STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009443	A. BUILDING: _____ B. WING _____	C 07/13/2023

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TRI-STATE VILLAGE NRSG & RHB	2500 EAST 175TH STREET LANSING, IL 60438

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S 000	Initial Comments Complaint Investigation: 2394934/IL160948	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)1)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999		

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S9999	Continued From page 1 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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. These Regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to effectively assess, treat, and manage pain for a resident at risk for pain due to multiple medical diagnoses and factors; and failed to follow their pain management policy for one (R1) of three residents reviewed for pain management. R1 was frustrated and experiencing psycho-social distress related to not receiving pain medication in a timely manner. Findings include: On 07/10/2023 at 12:47 PM, observed R1 lying in bed who said he had just finished eating lunch.	S9999		

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S9999	Continued From page 2 R1 reported medication issues at times on the evening shift. R1 said he knows the oxycodone (narcotic pain medication) is not scheduled and is prescribed "as needed". R1 then said he "should get it when needed or wanted". R1 added that his last dose was this morning around 8:00 or 9:00 AM. R1 reports having "some pain" at this time and that staff have never offered non-medicated pain relief measures and wants to take the oxycodone every 12 hours. Observed R1 to be visibly distraught and emotional. On 07/11/2023 at 1:28 PM, observed R1 lying in bed who said his current pain level was "9/10" and doesn't recall the last time that he received pain medication. R1 added that the nurse said he will get a pain pill at "1:00 PM to get him back on schedule". R1 then said it is "unbearable and frustrating" to not have his pain under control. Again, observed R1 to be visibly distraught and emotional. At 1:37 PM, V4 LPN (Licensed Practical Nurse) said R1 just received a pain pill and the last time he received one was at 1:00 AM. R1's face sheet indicates resident admitted to the facility on 06/05/2023, went on hospital leave on 06/20/2023 then re-admitted to the facility on 07/03/2023. Face sheet also indicates resident has a past medical history not limited to complex regional pain syndrome, Type 2 diabetes mellitus with hyperglycemia and diabetic neuropathy, other gram-negative sepsis, pain in left toe(s), unspecified open wound of left great toe with damage to nail, cellulitis of left toe, hypertensive heart disease with heart failure, peripheral vascular disease, acquired absence of other right toe(s), and difficulty in walking. R1's care plan last reviewed 07/05/2023 reads in	S9999		

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S9999	Continued From page 3 part, resident is at risk for generalized pain in which he is receiving an opioid pain medication with problem start date of 06/05/2023. Approach showed to administer pain medications as per physicians' orders, evaluate effectiveness of pain management interventions, and use non-medicated pain relief measures. Reviewed R1's current physician orders that showed the following pain medication orders for: acetaminophen 325 milligrams (mg) take 2 tablets by mouth every 6 hours as needed for pain, apply one lidocaine adhesive medicated 4% patch to affected areas once daily, oxycodone-acetaminophen 10-325 mg one tablet by mouth every 12 hours at 10AM and 10PM for optimum performance at therapy and bedtime rest with start date of 06/18/2023; diclofenac sodium 1% topical gel apply 4 grams topically to lower back at bedtime. Reviewed R1's readmission pain observation assessment with completion date of 07/07/2023 at 12:20 AM and noted assessment to be blank and not completed. Reviewed R1's medication administration record for June 2023 that showed R1's daily pain assessments were inadequately documented throughout the month for 1 of 3 shifts; his lidocaine medicated patch administrations were "circled" on the 17th, 18th, and 20th (no documentation that R1 refused meds or it was withheld); acetaminophen and oxycodone were minimally documented as being administered throughout entire month; diclofenac sodium 1% topical gel administration was "circled" on the 8th; acetaminophen 500 milligrams (mg) 2 tablets by mouth every 8 hours as needed for breakthrough pain showed no documented administrations (unsure of start and/or stop date, not included in	S9999		

