STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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F 000		F 000		8/8/2019

DC 8.13.19

INITIAL COMMENTS

Correction date 8/8/2019

The following deficiency resulted from the investigation of complaints #82892-C and #84101-C completed July 8 -17, 2019. Complaint #84101-C was not substantiated.

See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.

Correction of Deficiency related to the resident identified:
The discharge of the resident identified was 4/20/2019 prior to the complaint visit and is no longer affected.

Actions taken to protect residents in similar situations:

What are we doing to prevent it from effecting other residents?

-1:1 education with nursing staff regarding Hospital transfers per policy.

-Nursing education that a Physician needs to be notified of all falls via phone call after fall.

- Staff to inform D.O.N. if primary physician is not addressing pain

How will we monitor that this is being done.

-D.O.N or A.D.O.N or designee to review fall documentation and physician notification within 24-72 hours after fall. Times 4 weeks with reevaluation if more monitoring is needed

D.O.N/ A.D.O.N or designee Will monitor for changes in acceptable level of pain post fall and report to physician any unacceptable levels of pain for 72 hours and again 7 days post fall times 4 weeks with reevaluation if more monitoring is needed.
(See attached document)

-Monitor results through QAPI process and implement changes as need.

F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and family, physician and staff interviews, the facility failed to provide accurate assessment and timely intervention for all residents who had an onset of adverse symptoms which represent a change in mental, emotional, or physical condition for one of three residents reviewed (Resident #1). The facility reported a census of 47 residents. Findings include: The Minimum Data Set (MDS) assessment dated 1/22/19 noted Resident #1 had diagnosis of stroke, anxiety disorder, depression, pain in her	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684		F 684		

Continued From page 1 left foot, chronic kidney disease, shortness of breath and muscle weakness. The MDS noted people always understood Resident #1 and she always understood them. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated Resident #1 did not have any cognitive deficits. Resident #1 required extensive assistance of one or two staff members for activities of daily living (ADLs).

The Care Plan initiated on 8/21/18 noted Resident #1 had a risk for falls related to history of having a stroke and medication use. The Care Plan instructed staff to anticipate the resident's needs and observe for injuries if she fell.

According to the Care Plan, Resident #1 could call for assistance when in pain, ask for medication, say how much pain she experienced and say what increased her pain or relieved it.

The facility Fall Guidelines instructed staff to assist with the immediate needs of the resident, call the family for notification of the incident and seek their approval for newly implemented interventions and call the physician for notification of the incident and immediate order changes that may be implemented.

The May 2007 revised Nursing Clinical Policy/Procedure related to Care of Residents in Emergency Situations noted the facility will provide appropriate and expedient care in emergency situations; which includes falls and abrupt changes in behavior of physical condition. Any changes in physical condition or behavior will warrant the following nursing observations and measures; which includes the initial assessment. Notification of Resident's family will be made to

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F 684	Continued From page 2 report any change in the Resident's condition. If an emergency situation arises: 1. Call the attending Physician. Fully explain the emergency giving a brief medical history of the Resident (information from the chart only). 2. If the attending Physician cannot be reached, the staff Physician or an alternative will assume responsibility or emergency treatment. 3. If hospitalization is necessary, obtain phone orders or written orders from a Physician to transfer the Resident to the hospital. 4. Call the responsible party. 5. Complete a transfer form and send it with the Resident. 6. Call the hospital and notify them of the transfer. A Nursing Note dated 3/19/19 at 1:35 a.m. noted the nurse's post fall neurological assessment of Resident #1. The nurse documented the resident as alert and oriented. The nurse administered as needed (PRN) Tylenol earlier for Resident #1's complaints of back pain. A Nursing Note dated 3/19/19 at 7:20 a.m. noted details related to an unwitnessed fall Resident #1 sustained on 3/18/19 at 8:58 p.m. According to the nurse, Resident #1's roommate came into the hall and "hollered" for help. The nurse noted staff found Resident #1 on the floor of the bathroom leaning against a wall. Resident #1 told the nurse she fell while self-transferring from her wheelchair to the toilet. A Daily Skilled Note dated 3/19/19 at 12:00 p.m. noted Resident #1 was lethargic, very sleepy and said she did not feel well; "I feel foggy." Resident #1 complained of upset stomach and did not eat much. The nurse documented she administered	F 684		

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F 684		F 684		

Continued From page 3

PRN Tylenol because Resident #1 said she had back pain and rated it 9 out of 10.

