LPN stated "I was not working the day of the accident, but I heard about it. (R1) was dependent on staff and should not have been handling a hot drink by herself. (R1) sits at the table where staff feed the residents. I was told that (R1) wanted hot coco. The kitchen staff made it in the microwave. (V14/Cook) took it to the nurse's station to let it cool down and (V8/LPN) told (V14) to take it to (R1). (R1) was not able to hold her own cup or silverware. There were three burns, and they were large areas on (R1's) left hip in the front. They were nasty burns. They were painful for (R1)."

On 4/18/25 at 10:40 AM, V2/DON stated "I was off and when I came in on Monday, I was told that (R1) spilled hot chocolate in her lap. There were four areas, three were pink and one had blisters. I did the assessment and called (V5/R1's Power of Attorney), the doctor, and talked to hospice. Staff had put the hot chocolate in a pitcher (large cup) that had a straw and a handle. (R1) could feed herself some but (R1) sits at a table to be assisted during meals. This was not at mealtime, and I don't know that anyone was there to help (R1) with the drink. I have no idea why it was so hot. They (kitchen staff) were not checking temperatures at that time. That process was not in place but evidently needed to be."

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On 4/18/25 at 10:50 AM, V4/Dietary Aide stated "A CNA came to the kitchen and said that (R1) wanted some hot chocolate. We microwaved the water then added the ingredients. (V14/Cook) was who made the drink for (R1). (V14) took the drink to the nurse's station for it to cool down. (V14) was told to go ahead and take it to (R1). (V14) put the drink on the table in front of (R1). (R1) needed help with the drink because (R1) shakes. During meals (R1) sits at a table where staff can help (R1). Since this was not at mealtime, I don't think there were staff around to help (R1)."

On 4/18/25 at 11:23 AM, V5/R1's Power of Attorney stated "(R1) was burned on 3/16/25 by spilling hot chocolate on herself. (R1) should have had someone help her with the drink. (R1) has Dementia, Bipolar, Schizophrenia, and physical limitations. (R1) is on hospice because of her declining health that required (R1) to have assistance or at least supervision. (V10/Hospice Nurse) told me the burns were not looking good with one of them being 19 cm by 9 cm in size and they were causing (R1) pain. I was upset because from what I was told by the facility the burns were minor, this does not seem minor to me. I know that accidents happen, but this is not acceptable. If there had been someone close by at least supervising (R1) they would have been able to quickly get the cup picked up so the burn area would not have been as large. I did not get good answers to how this accident happened and why there was no supervision."

On 4/18/25 at 1:53 PM, V10/Hospice RN stated "(R1) got a burn on her hip/thigh area from spilling hot chocolate on herself. When I saw the wound the areas had blistered then the blisters opened. There was slough in the wound bed.

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(R1) was started on a prophylactic antibiotic to prevent infection. The first treatment was Silvadene cream for seven days then it was changed to Medi honey. The burn was through the second layer of skin. (R1) was having pain due to the burn especially during dressing changes. Hydrocodone was ordered for pain relief and was to be given before dressing changes and as needed every 4 hours." V10 also stated "(R1) needed supervision and help with all her activities of daily living including eating and drinking."

On 4/18/25 at 2:04 PM, V11/R1's Primary Care Physician stated that R1's burn was a second degree burn and there is some degree of pain with any burn. The pain may range from moderate to severe.

On 4/18/25 at 3:08 PM, V8/LPN stated "I was at the nurse's desk when the kitchen brought out hot chocolate in a bedside cup for (R1). I told the kitchen staff to take the drink to (R1). Later I heard a commotion in the dining room. (R1) had spilled the hot chocolate on her leg. I took (R1) to her room and looked at her leg. It was just pink at the time. I called (V1/Administrator) and reported it." V8 also stated that at times R1 could eat and drink on her own. V8 was asked how it was determined if R1 was able to feed herself or needed assistance. V8 stated "If there is a fork there and (R1) picks it up then she can feed herself." V8 also stated that she does not remember there being any staff in the dining room when R1 spilled the drink.