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S9999	Continued From page 4 active physician's orders). No documentation provided indicating R1 refused any medication administrations for month of June 2023. Reviewed R1's "PRN Medications Notes" showed resident received oxycodone-acetaminophen 10-325 mg one tablet on 6/18/2023 for pain rated at "7/10" and 6/20/2023 for pain rated at "8/10". Reviewed R1's medication administration record for July 2023 that showed R1's lidocaine medicated patch administrations were "circled" on the 7th, 10th, and 11th; acetaminophen and oxycodone were minimally documented as being administered throughout entire month. Reviewed R1's-controlled drug administration record that indicates R1 is to receive oxycodone-acetaminophen 10-325 mg one tablet as needed every 12 hours. The record shows R1 received one dose on unknown date at 6:00 PM, received one dose on 06/10/2023 at 10:00 AM then did not receive the medication again until 06/14/2023. The record also shows that R1 received 3 doses on 06/17/2023 and only one dose on July 5th and July 10th. On 07/11/2023, V1 (Administrator) provided June 2023 medication administration records for R1 that showed administration times for oxycodone-acetaminophen 10-325 mg scheduled for 5:00 AM and 5:00 PM from 06/16/2023 through 06/17/2023: at 10:00 AM and 10:00 PM from 06/18/2023 to current. On 07/12/2023 at 2:32 PM, V2 (Assistant Director of Nursing/ADON) said her expectations regarding medication administration are for nursing to follow physician orders, properly assess residents and to administer medications	S9999		

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S9999	Continued From page 5	S9999		

or treatments as ordered. When asked why it is important to administer pain medications as ordered by a physician, V2 (ADON) said because the physician prescribes what's best for the resident and implements orders that are needed for the resident. V2 added that pain medications should be administered as ordered to keep residents' pain free and to allow resident's the ability to function throughout the day. V2 then said nurses primarily document care provided within a resident's administration record by documenting with their initials and should document any missed administrations in the resident's medical record and/or progress note. V2 added that if an administration box is left blank or is circled, that could mean it was not administered, the resident was not available or the resident refused and should be documented in the resident's record/progress note.

On 07/12/2023, V1 (Administrator) provided completed medication administration in-service record dated 07/11/2023 that reads is part, "nurses are to administer medications according to policy IIA2".
Reviewed "IIA2 Medication Administration policy with effective date of 10/25/2014 that reads in part: Medications are administered in accordance with written orders of the prescriber, administered without unnecessary interruptions, and a schedule of routine dose administration times is established by the facility and utilized on the administration records.

Reviewed pain policy last revised August 2008 that reads in part: to identify individuals who have pain or at risk for pain; assessments should occur upon admission to facility, at each quarterly review, with any significant change and when pain is suspected; identify the nature and severity of

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S9999	Continued From page 6 pain with use of a standardized pain assessment appropriate to resident's cognition level; evaluate how pain is affecting mood, activities of daily living, sleep and selected quality of life measures; with the input from resident, establish goals of pain treatment; physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain; if there are more than occasional analgesic requests, the physician will consider changing to regular administration of at least one analgesic with another medication for as needed use, increasing the standard dose of the existing analgesic, or switching to another analgesic. (B)	S9999		

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F 000	INITIAL COMMENTS Complaint Investigations: 2394934/IL160948-F697 cited 2395278/IL161367-F684 cited 2395390/IL161520 no deficiency cited	F 000		
F 684 SS=D	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 observations, interviews, and record review, the facility failed to provide necessary care and services for residents in need of fall interventions and/or supervision for 2 of 3 residents (R2, R7) reviewed for falls; and failed to follow physician's orders and/or medication administration policy for 1 (R1) of 3 (R1, R4 and R6) residents reviewed for nursing care and services related to medication administration. Findings include: 1. R2's face sheet indicates that resident admitted to the facility on 03/15/2023 and has a past medical history not limited to: rheumatoid arthritis, cerebral infarction, sciatica (unspecified side), benign neoplasm of meninges (unspecified), unspecified cataract, iron deficiency anemia, hypotension, urinary tract	F 684		8/6/23

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

Electronically Signed | 08/04/2023

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	Continued From page 1 infection, syncope, and collapse. Reviewed fall list provided by facility which documents R2 had falls on 05/08/2023 and 06/12/2023. R2's progress note dated 05/08/2023 5:30 PM reads in part, "Writer notified by CNA (certified nursing assistant) that resident was on the floor next to her bed. Resident stated she was reaching for cookies and slipped out of bed. Residents' bolsters were in place at time of fall". R2's progress note dated 06/12/2023 4:11 AM reads in part, "Writer summoned to resident's room, noted resident on floor next to bed near window lying prone with head resting on pillow. Resident has bilateral side bolsters in place and bed in lowest position. Resident was asked what she was trying to do that she got out of bed and kept pointing to the window stating she heard someone out there. Frequent monitoring ongoing. Call light within reach". Upon further record review, R2's progress note dated 06/24/2023 2:11 PM showed, "resident was found on the floor by CNA (certified nursing assistant). Resident tried to walk her lunch tray to the hallway without help. Resident fall was unwitnessed". R2's fall assessment dated 06/26/2023 7:16 PM showed resident is a "high risk for falls". R2's care plan last reviewed/revised on 06/30/2023 reads in part: at risk for falling related to weakness secondary to diagnosis of rheumatoid arthritis, hypotension, cerebral infarction, malnutrition, sciatica, cataract, anemia,	F 684		

