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	146060	A. BUILDING _____ B. WING _____	12/21/2012

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F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) 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. (B) 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	F9999		

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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. (A, B) (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on observation, record review and interview, the facility failed to identify, assess and monitor and notify Hospice, Physician and Wound Nurse Consultant of a change in condition and provide effective pain control for 1 of 5 residents (R10) reviewed for effective pain control on the sample of 15. This failure resulted in R10 exhibiting extreme pain due to a decline in condition of her left foot that had foul odor and had turned a dark purplish/ black color.

Findings include:

1. R10's Hospital History and Physical of

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10-31-12 documents R10 had complained of a lot of pain in her left leg and left ankle. "Usually patient does not complain of having pain. She was brought to ER (Emergency Room) for further evaluation. Also her daughter noticed some swelling in her left ankle." Problem assessed, Cellulitis, Failure to thrive and Venous thrombosis. Plan: in part, "add pain meds."

Hospital Discharge Summary of 11-2-12 documents R10 is a 93 year old was doing fine until 3 weeks ago. She started declining slowly. Dementia is worse. R10 is more lethargic. She was brought to ER because she complained of a lot of pain. R10 was diagnosed with DVT (Deep Vein Thrombosis) throughout the femoral vein and popliteal vein with partial extension to the left common femoral vein and partial extension to the calf. X-ray of left ankle showed subtle fracture of left ankle. "On examination, the only positive thing was patient was lethargic." Prognosis is not good and Hospice was recommended. Discharge Diagnosis: DVT, failure to thrive and fracture of ankle.

Hospice Initial Orders and Plan of Care documented R10 was admitted to Hospice on 12-10-12 with a Hospice Diagnosis of Dementia. Hospice Order of 12-10-12 documents an order to increase Acetaminophen to 650 mg by mouth 3 times a day for pain.

Hospice Clinical Note - Nursing of 12-16-12 documents, "R10 did not eat any food today 12-16-12 only 150 ccs fluid intake per SNF (Skilled Nursing Facility) staff. R10 with slumped posture in wheel chair- sleeping 75 -90 % of the day...Necrotic area Left heel. Discontinue all PO

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(by mouth) medications except Morphine 15 mg at this time...comfort measures, wound care...Crush morphine and give SL (sub lingual) Tylenol Supp (Suppository) PRN (as needed) pain/fever." Note documents pain as being mild.

Hospice Collaboration/Contact Form of 12-17-12 documents, "Notified Med Dir (Medical Director) and PMD (Primary Medical Doctor) of R10's inability to swallow, increased pain to to L (left) foot/heel necrosis. N. O. (New Order) received from Z1 for Roxanol in place of crushing Morphine. Orders faxed to facility..."

R10' Physician Order Sheet (POS) show an order of 11-3-12 to monitor and assess for pain every shift and as needed. POS documents an order of 11-21-12 for outside wound consultant to evaluate pressure sore on the left heel. POS documents an order of 12-10-12 to consult Hospice. POS documents an order of 12-12-12 for Morphine 15 mg tab 1 po (by mouth) every 4 hours PRN (as needed) for pain. POS shows an order of 12-16-12 to discontinue all po meds except morphine sulfate 15 mg. Okay to crush morphine and give SL. POS shows an order on 12-17-12 for Roxanol 20mg/ml (milliliter) give 1/4 -1/2 ml every 2 hours PRN.

R10 was observed on 12-18-12 at 1:05PM to be in a wheel chair and being transferred from the wheel chair to bed by E13 and E14, Certified Nurse Aides (CNA's). E13 removed a pillow from behind R10's calves and R10 cried out in pain. E13 stated R10 had broken her foot about 1 month ago. R10 was observed to whimper, cry and moan when transferred. R10 continued to moan and whimper when lying in bed. During

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skin check. R10 was observed to have a bandage on her left heel and an open wound on the top of the left foot. R10's foot was dark purplish/black and had a very foul odor. E14 stated R10's foot did not look like that the day before. E14 stated she was shocked about how dark the foot looked and appeared very upset. R10 continued to whimper and moan while lying in bed. E13 was observed to talk to E18, Licensed Practical Nurse, concerning R10's foot and pain after giving care to R10. R10 was observed again 30 minutes later by another Surveyor and was lying in bed moaning and crying.

On 12-19-12, review of R10's Nurses Notes showed no documentation in the Nurses Notes since 12-16-12. There was nothing in the medical record showing that R10's Physician, Hospice or Wound Consultant had been contacted about R10's decline in left foot or exhibiting intense pain. At 12:50PM, E2, Director of Nursing (DON) was informed of concern of R10 left foot color and odor and pain and there was no documentation of assessment, monitoring and notification to Physician. At 1:35PM, E2 stated she had looked at R10's foot. E2 was asked if she noticed an odor and the foot color and E2 stated, "Oh yes, its rotting."

R10's Comprehensive Pain Assessment of 11-2-12 documents a score of 5. Interview with E16, Assistant Director of Nursing, on 12-21-12 at 10:30AM, states the score of 5 would mean the worse possible pain with a frowning, crying face.