A Fax correspondence dated 3/19/19 notified Resident #1's physician of the resident's complaints of back pain since her 3/18/19 fall. The nurse informed the physician Resident #1 had been very sleepy, had not eaten her meals and refused all morning medications. The physician ordered Tramadol (pain medication) 50 milligrams every 6 hours for severe pain.

A Nursing Note dated 3/19/19 at 3:14 p.m. noted a post fall follow up assessment that revealed Resident #1 complained of back pain.

A Medication Administration Note dated 3/19/19 at 5:03 p.m. noted administration of PRN Tylenol had been ineffective. Resident #1 still rated her pain as 9 out of 10.

A Nursing Note dated 3/19/19 at 5:13 p.m. noted Resident #1's physician said to continue monitoring the resident after the nurse informed him the resident said she still did not feel well.

A Nursing Note dated 3/19/19 at 6:00 p.m. noted a Case Manager from a hospital called to inform the facility the resident's wound cultures tested positive and the Dr. ordered intravenous (IV) antibiotics to be administered. Once the nurse learned of an allergy alert related to the antibiotic, she attempted to contact the prescribing physician. Because that Dr. could not be reached, the nurse contacted Resident #1's primary physician who ordered staff to transfer Resident #1 to the hospital with increased lethargy and minimal oral intake throughout the day. Resident #1 stated she did not feel well.

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F 684		F 684		

Continued From page 4

Chest X-ray results dated 3/19/19 at 7:30 p.m. documented Resident #1 had a mildly enlarged heart accentuated by low lung volumes and the absence of part of her left clavicle (collar bone).

The Emergency Room (ER) Record dated 3/19/19 at 9:24 p.m. noted the history of Resident #1's present illness. The Record noted Resident #1 had recently been seen for a seizure. They drew blood at that time, which tested positive. They drew a subsequent blood culture. Another positive result confirmed the initial result; resident required antibiotic therapy. Due to weakness and fever, Resident #1 presented to ER for further treatment. Further testing revealed Resident #1's chest x-ray negative, but urinalysis grossly positive for a urinary tract infection. They implemented antibiotic therapy, but could not reach Resident #1's primary care Provider for input. Resident discharged back to nursing home on antibiotic therapy. The ER's Diagnostic Impression revealed: Acute urinary tract infection and acute positive blood cultures with a diabetic foot ulcer. The ER Record lacked any information related to Resident #1's complaints of pain associated with the 3/18/19 fall.

A Nursing Note dated 3/19/19 at 11:55 p.m. noted Resident #1 returned to the facility.

A Weekly Skilled Review dated 3/20/19 at 1:05 p.m. noted Barriers to Safe and Effective Discharge included Resident #1 felt unwell and experienced back pain related to a recent fall.

A Medication Administration Note dated 3/20/19 at 2:30 p.m. noted staff administered Tramadol 50 mg severe pain.

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F 684		F 684		
	Continued From page 5 A Nursing Note dated 3/20/19 at 5:07 p.m. noted Resident #1 reported she felt nauseated. The nurse notified the Dr. and requested orders via fax. A Daily Skilled Note dated 3/20/19 at 7:00 p.m. noted Resident #1's anxiety and documented she remained in bed during the shift. The nurse documented she administered PRN medication because Resident #1 continued to complain of post fall back pain rated 10 out of 10. The nurse documented Resident #1 could make her needs known. A Nursing Note dated 3/20/19 at 9:00 p.m. noted the nurse contacted the on-call provider, who prescribed medication for Resident #1's complaints of nausea and vomiting. At 10:00 p.m., the nurse contacted the on-call provider, and received an order for IM (intramuscular injection) Toradol (pain medication) for continued complaints of severe back pain. When the nurse realized the potential for an allergic reaction to the Toradol, the nurse contacted the on-call provider again, who then prescribed IM Haldol (anti-psychotic medication). A Daily Skilled Note dated 3/21/19 at 11:07 a.m. noted Resident #1 received Tramadol for sharp back pain, rated 10 out of 10. At 8:23 p.m., Resident #1's blood pressure reading was 81/40. The resident was lethargic, short of breath and hyperventilated due to being very anxious at times. The nurse encouraged Resident #1 to take deep breaths. The nurse administered PRN pain medication for Resident #1's aching, cramping back pain.			

