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	145892	A. BUILDING ______ B. WING ______	C 10/30/2012

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SUNNY HILL NURSING HOME OF WILL COUNTY	421 DORIS AVENUE JOLIET, IL 60433

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F 323	Continued From page 13 program are not to be left alone in their rooms, monitored closely and in view of staff. The area where R2 was found was observed with E17 (unit supervisor) on 10/24/12. The distance from where the nurses station and the other residents room was approximately 55-60 feet. The red star interventions was discussed with E17. E 17 stated residents on the red star program are not to be left alone in their rooms to be monitored closely and in view of staff. The E16 and E13 stated R2 must have rolled self down the hall and into the other residents room without being noticed. A occurrence report for R3, dated 10/6/12 was reviewed with E18 (Minimum data Set/care plan nurse) for unit 3 on 10/24/12. The report read R3 was found by a housekeeping staff on the floor in the day room laying on the side at 11:25 a.m.. R3 did not sustain injury. The report documents R3 to have poor safety awareness. R3 was observed on 10/24/12 seated in a wheelchair in the dining room at 1 p.m. R2 was alert and oriented and unable to recall the fall on 10/6/12. E18 (nurse/care plan coordinator) and E19 CNA were both present during this conversation with R3. E18 stated that the staff are to follow the Red Star procedure for R3, which is not be left alone and in view of staff at all times. E18 stated R3 is assessed to be at high risk for falls. E5 and E18 were unable to explain why R3 was left alone in the dining room.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 14 300.1210b) 300.1210d)3) 300.3240a) 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	F9999		

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F9999	Continued From page 15 THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on observation, review of records and interviews, the facility failed to assess and evaluate the cause of R1's continued complaints of pain and decline in ambulation. This was for 1 of 3 sampled residents (R1) who was diagnosed with a left hip dislocation and possible left trochanteric fracture in the hospital emergency room. Examples include: R1 was transferred to the hospital emergency room on 9/27/12 at 3:30 a.m. Z1 (primary care physician) completed a history and physical on 9/27/12 that read: Chief complaint, Pain...transferred for evaluation of fever, temperature 101 degrees...complaining of hip pain at the nursing home...x-ray done...showed dislocation left hip...patient with shortened left hip and rotation...recent hip surgery. E8 (certified nursing assistant) CNA on 10/24/12, verified being R1's direct care giver from 10:45 p.m. on 9/26/12 to 3:30 a.m. on 9/27/12. E8 stated being assigned to take R1's temperature and vital signs. E8 stated the night nursing supervisor was making rounds at the time she began to change R1's brief around 2:30 a.m. E8 said when R1's incontinent brief was pulled back she began to scream in pain. E8 said I could not touch, turn or move her. "The left hip looked out of place and you could tell there was something did not look right." E6 the nursing supervisor was making rounds and coming down the hall, I asked	F9999		

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F9999	Continued From page 16 her to come into R1's room. E8 said E6 saw the hip and we both were asking what happened. E 8 stated not knowing the condition of R1's leg until the brief was removed. E8 stated the brief covered the hips, so you would not be able to see the hip bones if the brief was not removed. E8 stated examining the color strip on the incontinent brief earlier in the shift and R1's brief was not wet. E 8 stated the strip on the brief will change colors from blue to green if the resident is wet. A interview with E6 was conducted on 10/23/12 and a review of the nurses notes documented by E6 at 2:30 a.m., on 9/27/12. E 6, stated was making rounds on the units and was told by E7 (charge nurse) that R 1 had a temperature and it was not coming down. E6 documented, " assessment done and resident is very weak and slow to response, skin flushed and warm to touch, lungs diminished...slight labored breathing...left leg internally rotated and left hip protruded compared to the right hip and resident screaming out aloud in pain during movement of left leg." E6 stated telling E7 to notify the physician at 2:30 a.m. Interview with E 7 on 10/24/12 showed, R1 was found to have a temperature (101.3) and E7 said was concerned that R1's temperature was not coming down. E7 stated medicating R1 at 12:a.m. for the elevated temperature, temperature taken again at 1:a.m. was still 101.3 said E7. E7 stated informing E6 around 2:30 a.m. when she was making rounds about R1's elevated temperature and documented this at 2:30;a.m. as 100.7. E7 stated not being aware of the condition of R1's left leg and hip. E7 stated and documented several attempts were made to	F9999		

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F9999	Continued From page 17 notify the Z5 the physician (2:30 a.m., 2:55 a.m., 3:25 a.m.) with no call back. E7 stated R1 was sent to the hospital after consent from Z6. Z3 (physical therapy assistant), on 10/25/12, stated R1 receives physical therapy five times a week. R1's, "Therapy Progress Notes", notes completed by Z3 were reviewed. Z3 stated R1 was ambulating with a rolling walker 25 to 35 feet with minimal assistance before the fall on 9/23/12. Z3 said after R1's fall she complained of increased pain and was no longer able to participate as before in the physical therapy sessions. Z3 stated notifying R1's nurse each time the resident complained. Z3 documented on 9/25/12, R1 was given sit to stand training at the parallel bars with minimal assistance and sat down right away and complained of pain. R1 reported the pain was 7/10 on scale of 1-10. Z3 said R1's nurse was notified and it was documented in the therapy note. There was no assessment found that the facility had evaluated R1's decline on 9/25/12. Review of the MAR for 9/25/12 and the nurses notes show that no pain medication was documented administered on this day. The nurses notes do not indicate the facility being informed the resident had pain in therapy. The nursing note document, R1 complained of pain at 12 p.m.: however there were no nursing interventions documented or an assessment of the pain R1 was experiencing. Further review of Z3's therapy notes document on 9/26/12 , R1 "complained of pain in left lower extremity, so nurse was notified and administered pain medication for left hip to help decrease the	F9999		