Record review of R10's Medication Administration Record (MAR) from 11-3-12 to 11-15-12 shows

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no documentation for assessing pain every shift and prn. Interview with E2, Director of Nursing, on 12-21-12 at 9:00AM, E2 stated Nurses are to document pain assessment every shift on the MAR. E2 stated the Nurses failed to added R10's order to assess and monitor pain every shift and prn to the MAR until 11-16-12. MAR documents on 11-16-12 no pain on each shift yet R10 was given Morphine at 7AM. MAR documents pain rated at 4 on the 3 - 11 shift. MAR documents Morphine was given twice on 12-17-12 but documents only 1 time as given due to left heel with result of pain relief. There is no documentation on the MAR as to why the other dose of Morphine was given. R10's MAR documents pain rated as a 5 on the 11-7 & 7-3 shift and a 4 on the 3-11 shift. MAR documents Morphine was given on 12-18-12 at 12AM due to complain of increased pain level to the left heel with pain relief after giving Morphine. Morphine was given at 7AM due to pain with decreased pain after medication. Morphine was not given again until 4PM with documentation that it was given due to teeth grinding and documentation of being calmer at 5PM. (Yet R10 was exhibiting extreme pain at 1:05PM and 1:35PM.) MAR documents Morphine was given at 8PM due to facial grimacing. MAR shows no Roxanol was given on 12-17-12 or 12-18-12. There is no pain assessment documented on the MAR for 12-19-12. The MAR documents Roxanol was given 4 times on 12-19-12 due to increased pain and facial grimacing.

Record review of R10's Nurses Notes of 12-16-12 documents Hospice discontinued all po meds except Morphine Sulfate 15 mg. OK to crush Morphine and give SL every 4 hours prn for pain.

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There are no further Nurses Notes until 12-19-12 at 1:10PM documenting R10 was having more pain and Roxanol given at 7:30AM and 12:45PM. Discoloration to foot increasing, now has odor and dark purple toes. Call placed to hospice to have Nurse come out and reassess R10. Nurses Note at 1:30PM documents R10 has a change in condition in that she is not eating or drinking, resting in bed. Call placed to POA (power of attorney) to inform of condition. Note documents R10's POA stated she would be at the facility in 45 minutes. Note at at 4PM documents family at bedside. Pain med given PRN and every 2 hours. Right leg mottling and left foot remains dark in color. Occasionally jerking and moaning noted. Note at 9:25PM documents R10 is deceased.

Interview with E2, DON on 12-19-12 at 1:45PM, E2 stated she had gone through R10's record and could not find an assessment on R10's left foot. E2 stated she would have expected R10's Physician to be notified of R10's foot being dark purple almost black and the odor. E2 stated she reviewed R10's medical record, Hospice Notes and Wound Consultant Notes and could not find an assessment of the decline of the foot or Notification.

Interview with Z1, R10's Physician, on 12-20-12 at 2:45PM, Z1 stated he was not informed of R10's decline in her left foot. The dark color or odor and R10's pain. Z1 stated the family had decided not to seek any further treatment to R10 and if he was informed the outcome would not have been different. Z1 stated his biggest concern is pain control for R10. He expected

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F9999	Continued From page 29 R10 to be kept as comfortable as possible. Pain should have been assessed and treated as ordered. Interview with E4, Facility Wound Nurse, on 12-19-12 at 2:30PM, E4 stated she had not seen R10's foot since 12-13-12 when she did rounds with the Wound Consultant. E4 stated at that time R10's toes were pink. The heel wound did have an odor and some drainage. E4 stated she heard today that R10's foot is black. Interview with E15, Licensed Practical Nurse (LPN) on 12-19-12, at 3:10PM, E15 stated R10's foot was black last night (12-18-12) and she noticed an odor. E15 stated she probably should have contacted Z1 but didn't. Interview with Z3, Wound Consultant Nurse/Nurse Practitioner on 12-20-12 at 11:20AM, Z3 stated she last saw R10 on 12-13-12. At that time, there was an unopened red area on the top of R10's left foot that she thought was caused from the gauze. R10's foot was not dark purple or black. The facility should have contacted her and the Physician when the area opened on the top of the foot, change in color and odor. Z3 stated that R10 exhibited some pain when cleansing the pressure sore but no facial grimacing or crying. Z3 stated R10 obviously had a tremendous change in pain and a decline in the past week. Interview with Z4, Hospice Patient Care Coordinator, on 12-20-12 at 3PM, Z4 stated Hospice assessment of 12-10-12 documents a wound on the heel with black eschar. Pain rated	F9999		

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as 3 and R10 was receiving Tylenol at that time. On 12-17-12 Hospice received a call from the facility that R10 could not swallow and Roxanol was ordered every 2 hours prn. Z4 stated they were not informed of R10's increased pain. If they were the pain medication would have been scheduled to routine pain medication. Z4 stated it is Hospice job to manage resident care. "We may have dropped the ball by not scheduling routine pain medication."

Interview with E13, CNA, on 12-21-12 at 9:05AM, E13 stated she had talked to E18, LPN, on 12-18-12 about the color of R10's foot and odor and increased. E18 stated they were aware and trying to figure out what to do. E13 told E18 of R10's was crying in pain. E13 stated R10 exhibited pain even when she wasn't being touched. "Sometimes when we set her at the table she would cry and sob."

Interview with E17, LPN, on 12-21-12 at 9:10AM, E17 stated she was helping E14, CNA, with another residents care right after E14 had seen R10's foot. E14 told E17 how bad the foot was. E17 stated she went to look at her foot and was surprised how bad the foot looked. E17 stated this would have been around 1:30PM. R10 was in extreme pain. "I kissed her on the head and said R10 I am so sorry." E17 stated she told E18 who was caring for R10 that day. E17 stated E18 was trying to get the Roxanol that had been ordered the previous day. "There was none in the facility. The facility had not gotten the order yet from Hospice. E18 was trying to call Hospice and get the order so they could get it from the pharmacy."

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