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F 684		F 684		
	Continued From page 6 A Daily Skilled Note dated 3/22/19 at 9:40 a.m. noted Resident #1 as being lethargic, quieter, and more tired and withdrawn than unusual. The nurse administered medication due to Resident #1's complaints of nausea and lower back pain. A Medication Administration Note dated 3/22/19 at 9:51 p.m. documented staff gave Resident #1 PRN IM medication for nausea. A Medication Administration Note dated 3/23/19 at 9:53 a.m. documented staff gave Resident #1 PRN Tramadol for severe back pain. A Medication Administration Note dated 3/24/19 at 11:12 a.m. noted Resident #1 received PRN Tramadol for severe kidney pain. A Nursing Note dated 3/24/19 at 5:34 p.m. documented a CNA notified the nurse Resident #1 started shaking at the table. The nurse documented someone mentioned Resident #1 did it for attention and then stopped. Staff took the resident's vital signs, which were normal. The nurse documented she would continue to monitor Resident #1 for "behaviors." A Medication Administration Note dated 3/24/19 at 8:37 p.m. noted Resident #1 received PRN Tramadol for severe back pain. A Daily Skilled Note dated 3/24/19 at 9:34 p.m. noted Resident #1 complained of back pain but voiced no other complaints. The nurse documented Resident #1 could make her needs known. A Medication Administration Note dated 3/25/19 at 5:42 a.m. noted Resident #1 received PRN			

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F 684		F 684		

Continued From page 7

medication for nausea.

A Daily Skilled Note dated 3/25/19 at 12:45 p.m. documented Resident #1's blood pressure was 93/50 with a temperature of 96.3 F. Resident #1 was "depressed" and more "withdrawn" during the shift.

A Medication Administration Note dated 3/25/19 at 2:54 p.m. noted Resident #1 received PRN Tramadol for severe pain.

An MDS Note dated 3/25/19 at 8:23 p.m. noted Resident #1 reported frequent pain in the past 5 days, as high as 8 out of 10. The resident stated the pain interrupted her sleep and limited day-to-day activities.

A Daily Skilled Note dated 3/30/19 at 3:13 p.m. showed Resident #1 cried and argued with staff during the shift. The nurse gave her medication for nausea and vomiting and documented Resident #1 could make her needs known.

An MDS Note dated 4/1/19 at 1:32 p.m. noted Resident #1 reported frequent pain in the past 5 days, as high as 8 out of 10, which interrupted her sleep and limited day to day activities.
A Medication Administration Note dated 4/1/19 at 5:21 p.m. documented staff gave Resident #1 PRN Tramadol for severe pain.

A Daily Skilled Note dated 4/1/19 at 9:48 p.m. documented Resident #1's temperature as 94.6 F. The Nurse noted Resident #1 yelled, called staff names, refused medication and kicked them out of her room.

A Nursing Note dated 4/2/19 at 4:38 a.m.

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F 684		F 684		
	Continued From page 8 documented Resident #1 had been awake on and off during the shift and complained of occasional pain to the right kidney area. A Medication Administration Note dated 4/2/19 at 6:51 a.m. noted Resident #1 received PRN Tramadol for severe pain. A Daily Skilled Note dated 4/2/19 at 10:40 a.m. documented Resident #1 as "depressed" and "rude" and noted she yelled and cried at staff. The nurse gave PRN pain medication for sharp back pain rated 10 of 10. A Medication Administration Note dated 4/2/19 at 2:06 p.m. documented staff gave Resident #1 PRN Tramadol for severe pain. A Nursing Note dated 4/2/19 at 2:12 p.m. documented Resident #1 yelled "you don't do anything for me and you don't care" at the nurse. The nurse offered PRN Tramadol for the Resident's complaint of pain. Resident #1 yelled even louder that the medication did not help. A Medication Administration Note dated 4/2/19 at 4:49 p.m. noted Resident #1 received PRN Tylenol for pain. At 6:47 p.m. documented the PRN Tramadol as ineffective and resident still rated lower back pain at 7 out of 10. At 8:47 p.m. staff documented the PRN Tylenol Resident #1 received was ineffective and she still rated her pain 7 out of 10. A Daily Skilled Note dated 4/2/19 at 9:07 p.m. noted Resident #1 hollered and moaned as she laid in bed while staff attempted to talk to her. Resident #1 "hollered and whimpered, 'my kidneys hurt'" when they tried to move her. The Nurse gave the resident cranberry juice.			

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F 684	Continued From page 9	F 684		

According to the note, Resident #1 hyperventilated when she got herself "worked up". The Nurse administered PRN pain medication for Resident #1's complaint of lower back pain she rated 7 out of 10.