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F9999	Continued From page 18 pain, R1 still complained of pain, so nurse notified again, no standing or walking given due to pain". Z3 documented R1's pain as 9/10 on scale of 1-10. Z3 stated telling the physical therapy supervisor about R1's increase pain and was directed to examine R1's left extremity. Z3 stated, R1's left hip felt odd and the bony prominence was sticking out. Z3 stated R1 was transported back to the unit. Z3 stated being the one who spoke with the nurse E13, about R1's inability to perform therapy due to pain in the left extremity and that the hip felt odd and the bony prominence was sticking out. On 10/24/12, E21 (day nurse) assigned to R1 on the day shift and, stated that R1, did not complain about pain on 9/26/12. E21 recalled being told by therapy staff Z3, after R1 returned from therapy and administered pain medication. I assessed R1 and everything looked all right. The medication administration (MAR) record showed that R1 was given pain medication after therapy by E21. The MAR read pain pill administered at 13:17 by E21. E21 scored R1's pain at 6 of 10 on pain scale of (1-10). R21 was could not recall a conversation taking place between the therapist Z3 and self about R1's pain and inability to participate in therapy on 9/26/12. E21 was unable to describe the type of pain, location of the pain or the condition of R1. E21 did not document anything in the nurses on 9/26/12 for this resident to indicate a assessment of the pain and a assessment of left extremity was conducted. E10 (evening nurse) on 10/23/12 stated remembering administering pain medication to R1 on 9/26/12. Review of the nurses notes document that Norco one tablet was given for	F9999		

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R1's complaint of pain to back and left hip at 9:30 p.m. E10 stated "I did not examine R1's leg at that time." E10 stated not being able to recall how much pain R1 was experiencing. The medication administration record was reviewed with E10 for the date 9/26/12. E10's documentation show, R1 with zero documented for pain.

A review of the physicians order show that R's physician Z1, increased the Fentanyl patch on 9/25/12 from 25 mcg/hr to 50 mcg/hr to be changed every 72 hours an administered to treat R1's pain after the fall on 9/23/12. The facility's nursing staff did not document the occurrence surrounding why R1's pain medication needed to be increased. There were no physical assessments documented describing the the nature of R1's experience with pain by the facility nursing staff.

Interview with Z1 on 10/24/12 said R1 showing signs of increased pain could be a symptom that there was something different happening with the left extremity. Z1 stated R1 has complaints of chronic pain.

The pain last pain assessment completed by the facility prior to the fall was 8/20/12. This pain assessment documented R1's pain to be left leg & knee, as a 4 of 10 on pain scale of 1-10. The pain assessment had not been revised or updated with R1's current pain related condition after the fall on 9/23/12. E13 (nurse supervisor) reviewed R1's pain assessment that are documented in the MAR for each resident. E13 said nursing staff are to assess and document the pain that R1 is experiencing on every shift.

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The MAR from the dates prior to the fall 9/11/12 to 9/26/12 were all zeros, denoting no pain experienced. Documented on the MAR for 9/24/12 are scores of 4 on the day shift and a score of 5 on the evening shift for pain. The remainder of the shifts for 9/25/12 and 9/26/12 were zeros. There were no pain assessments documented.

R1 has has multiple diagnoses which lists, left hip fracture with arthroplasty 7/12, Rheumatoid Arthritis, Osteoarthritis. R1 is assessed by the facility to require total assistance in all areas of activity of daily living as documented in the care plan and assessment.
R1 was observed in bed on 10/23/12 at 11 a.m. alert and oriented and able to recall the fall on 9/23/12. R1 stated she thought she could walk, got up and fell. R1 could not provide information about how the left leg became dislocated. R1 was queried about the frequency of pain. R1 stated on a scale of 1-10 her pain is usually a 12. R1 stated always being in pain and never pain free. R1 stated usually after the pain medicine her pain becomes a eight. R1 stated at the time of interview her pain in the back was a 12. R1 requested pain medication and the nurse was notified.

The facility's Occurrence report dated 9/23/12 for R1 was completed by E5 (nurse risk manager). The report was reviewed with E5 on 10/23/12 and 10/24/12. The report documented, R 1 was found on the floor in room laying on the right side at 1:05 p.m., wheelchair facing bed, R1 stated, " I was trying to sit on the bed and fell, sustained a skin tear to the right elbow". E5 stated on 10/25/12 that an investigation was not completed

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	Continued From page 21 and the cause of the R1's left hip dislocation on 9/26/12 had not been investigated. (B)	F9999		