On 4/18/25 at 3:19 PM V13/RN stated "I was at the nurse's station when (R1) spilled the hot chocolate. It depends on the day if (R1) could feed herself. I don't remember there being any

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staff in the dining room with (R1)." V13 also stated "The wounds were not good; they were red then blistered and broke open. They were substantial."

On 4/18/25 at 4:59 PM, V14/Cook stated "I made the hot chocolate for (R1). I made it in the microwave. I don't know how hot it was. I did not take the temperature. That was not the protocol at the time. It was put in a blue cup with measurement lines on the side. The cup had a handle on it but no lid. I took the drink to the nurse's station and put it on the counter. The nurse said to give it to (R1). I did not know anything about how (R1) drinks, so I put it (hot chocolate) on the table instead of giving it to (R1). I don't remember there being any staff in the dining room."

On 4/19/25 at 10:43 AM, V15/Previous Dietary Manager stated "I was told that (R1) asked for hot chocolate. The kitchen staff asked the nurse if (R1) could have hot chocolate and the nurse said it was ok. The water for the drink was put in the microwave to get it hot. I don't know how hot it was. We were not temp testing the drinks or logging what the temp was."

On 4/19/25 at 1:36 PM, V1/Administrator stated they did not have a hot liquid assessment for R1.

On 4/19/25 at 1:42 PM, V17/CNA stated that she has worked at the facility for three years and was familiar with caring for R1. R1 ate at the assisted table and needed supervision when eating or drinking. Most days R1 was not "with it" enough to help herself and R1 was "shaky."
(B)
Statement of Licensure Findings (2 of 2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 13 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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 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	S9999		

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applicable. (Section 3-202.2a of the Act)

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.

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to provide pain medication as needed for one of three residents (R1) reviewed for quality of care. This failure resulted in R1 experiencing unrelieved pain.

Findings include:

The Pain Management and Assessment policy dated 11/22/21 documents "To provide a broad spectrum of treatments for pain management as they apply specifically to older people and with specific recommendations to aid in decision making about pain management. To develop

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clinical practice guidelines for the management of acute or chronic pain. Policy Interpretation and Implementation Evaluation and Assessment: Comprehensive pain assessment tool will be completed upon admission, transfer, or on onset of new pain which includes: 1. Quality of pain (e.g. (example), "Burning", "Aching", "Numbness") 2. Pain intensity (numeric, visual analog scale, or nonverbal behavior, changes in function observation). 5. Factors that palliate or provoke pain."

The Skin Prevention, Assessment and Treatment policy dated 5/2/22 documents "Purpose: To promote a systemic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. Treatment Guidelines: 8. Residents should be assessed for pain, related to the skin alteration or its treatment. A. Manage pain by eliminating or controlling the source when possible (wound coverings, support surfaces, repositioning). B. Try to prevent or relieve pain associated with or made worse during dressing changes and debridement. C. Analgesics may be given routinely before dressing changes and as needed after dressing changes or debridement. D. Assess and care plan pain management (i.e. (that is), analgesia 30-45 minutes prior to dressing change) when appropriate."

R1's electronic Medical Record documents R1 was admitted to the facility on 6/12/24 with the following, but not limited to, diagnoses: Unspecified Sequelae of Cerebral Infarction, Schizophrenia, Bipolar Disorder, Other Disorders of Physiological Development, Unspecified Focal Traumatic Brain Injury without Loss of Consciousness, Sequela, Heart Failure, Other Pulmonary Embolism without Acute or Cor

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Pulmonale, Pulmonary Hypertension, and Muscle Weakness (generalized). R1 was admitted to Hospice Care on 12/19/24 due to terminal diagnosis Unspecified Sequelae of Cerebral Infarction.

R1's Minimum Data Set (MDS) assessment dated 2/24/25 documents R1 had a Brief Interview for Mental Status/BIMS of 4 (severe cognitive impairment).