According to a Nursing Note dated 4/3/19 at 1:16 a.m., staff administered the Resident PRN Tylenol because she complained of lower back pain again.

A Medication Administration Note dated 4/3/19 at 3:30 a.m. noted Resident #1 received PRN Tramadol for severe pain as she "hollered and cried" with movement.

A Medication Administration Note dated 4/3/19 at 7:08 a.m. noted that the PRN Tylenol Resident #1 received was ineffective as she still rated her pain 6 out of 10 with movement.

Fax correspondence to Resident #1's Physician dated 4/3/19 noted the resident still complained of severe lower right back pain that radiated to the front that she described as sharp and fast at times and throbbing continuously at other times. The nurse informed the Dr. the PRN Tramadol and Tylenol only provided slight relief and the resident stated it did not really help. The resident also said she fell on 3/19/19. Resident #1 went to ER at that time, but returned to the facility without any new orders. Resident #1 continued working with therapy related to a left heel ulcer. The fax documented the resident asked staff to notify the physician of her symptoms and requested further treatment for pain. The doctor ordered physical therapy (PT) for Resident #1's back pain.

A Medication Administration Note dated 4/3/19 at

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F 684		F 684		

Continued From page 10

5:30 p.m. noted that Resident #1 received PRN Tramadol for severe back pain.

A Daily Skilled Note dated 4/3/19 at 9:42 p.m. noted Resident #1 got very anxious, restless and "hollered" continuously with movement and also when other people were in the room. Staff sent a fax to the doctor because the resident still complained about lower left back pain that radiated to the front.

A Medication Administration Note dated 4/4/19 at 11:49 a.m. documented staff gave Resident #1 PRN Tramadol for severe back pain.

A Nursing Note dated 4/4/19 at 1:53 p.m. noted the Physician ordered PT via return fax.

A Daily Skilled Note dated 4/4/19 at 8:00 p.m. noted Resident #1 continued to complain of back and side pain.

A Daily Skilled Note dated 4/5/19 at 10:30 a.m. noted Resident #1 had pale skin and became "rude" towards staff and anxious about seeing the doctor at 2:15 p.m. for pain. The nurse administered pain medication to the resident for the sharp back pain she rated 10 out of 10.

A Medication Administration Note dated 4/5/19 at 2:33 p.m. documented the PRN Tramadol Resident #1 staff gave was ineffective because she still rated her pain 10 out of 10.

A Healthcare Clinic Note dated 4/5/19 at 2:23 p.m. noted the Physician's encounter with Resident #1. The doctor noted the resident presented with complaints of lower back pain she described as intermittent shooting pain in the

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F 684		F 684		

Continued From page 11 lower back that goes to the right side. Resident #1 said it hurt worse with movement and she now required assistance of 2 people for transfers. The resident rated her pain 10 out of 10 and said Tramadol and Tylenol did not help. The Physician noted the Nursing Home sent a fax on 4/3/19; at which time he ordered PT for her back pain.

The Physician noted his Assessment and Plan:

1. Right gluteal (buttocks) pain that appears to be secondary to muscular strain. Official films are pending.
2. Tramadol.
3. Tylenol.
4. Lidoderm (local anesthetic) patch.
5. PT.
6. Return to care for any worsening or failure to improve.

X-ray results dated 4/5/19 of the right hip and lumbar (lower) spine both proved negative for fracture.

A Daily Skilled Note dated 4/5/19 at 9:55 p.m. noted Resident #1 received PRN pain medication because she continued to complain of a dull, achy back pain rated 10 out of 10.

A Daily Skilled Note dated 4/6/19 at 1:57 p.m. documented Resident #1's temperature at 95.9 F. The resident became anxious and "rude" towards staff regarding her pain. The nurse administered pain medication for the sharp back pain Resident #1 rated 10 out of 10.

A Medication Administration Note dated 4/6/19 at 4:31 p.m. noted the PRN Tramadol Resident #1 received was ineffective as she still rated her pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 684		F 684	

Continued From page 12

10 out of 10.

A Nursing Note dated 4/6/19 at 4:52 p.m. documented Resident #1 continued to have behaviors. Resident #1 continued to express concerns about staff and treated them "rudely."

A Daily Skilled Note dated 4/6/19 at 10:44 p.m. noted Resident #1 frequently became upset and anxious toward staff. Resident #1 described her pain as sharp and rated it 7 out of 10.
A Medication Administration Note dated 4/7/19 at 2:34 a.m. documented PRN Tramadol as ineffective resident continued to rate her pain at 10 out of 10. The resident told the nurse "it doesn't help, it didn't work".

