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SUNNY ACRES NURSING HOME	RURAL ROUTE 3 PETERSBURG, IL 62675

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 20 2. The facility developed a new policy and procedure regarding significant change, and all staff were inserviced on 10/28/05.	F 309		
F9999	FINAL OBSERVATIONS 300.1010(h) 300.1210(a) 300.1210(b)(3) 300.3240(a) 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. 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. The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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. Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	F9999		

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F9999	Continued From page 21 An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. These requirements are not met as evidenced by : Based on observation, interviews, and record review the facility neglected to assess the significant change in 1 of 9 sampled residents (R 1's) condition over a 3 day period. The facility neglected to follow their own policies and procedures regarding change in condition, neglected to have procedure in place directing staff on how to notify the physician within time frames, neglected to aggressively pursue changes in pain medication and treatment despite R1's increase in signs/symptoms of pain and significant cognitive changes. R1 was admitted to the hospital, unable to answer questions and only responding to pain. R1's entire buttocks was reddened with multiple open sores. Findings include: R1 was admitted to the hospital on 10/17/05 per nursing notes. Interview with Z4, RN, (Emergency Room Nurse at hospital) on 11/2/05 at 2:30 PM stated, "When she (R1) came in (10/ 17/05) her whole buttocks was reddened including hip. Her entire buttocks had open sores . She moaned and groaned as we turned her over but she was not able to answer any questions. I got an order from the doctor to have wound care see her. She appeared to be in pain when we moved her and when we tried to apply cream she would grab at our hands."	F9999		

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F9999	Continued From page 22 R1 is an 85 year old female resident with diagnoses including: Atrial Fibrillation, Edema, Hypertension, History of TIA (Trans-Ischemic-Attack), Osteoarthritis, and History of Herpes Simplex per current Physician's Order sheet dated October 2005. MDS's (Minimum Data Set) from 4/14/05 through significant change assessment 9/30/05 documents a change in R1's condition in regard to pain, behavior and cognition. MDS assessment of 4/14/05 list no behaviors, independent with daily decision-making and no pain symptoms for R1. MDS dated 7/13/05 list no behaviors, independent with daily decision-making and moderate pain daily. MDS significant change assessment dated 9/30/05 documents R 1 as significantly impaired for daily decision-making with multiple mood and behavioral symptoms occurring daily to include: Repetitive verbalizations/health complaints, persistent anger, sadness, verbally/physically abusive, socially inappropriate, and resistive to cares. Pain is documented as occurring daily with intensity of "Times when pain is horrible or excruciating." RAP (Resident Assessment Protocol) Narrative Report dated 9/30/05 documents under Behavioral Symptoms: "She (R1) has several open sores on her that are very painful and she does yell, scream, grab, hit, slap and generally becomes very upset when any cares are offered .....She appears to be in so much pain that she doesn't even realize what she is doing during these episodes."	F9999		

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F9999	Continued From page 23 Skin Condition Report forms dated 10/12/05 document 5 different locations with multiple open areas as follows: Left Thigh - 5 open areas. Right Thigh - 3 open areas. Right Buttocks and Coccyx - 7 open areas. Left Buttocks - 5 open areas. Right Abdominal Fold - 1 open area. Nursing notes dated 10/13/05 through 10/17/05 document R1 experienced increased pain with treatments and activities of daily living, as well as significant cognitive changes. The following notes document that R1 is receiving pain medication regularly but still continues to experience excruciating pain. 10/13/05, 1:30 AM, "(R1) refuses tx (treatment). States they hurt too bad.... Groin area reddened with open sores. Breast and abd (abdominal) folds worst. 10/13/05, (no time documented), "(R1) alert - up to DR (Dining Room) for breakfast. Hollering and screaming to go back to bed. (R1) c/o (complains of) pain and discomfort R/T (related to) open areas/lesions on inner thighs and buttocks. Tylenol with codeine given per MD's order. Lesions to inner thighs draining blood tinged serosanguinous drainage." 10/13/05, 8:45 PM, "Resident has had PRN Tylenol with Codeine #3 and Benadryl 25 mg (milligram) x (times) 2 this shift still moaning out in pain." 10/13/05, 9:25 PM, "Refused to have VS (Vital	F9999		

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Signs) taken otherwise refused to let CNA (Certified Nurse Aide) have dentures to clean yelled, 'get out, don't touch me' repetitively while oint (ointment) applied sparingly. Writer told (R1) 'this has to be done to help you.' (R1) became extremely anxious, yelling at everyone."