R1's current Care Plan documents "I (R1) am currently on Hospice/Palliative Care related to unspecified Sequelae of Cerebral Infarction. Goal: I will be free of pain or at least comfortable. Intervention: adjust provision of activities of daily living to compensate for residents changing abilities. Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain." Date Initiated 12/19/24. On 3/16/25 R1 was in main dining room and spilled hot chocolate in her lap/hip area. R1 currently has an alteration pain related to a wound to R1's left hip. Hydrocodone 5-325 mg (milligrams) every four hours as needed. Date initiated 3/31/25. R1 currently has an alteration pain related to a wound to left hip. Intervention: Administer medication and treatments as ordered by the physician and monitor for side effects and effectiveness to current medication regimens. Date initiated 3/31/25.

The Hospice Plan of Care signed by V10/Hospice Nurse dated 3/12/25 at 8:20 AM documents Interventions: "(R1) will maintain a pain score of 4 (four) or less, per patient/family preference, on a scale of 0 (zero)-10."

R1's Physician Orders document Pain

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Assessment every shift. Order date 12/7/24. Hydrocodone-Acetaminophen 5-325 mg give one tablet by mouth every four hours as needed for pain related to burn on left hip/thigh. Order date 3/24/25.

The Hospice Visit Note signed by V10/Hospice Nurse dated 3/24/25 at 9:43 AM documents R1 has burns to left hip/thigh causing pain "Soreness, Tender." "(V10) completed PRN (as needed) visit. Ordered Norco 5/325 (milligrams) give one tab every 4 (four) hours PRN for pain. Discussed with facility nurse (V3/Licensed Practical Nurse/LPN) about giving Norco before dressing changes due to (R1) having pain during dressing change."

R1's Nursing Note written by V3/LPN dated 3/24/25 at 4:13 PM documents that V10/Hospice Nurse was in to see R1. V20/Hospice Physician gave a new order to continue Silvadene to the burn on R1's left hip/thigh, cover with (dressing) and secure with tape twice a day for seven days. Give Norco 5-325 mg one tab by mouth every four hours as needed for pain related to R1's burn.

R1's Medication Administration Record dated 3/1/25 - 3/31/25 documents Hydrocodone-Acetaminophen Oral Tablet 5-325 mg to give one tablet by mouth every four hours as needed for pain related to burn on left hip/thigh. Start date 3/24/25. (The medication was only given one time on 3/28/25 at 2:06 PM due to R1 having pain rated as a five)

R1's Medication Administration Record dated 3/1/25 - 3/31/25 and 4/1/25 - 4/30/25 documents there is to be a pain assessment every shift day and night. Start date 12/8/24. (Pain is based on a

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S9999	Continued From page 18 0 (zero) -10 scale) Pain was documented as follows; 3/17 both shifts 3 (three), 3/18 days 1 (one), nights 3, 3/22 days 7 (seven), 3/23 both shifts 5 (five), 3/24 both shifts 7, 3/26 both shifts 6 (six), 3/29 both shifts 6, 3/30 days 4 (four), 3/31 both shifts 5, 4/1 both shifts 4, 4/2 nights 3. (3/4/25 was the only day that pain was documented before the burn incident, and it was rated at a 3) On 4/18/25 at 10:22 AM, V3/Licensed Practical Nurse stated "There were three burns, and they were large areas on (R1's) left hip in the front. They were nasty burns. They were painful for (R1)." On 4/18/25 at 1:53 PM, V10/Hospice Registered Nurse stated "(R1) got a burn on her hip/thigh area from spilling hot chocolate on herself. When I saw the wound the areas had blistered then the blisters opened. There was slough in the wound bed. The burn was through the second layer of skin. (R1) was having pain due to the burn especially during dressing changes. As I was doing the treatment (R1) would be reaching for the wound. I asked (R1) if it hurt and (R1) said "yes." (R1) already had an order for Tylenol for general pain but (R1) needed something stronger. Hydrocodone was ordered for pain relief and was to be given before dressing changes and as needed every 4 hours. When I was at the facility, I gave (R1) the Hydrocodone before I did (R1's) treatment." On 4/18/25 at 2:04 PM, V11/R1's Primary Care Physician stated that R1's burn was a second degree burn and there is some degree of pain with any burn. The pain may range from moderate to severe.	S9999		

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S9999	Continued From page 19 No violation issued	S9999		