A Daily Skilled Note dated 4/7/19 at 10:13 a.m. noted Resident #1's blood pressure was 104/40 and her temperature was 96.8 F. Resident #1 requested staff to transfer her with the EZ Stand (mechanical sit to stand machine) due to back pain. The resident complained of shortness of breath and received pain medication for her complaints of sharp back pain rated 10 out of 10.

A Nursing Note dated 4/8/19 at 2:51 a.m. noted Resident #1 received PRN pain medication for complaints of right lower back pain. The resident moaned with movement and hollered at staff.

A Daily Skilled Note dated 4/8/19 at 10:43 a.m. noted Resident #1's blood pressure was 184/88 and her temperature as 96.8 F. At 10:46 p.m. Resident #1's refused to let the nurse take her vital signs. The resident told the nurse she wanted to go to the ER for back pain and referred to the doctor as a "quack". Resident #1 told the nurse she believed that nobody believed she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684		F 684		

Continued From page 13

in pain.

A Daily Skilled Note dated 4/9/9 at 8:32 p.m. noted Resident #1 moaned with staff in the room but stopped when they exited. Resident #1 told the nurse PRN Tramadol did not help her pain and requested to be seen by the rounding doctor. Resident #1 rated her right lower back to side pain as 8 out of 10.

A Medication Administration Note dated 4/9/19 at 8:52 p.m. noted the PRN Tramadol Resident #1 received was ineffective as she still rated her pain 6 out of 10. The resident told the nurse "the pain never goes away". At 10:06 p.m. noted Resident #1 received PRN Tramadol earlier for lower right back pain but continued to moan and complain when staff are in her room.

A Nursing Note dated 4/10/19 at 2:51 a.m. noted Resident #1 still complained of lower right back pain and continued to moan with movement.

A Daily Skilled Note dated 4/10/19 at 1:06 p.m. noted Resident #1 moaned and cried when staff entered her room and told them she was in pain. Resident #1's moans and cries stopped when they left her room. The Nurse documented she applied PRN topical pain ointment and administered PRN Tramadol for the sharp back pain the Resident rated 10 out of 10.

An untitled document dated 4/11/19 at 10:46 a.m. noted Resident #1's primary Physician's assessment of the resident. His subjective findings: Resident #1 complained of pain with movement; despite being treated with a Lidoderm patch, Tylenol and Tramadol. The Dr. noted Resident #1 worked with PT for her left heel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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F 684		F 684	

Continued From page 14

diabetic ulcer.

His objective findings: Resident's hips non-tender with range of motion. The lumbar spine revealed moderate tenderness, but her primary pain was located along the right SI joint (between the hip and tailbone). The physician noted he injected the area with a steroid and anesthetic mixture; which provided some improvement of her pain. The physician's plan included Tylenol 650 mg three times a day (TID) and every 4 hours as needed and a heating pad for ½ hour TID. He instructed the facility to call or return sooner if there were any problems.

A Daily Skilled Note dated 4/11/19 at 1:48 p.m. documented Resident #1's temperature measured 96.8 F. The note also showed Resident #1 became anxious at times while in pain, cried in the dining room during lunch because of her pain, and rated her pain as 10 out of 10.

A Daily Skilled Note dated 4/12/19 at 2:30 p.m. noted Resident #1's temperature was 96.4 F. The nurse documented Resident #1 continued to complain of chronic back pain rated 10 out of 10.

A Nursing Note dated 4/13/19 at 9:46 a.m. documented Resident #1 had "tons of behaviors" that morning. After screaming at the nurse that she wanted a doctor to come and see her, Resident #1 became very upset when the nurse told her the doctor would not be coming into the nursing home on a Saturday.

A Daily Skilled Note dated 4/15/19 at 1:19 a.m. noted Resident #1 refused to allow staff to assist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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F 684		F 684		

Continued From page 15 to get ready for bed. Resident #1 called her sister. The nurse spoke to the resident's Mother and sister. The resident rated her back and side pain 10 out of 10.

A Daily Skilled Note dated 4/17/19 at 10:32 a.m. noted Resident #1 could make her needs known and rated her sharp back and side pain 10 out of 10.

A Daily Skilled Note dated 4/19/19 at 8:05 a.m. noted Resident #1 could make her needs known and rated her back and side pain 8 out of 10.