10/13/05, 10:10 PM, "Still yelling and moaning constantly, unable to get her (R1) comfortable or quiet. Refusing care. Dr. on call paged."

10/14/05, 1:50 PM, "Got up in recliner for meals. Ate cereal at breakfast with few sips of juice. Ate 50% of lunch and 240 cc (cubic centimeter) of milk. Wouldn't feed self at lunch so staff fed. Yelled out during care and while up."

10/14/05, 4:00 PM, "Yelling loudly rather anyone in room or not."

10/14/05, 9:40 PM, "Appetite poor ate 30-40 % of meal refused to let staff feed her. PO fluid intake decreased took in very little fluids tonight 200 cc .....Still yelling and screaming during care given each time."

10/15/05, 5:00 AM, "Had medium loose stool - Buttocks raw, with red bloody discharge D/T (Due To) excoriation - EPC (Emollient Protective Cream) applied lightly - screams when any skin care done - needs 4 to move/hold so tx's (treatments) can be done....Keeps eyes closed and doesn't respond to verbal directions."

10/15/05, 6:30 AM, "Moaning some but is not as aware D/T medication for pain."

10/15/05, 1:15 PM, "yelled out during cares and

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F9999	Continued From page 25 tx also while sitting up in w/c (wheelchair) for breakfast." 10/16/05, 2:00 AM, "Turned - repositioned - hollers/moans and doesn't respond to verbal instructions keeping eyes closed...would only take a few sips of water. 10/16/05, 1:00 PM, "Has been yelling out and moaning a lot today esp. (especially) during cares...spit out Acyclovir, Tylenol #3, ativan, and Keflex. yelled 'No!' Ate yogurt at breakfast and fruit and yogurt at lunch then began spitting at CNA and refusing to eat or drink any more. Fluid intake poor. Drank approximately 200 cc of fluids ." 10/16/05, 9:30 PM, "T (Temperature) 99.3 Resistive to cares. took meds (medications) with muchdifficulty. Refused to eat." 10/17/05, 12:15 PM, "Resident more confused. Speech unclear. yelling out with care. Faxed progress to (Z1) of above and refusal to eat or drink at times." 10/17/05, 2:50 PM, "Grabbing out at stuff in the air that isn't there. Yelled out with care.... Awaiting reply from (Z1)." 10/17/05, 10:10 PM, "VS 102/54 - 64 - 20 - 100.1 resident very confused, had large dark red amount of blood in stool, dr. called, urine in bag tea colored, resident choked on supper when CNA tried to feed her, resident responds to pain and can be aroused with verbal cues, N.O. (nursing order) received to change Tylenol #3 and Ativan to PRN." (previously ordered routine 3	F9999		

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F9999	Continued From page 26 times a day). 10/17/05, 10:35 PM, "Ambulance here transported to (local hospital) ER (Emergency Room) per stretcher." During the time that the above nursing notes were written; the Physician's order sheet dated 10/12/05 noted that only one pain medication was ordered as a PRN for R1. That same pain medication was ordered as a routine medication on 10/15/05 to be administered 3 times a day. On 10/17/05 the pain medication was changed back to a PRN. The following is the facility's "PAIN POLICY" current at time of investigation: "Policy: The goal of Sunny Acres Nursing Home is to improve quality of life through good pain control. All residents have a right to be pain free. Procedure: A. Assessment: 1. All residents will be assessed for pain by the admitting nurse. The care plan team will assess for pain quarterly, annually, with a significant change and if suspicious of a new onset of pain. 2. Residents who are able will use the pain scale on the Patient Comfort Assessment Guide. 3. Advanced dementia residents will use the PAINAD (Pain Assessment in Advanced Dementia) scale for pain assessment. B. Pain Management: 1. All residents who sustain a fall will receive Tylenol 650 mg (milligram) po (by mouth) for 48 hours. 2. Nurse will assess resident no longer than one hour later after initiation of pain med to assure	F9999		

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pain relief and document.
3. If resident continues to experience pain will notify MD (Medical Doctor) and document.
4. Nurse will monitor use of prn pain meds (medications). If increase in frequency of use will notify MD of need for around the clock pain control."