A Nursing Note dated 4/20/19 at 1:49 a.m. noted Resident #1 became upset and said "nobody takes me seriously; nobody cares about me". The Nurse applied topical ointment and administered Tramadol for the resident's complaints of back and side pain. When asked if she would like to be repositioned, Resident #1 said she did not want to be touched, she either wanted 911 to be called or to be taken to ER. The nurse suggested they wait for the pain pill to "kick in" to see how she felt. The resident repeated nobody cared and everyone ignored her.

A Nursing Note dated 4/20/19 at 7:21 a.m. noted Resident #1 got up at 6:15 a.m. and complained of pain so severe she needed to go to the hospital. The resident refused to let anyone touch her saying nobody cared about her. When the nurse inquired about her pain, Resident #1 yelled "I've already told you stupid people; I won't say it again because you people don't give a damn about me". The resident was inconsolable. The nurse called the resident's sister. The nurse noted the resident's sister did not want to send

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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HILLCREST HEALTH CARE CENTER	2121 AVENUE L HAWARDEN, IA 51023

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F 684		F 684		
	Continued From page 16 her to ER at that time; she would come and speak to Resident #1. A Medication Administration Note dated 4/20/19 at 10:38 a.m. noted Resident #1 said "I have sharp shooting pain in my upper back." A Daily Skilled Note dated 4/20/19 at 10:54 a.m. noted Resident #1 complained of shooting back pain and her family demonstrated concern for the resident. A phone call placed to the on-call ER physician who felt it was necessary for the resident to be further evaluated. Resident #1 was transported to ER via ambulance at 11:44 a.m. The computed tomography scan (CT) results dated 4/20/19 of the thoracic (middle to upper) spine revealed acute fractures of T9 and T10 (thoracic vertebrae). The ER Record dated 4/20/19 at 10:08 p.m. revealed Resident #1 presented with mid back pain. The author noted the resident reported she fell about 3 weeks prior. According to the resident, they x-rayed her lumbar spine and pelvis; which proved to be unremarkable. The resident also said her pain continued and had been getting worse. Resident #1 received Fentanyl (narcotic pain medication) 100 mcg IV; which reduced her pain to 4 out of 10 on the pain scale. The author's note revealed the Hospitalist accepted Resident #1 for further evaluation and treatment. The assessment showed the resident had a compression fracture of T9 and T10 and leukocytosis (elevated white blood cell count; often an indicator of infection). The Hospitalist Consultation dated 4/21/19 noted the Physician's Plan for Resident #1's diagnosis of bacteremia (infection in her blood) and severe			

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	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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HILLCREST HEALTH CARE CENTER	2121 AVENUE L HAWARDEN, IA 51023

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F 684		F 684		

Continued From page 17 mid back pain. The Physician recommended bed rest until they could acquire a particular brace, which he wanted the resident to wear at all times when she was upright. The Physician also recommended a thoracic MRI (imaging) to evaluate her for discitis/osteomyelitis (infection in the spine; bone and spaces). The Physician recommended antibiotic therapy and external stabilization with the brace for at least 2 months.

The details of the Consult documented Resident #1 being transferred to their hospital for management of severe back pain in the setting of possible fracture. As reported by the resident, she fell while ambulating in her nursing home several weeks ago. Since that time, she has had severe and progressive pain involving the mid position of her back, which caused her to be less ambulatory (referring to the resident's ability to walk). The Physician noted CT results obtained at an outside hospital demonstrated changes at the T9 and T10 level. The Physician also noted several positive blood cultures were grown overnight.

An Infectious Disease Consultation dated 4/21/19 documented positive bacteremia and an infected left heel wound led to the consultation. According to the record, Resident #1 received antibiotic therapy for 2 weeks after being diagnosed while in the hospital with bacteremia on 3/18/19. The record revealed Resident #1 fell in the nursing home about 3 weeks prior and developed mid back pain, which she said persistently got worse. The resident rated that pain 15 out of 10. A CT obtained at an outside facility revealed abnormalities at T9 and T10 with concern for infection. The outside facility also obtained blood cultures which were positive for bacteria. The consult documented Resident #1 had a chronic,

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	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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F 684		F 684		

Continued From page 18 non-healing left heel wound and with a concern for osteomyelitis and antibiotic therapy initiated.

MRI results dated 4/22/19 showed abnormal swelling in the T9 and T10 vertebrae with erosions along the endplates of the T9-T10 disc; findings consistent with T9-T10 discitis and vertebral inflammation and adjacent osteomyelitis.

The Certificate of Death documented Resident #1 died on 4/30/19 at 3:10 p.m. of respiratory failure, osteomyelitis of the thoracic region and discitis of the thoracic region.

The Discharge Summary dated 5/7/19 noted the hospital course began on 4/21/19 upon admission and ended on 4/30/19 at the time of death. It documented back pain as reason for the visit and indicated the resident was delirious on admit. The resident fell 3 weeks prior and a hip x-ray and pelvic x-ray were negative for fracture, and was sent for progressive confusion and increased pain. They placed Resident #1 on bed rest and recommended a brace. Laboratory findings caused concern for osteomyelitis, which an MRI confirmed as positive. Resident #1 began antibiotic therapy, but her hospital course became complicated by seizures. Although neurology followed her, her mental status did not improve. They believed recurrent aspiration caused her deterioration, which led to a palliative care consult during hospitalization. Family opted for comfort care on 4/29/19 due to increased shortness of breath and non-response to Lasix (diuretic) therapy. Because they deemed Resident #1 as too unstable to transfer, staff kept her comfortable in the hospital, where she died.

F 684		F 684		

Continued From page 19

An interview on 7/9/19 at 2:10 p.m. with Staff D, CNA revealed Resident #1 had a lot of pain some days. Staff D said the resident said her back hurt. Prior to the fall, Staff D said Resident #1 complained about non-specific generalized pain. According to Staff D, Resident #1 complained of pain more frequently after the fall; specifically back pain. Staff D reported before the fall, one person could transfer Resident #1 with either a walker or an EZ stand. The CNA said they had to use the EZ stand after the fall when the resident's pain was bad. Staff D stated Resident #1 moaned and complained of pain when they were nearby. The CNA said she could hear Resident #1 stop moaning when she thought they could not hear her; while telling her roommate "they think I'm faking". Staff D said they did not discount the resident's complaints, although she had a history of attention-seeking behaviors.

An interview on 7/9/19 at 2:45 p.m. with Staff E, CNA revealed she knew Resident #1 fell because she heard about it in report the morning following the event. Staff E said Resident #1 had quite a bit of lower back pain; she went from being able to help them during transfers to not being able to do much. Staff E thought the resident had "given gave up," probably due to the pain. Staff E recalled how Resident #1 had non-specific generalized pain before the fall and Staff E wondered if Resident #1 faked her pain sometimes. She recalled a time when Resident #1 "came around" when she called the resident's name during a seizure she was "supposedly having." Staff E said she questioned how legitimate her complaints were after that because she had heard Resident #1's moaning stop once she left the room. Staff E stated Resident #1 did not always fake it, she believed she had back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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F 684		F 684		

Continued From page 20

pain after the fall, and they finally realized Resident #1 actually had some fractured vertebrae.

An interview on 7/10/19 at 9:50 a.m. with Staff B, CNA revealed she knew Resident #1 had a fall that led to her decline. Staff B said Resident #1 had a lot of post fall back pain. She said she knew because Resident #1 yelled, moaned, and verbalized it very loudly. The CNA said "I'm torn between believing whether she was in pain or not because of the noticeable difference in how she acted when her family was here." Staff B recalled before the fall, Resident #1 typically rose around 6:30 a.m. prior to the fall, but gradually wanted to stay in bed longer or not get up at all after the fall. Staff B reported they had to use the EZ Stand for transfers at times before the fall, but Resident #1 no longer participated in transferring and required EZ stand transfer with assist of 2 staff after the fall.