The facility failed to follow their own policy and procedure regarding pain for R1. Interview with E2, DON and E8, LPN on 10/26/05 at 1:15 PM stated that R1 did not have any other assessments for pain other than the PRN (as needed) MAR (Medication Administration Record) sheet and nursing notes. The facility did not identify R1 with a new onset of pain (skin lesions/ open sores) and plan treatment specific to that condition. The facility did not use their "Patient Comfort Assessment Guide" to monitor and assess R1's pain. E8 stated that she filled out a " Skin Condition Report" form for each of R1's open areas on 10/12/05 after measuring them. E 2 looked through R1's chart and confirmed that there were no other skin assessment forms for R 1.

Current care plan does not address R1's pain specific to her rash and open sores until 10/11/05 . The care plan does not address how R1's pain will be monitored.

Interview with E2, DON on 10/26/05 at 1:05 PM states, "Pain is assessed on the PRN (as needed) MAR (Medication Administration Record) sheet ."

Review of the facility's standard PRN MAR sheet documents only the "Reason" and "Result" of the

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F9999	Continued From page 28 PRN. The time the PRN was administered, and time of the result is to be documented along with licensed staff initials. Physician's orders reviewed from 5/13/05 through 10/11/05 list no orders for pain medication to treat pain specific to skin lesions and open sores. R1 did have pain medication orders for Tramadol, Naprosyn, and Tylenol to treat osteoarthritis pain. Physician's order dated 10/12/05 states, "D/C (discontinue) Tramadol, Naprosyn, and routine Tylenol orders (for diagnosis of Osteoarthritis). Start Tylenol with Codeine 1/2 grain po (by mouth) q (every) 4 hrs (hours) PRN (as needed)." Nursing notes from 6/1/05 through 10/13/05 document multiple entries regarding skin issues and pain/itching associated with skin. The notes focus primarily on areas of redness, gaulding and open sores on bilateral inner thighs, under breasts, between abdominal folds, behind left knee, groin and buttocks. The notes document multiple entries of R1 experiencing severe pain during incontinent care or while treatments were being administered to these areas. R1 began experiencing behavioral changes; yelling at staff, refusing treatments to skin, hitting at staff during incontinent care and transfers. The facility did not assess R1's pain according to their pain policy. The facility did not notify the attending physician and aggressively pursue changes in pain medications. The facility did not notify the attending physician of R1's behavioral changes over a five month period. The following is the facility's "CHANGE OF CONDITION POLICY" current at time of	F9999		

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investigation:
"The facility shall notify the resident's physician of any accident, injury, or significant change in 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 or treatment of such accident, injury or change in condition at the time of notification."

The policy does not include time frames of when to notify the physician, mode of notification, or the person responsible for notifying the physician.

Review of Nursing notes dated 10/15/05 through 10/17/05 note multiple entries of all 3 shifts documenting R1 experiencing severe pain, cognitive changes, appetite changes, unresponsiveness, and not acting like herself.

Interviews with multiple staff members (E1 through E10) on 10/21/05 and 10/26/05 all reported R1's significant changes in responsiveness, refusal to eat and take in fluids, and not acting like herself from 10/15/05 through 10/17/05. Interviews with staff corroborated nursing notes reviewed, and the 3 day time period before the doctor was notified and R1 was sent to the hospital.

Interview with E5, CNA (Certified Nurse Aide) 10/21/05 at 2:45 PM stated, "Friday (10/14/05) seemed fine, yelling, screaming, combative, verbally abusive. This was typical for (R1), she didn't want to be touched, too painful, sores hurt. Monday (10/17/05) just laid there and was

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twitching, not responding until we tried to get her blood pressure and then yelled a little. Wouldn't leave gown on, kept taking it off. Rolled her over and bottom was bloody all over from sores. I cleaned her but the sores kept oozing blood."