An interview on 7/10/19 at 10:10 p.m. with Staff C, CNA revealed she knew Resident #1 fell. Staff C said Resident #1 began to complain about side pain a couple days after she fell, and complained of back pain about a week later. According to the CNA, her pain got pretty severe; Resident #1 hollered quite a bit and started screaming in the middle of the night. According to Staff C, it seemed like Resident #1 cried more when her family visited and had a history of attention seeking behaviors. Staff C said she never doubted that Resident #1 had pain, but wondered about the severity based on the way she acted when family visited. Staff C reported the had started to scream about 20 minutes after a nurse gave her something.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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HILLCREST HEALTH CARE CENTER	2121 AVENUE L HAWARDEN, IA 51023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 684		F 684		
	Continued From page 21 An interview on 7/10/19 at 3:45 p.m. with Staff A, LPN, revealed Resident #1 complained of back pain after her fall; varying between her upper back, lower back and her side. The LPN said she notified the doctor a couple of times. An interview on 7/11/19 at 7:50 a.m. with the Assistant Director of Nursing (ADON) revealed she called the on-call physician on 3/20/19 to inquire about sending Resident #1 to ER to obtain x-rays due to complaints of post fall back pain. The Physician prescribed Haldol IM instead of sending her for x-rays. The ADON said she not only was surprised that he wanted to try Haldol for pain relief; but also surprised that he wanted to try that instead of sending her for x-rays because of her recent fall. When asked about a Nurse's Note on 3/24/19 where she recorded Resident #1's temperature of 96.2 F with complaints of pain, the ADON said she did not contact the doctor. She believed they addressed the resident's fall issues with the physician on multiple occasions; but did not make any "headway" in getting them addressed. The ADON said they have discretion to send residents to ER without a Physician's orders. The ADON said she thought Resident #1 faked her pain at times because she believed the resident had behaviors. The ADON said she never doubted that Resident #1 had pain; but she doubted the severity because the resident had a history of manipulative behaviors to get what she wanted. The ADON stated she found it difficult to tell the difference between what was actually true and what was behavioral. The ADON stated that everything residents say should be taken seriously; but she did not think everything Resident #1 said was always taken seriously. When asked how Resident #1 expressed her			

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	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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HILLCREST HEALTH CARE CENTER	2121 AVENUE L HAWARDEN, IA 51023

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F 684		F 684		
	Continued From page 22 pain, the ADON said sometimes she screeched very loudly while other times she would verbalize her pain and ask for medication. She said Resident #1 always described it as back pain, but would say it hurt "all over" when asked for specifics. The ADON said "I think we tried our best." An interview on 7/15/19 at 1:10 p.m. with the previous Director of Nursing (DON) revealed she took the call to have Resident #1 sent to the ER on 3/19/19. Although she received the order, the DON said she did not assess the resident before she went; the floor nurse would have been the one to do that. The DON said she did not recall if she knew Resident #1 fell the night before. The DON said nobody to her Resident #1 had post fall back pain rated 9 out of 10. Although she could not verify that the ER addressed Resident #1's post fall pain during that visit, she knew the resident had been seen for back pain at some point. The DON said nurses have discretion to send residents to the ER in the event of a true emergency. According to the DON, someone should have either called the physician to have her sent to the ER for newly developed post fall back pain, or used their own discretion to send transfer her. The DON said she would have called the physician with her findings rather than send a fax. An interview on 7/15/19 at 2:40 p.m. with the current DON revealed she expected staff to notify the doctor of post fall back pain by phone rather than fax. The DON said she expected nurses to use their critical thinking skills. She said they have discretion to send residents to the ER in case of emergency, and said she felt like Resident #1's primary Physician "brushed her off"			

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	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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F 684		F 684		
	Continued From page 23 by not taking her complaints of pain seriously. The DON said the resident's complaints of pain should be taken seriously; even with a history of behaviors. She said they should have sent her to the ER even if the physician did not authorize her to be transferred. In an interview on 7/15/19 at 3:10 p.m. with the MDS Coordinator reported Resident #1 never seemed to exaggerate whenever she talked with her. The MDS Coordinator said she read other nurse's documentation and heard other nurses say Resident #1 exaggerated even more in the last few months. In an interview on 7/24/19 at 9:10 a.m., the Chief Medical Officer of the hospital where Resident #1 transferred opined it would be reasonable to order x-rays for complaints of post fall back pain. According to the Physician, an assessment would indicate which part of the resident's body should be x-rayed and whether it was warranted. The Physician said subsequent changes in the location and/or severity of the resident's pain would warrant further x-rays focused on those specifics. The Physician recalled hospital staff had to administer significant amounts of pain medication by the time Resident #1 arrived in their facility and it caused her oxygen level to drop. When asked, the Chief Medical Officer said it would be reasonable to order x-rays before prescribing Physical Therapy for pain and not prescribe PT without knowing if the resident sustained an injury and whether or not the injury was stable. He reported it could cause additional pain, inflammation and discomfort. The Chief Medical Officer reported they ordered a brace for Resident #1's back injury because it typically facilitated healing in that type of injury by			

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	165245	A. BUILDING _____ B. WING _____	C 07/24/2019

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F 684	Continued From page 24 protecting the bones from shifting. The Physician said treating the pain for a day or two after a fall would be acceptable, unless the assessment revealed deformity, gross abnormality or obvious signs of a spinal fracture. The Physician reported if the resident failed to respond favorably to that treatment, the physician should then order x-rays.	F 684		