Interview with E6, CNA on 10/26/05 at 1:55 PM stated, "I took care of (R1) on ... roughly a couple of weeks. Before last weekend she would holler out in pain during cares, especially washing her skin, she was real sweet. She was alert and oriented to person place and time. She went to doctor on Thursday 10/13/05. Saturday (10/15/05) she was wasn't acting like herself, confused, reaching out for things. We could get her to talk to us but she was slow to respond. I notified E8, LPN (Licensed Practical Nurse) of this and she came in to see (R1). Wasn't using call light and probably wouldn't know how to like she did before. Saturday got her up in wheelchair and had to assist her in eating (had never been assisted before with eating). Was spitting food out. Spit food in my face on Sunday at breakfast. Sores were there all along since I worked with her ... There was no bleeding until that weekend, Sunday I believe. I notified the nurse and E8, LPN saw it. We got her up per her routine, no one told us not too. She was bleeding same amount on pads on Monday (10/17/05)."

Interview with E7, CNA on 10/26/05 at 1:20 PM stated, "Before pain medications she was alert and oriented times three. We would get the nurses to come in and look at her when we laid her down or to change her. The nurses were putting creams on her every day. A lot of times she would scream and refuse the cream, I heard this through report that the cream was burning

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her. I worked Monday 10/17/05. She was out of it, confused, not (R1) at all. We had to feed her. Her bottom was really bad that day and bleeding a little. The week before she would ring to get up and out of bed."

Interview with E8, LPN (Licensed Practical Nurse) on 10/26/05 at 9:35 AM stated, "She (R1) was a little more confused and irritable over that weekend from the previous week. I attributed her increase in confusion to pain medication and Ativan."

Interview with E4, LPN on 10/21/05 at 2:50 PM stated, "Monday came on shift, she (R1) was confused and shaking a bit. Refused to eat, and choked a little when we fed her. Around 8 or 9 PM she had blood under her and thought that she was bleeding from the rectum. I had been off for 5 days, she was a lot more confused. I attributed her confusion to the increase in her pain medication and Ativan. She moved to ... a few weeks ago, had sores when she moved. Wouldn't let us do treatments or would make us wash off the creams, would scream out in pain."

Interview with E10, LPN on 10/26/05 at 9:55 AM stated, "Worked Friday 10/14/05, charted that staff fed her (R1) lunch and yelled out during care and while up. This was not typical for (R1) to be fed. Up to Friday she was alert and oriented times three, understood directions and could make her needs known to staff. On Monday 10/ 17/05, I felt that (R1) was having a significant change and thought that it was related to the new medications ordered on Friday (Ativan and Tylenol #3). Sent progress note to (Z1). We usually fax notes to the doctor versus calling. I

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would call for injuries or fractures and talk to the doctor, but I didn't feel that (R1's) condition was at that level."

Interview with E3, ADON on 10/26/05 at 1:00 PM in regards to faxing important information to doctor's offices states, "It depends on the situation, if we fax and need a response that day then we will call and follow-up to get that order. There is no policy regarding faxing doctor's and following-up."

Interview with E2, DON, on 10/26/05 5 minutes later confirmed that the facility has no policy on faxing doctors, stating that they try to get an order the same day.

Nursing notes dated 10/17/05, 12:15 PM documents that Z1 was faxed a progress note regarding R1's condition, this is confirmed by above interview with E10, LPN. The next documentation in the nursing notes that the doctor was called was not until 10 hours later at 10:15 PM. No evidence could be provided by the facility to show that the physician was called at an earlier time. An on call doctor covering for Z1 was notified regarding R1's condition and gave an order to send R1 to the hospital.

Interview with Z1, (R1's attending physician) on 10/26/05 at 11:30 AM in his office stated, "She was last seen by me on 8/25/05, I haven't seen the spots or sores." In response to photographs taken of R1's sores on 10/14/05 by facility staff, Z 1 stated, "I should have seen her, I assumed that dermatology was taking care of her." Z1 denies receiving a fax to his office on 10/17/05. Review of R1's medical chart at Z1's office does not

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	146068	A. BUILDING _____ B. WING _____	C 11/10/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY ACRES NURSING HOME	**RURAL ROUTE 3 PETERSBURG, IL 62675**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 33 include any faxed information from facility on 10/17/05. Interview with Z3, (R1's attending physician at local hospital) stated. "Her (R1) cause of death was probably related to an infectious process, either urinary tract infection or skin lesions which may have lead to sepsis. If she were my patient I would have expected the nursing staff to call me right away with cognitive changes."	F9999		