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F 684	Continued From page 2 and urinary tract infection. Problem Start Date: 05/10/2023. First approach listed but not limited to "keep bed in lowest position with brakes locked". Problem Start Date: 06/25/2023. Care plan does not indicate whether R2 is in a fall prevention program. 2. R7's face sheet indicated that she admitted to the facility on 06/29/2023 and has a past medical history not limited to: hypertensive heart disease without heart failure, unspecified dementia, difficulty in walking, weakness, malaise, and history of falling. R7's fall assessment dated 06/29/2023 showed resident is a "high risk for falls". R7's care plan last revised 07/06/2023 reads in part that resident is at high risk for falling related to history of fall and weakness with problem start date of 07/03/2023. Approaches listed but not limited to equip resident with device that monitors rising and place resident in a fall prevention program both dated 07/03/2023. On 07/10/2023 at 1:11 PM, V5 (Licensed Practical Nurse/LPN) showed surveyor a list posted on the bulletin board behind south nurse's station (privacy observed). V5 said this list is a "get-up list/fall risk residents". V5 (LPN) then said staff try to monitor these residents at all times and make sure they are not left in their rooms unattended. R2 and R3 are both listed on the "get up list". On 07/10/2023 at 1:16 PM, observed R2 lying in bed receiving incontinent care by certified nursing assistant. Noted bed to be at knee level with no	F 684		

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F 684	Continued From page 3 fall precautions observed in place at this time. On 07/11/2023 at 10:19 AM, observed R2 lying in bed on her right side near edge of the mattress and wearing a hospital gown. Noted bed to be at knee level. At 11:47 AM, observed R2 lying on back in bed fully dressed and noted bed to be at knee level. No fall precautions observed in room at this time. At 1:34 PM, observed R2 lying in bed that was again at knee level position. No staff were observed near R2's room or in the hallway during these observations. On 07/11/2023 at 1:47 PM to 1:54 PM V6 (Licensed Practical Nurse) stated she thinks the facility does fall in-services every month. She added that there was one recently but doesn't recall the date. On 07/11/2023 at 3:10 PM, V9 (Registered Nurse) said restorative tells staff if a resident was identified as a fall risk and place an identifier card in a resident's closet indicating that resident is a fall risk. V9 added that fall interventions for those that are confused include use of floor mats, used to use alarms but some staff stopped checking on fall risks and waited for the alarm, while some residents could disable the alarm. V9 said wedges and boosters can be used as directed by therapy. V9 added that a fall risk resident's bed should always be in low position, and he wouldn't consider a bed positioned at knee level a proper height for fall risks. V9 then said ideally, residents are checked on every two hours, some have to be checked more frequently "like every 15 to 30 minutes" but these checks are not always documented. V9 added that documentation of frequent checks can be done per nursing judgement as needed, after a fall or with a	F 684		

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F 684	Continued From page 4 confused or anxious resident. On 07/12/2023 at 11:39 AM, observed R2 sitting in a wheelchair in her room near foot of her bed facing the window, call light not within reach. At 11:43 AM, observed R2 still in wheelchair resting her head on the frame at foot of bed. No staff were observed near R2's room or in the hallway of south unit during these observations. On 07/12/2023 at 12:50 PM, V8 (Certified Nursing Assistant) said she has been employed at the facility for 5 years and has worked on the "south" unit for the past 2 months. V8 then said R2 is confused, requires assist of two with transfers and that R1 hasn't had any falls recently to her knowledge. When asked how staff can identify who the resident's at risk for falls are, V8 (certified nursing assistant) said they would be wearing "a yellow bracelet" and would use "fall mats, bolsters/wedges and non-skid socks. V8 added that all residents are "checked on whenever we're on the hall" and indicated there "should be a list of fall risks hanging up somewhere". When asked when the last fall in-service was, V8 said a few weeks ago but could not recall the exact date. On 07/12/2023 at 12:53 PM, observed R2 sitting in wheelchair in main dining room with multiple other residents. Observed one staff member across the hallway from dining room in a smaller room feeding a resident with her back towards the main dining room. No other staff where present. At 12:58 PM, observed V12 (Activity Aide) walk up to R7 in the dining room and attempt to wheel her away but R7 continued attempting to stand, began grabbing ahold of the table several times all while seated at the edge of	F 684		

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F 684	Continued From page 5 wheelchair. At 1:05 PM, V12 said normally he and another activity aide monitor the dining room but thinks "she" is on break. V12 then said he was never told by the facility who the fall risk residents are. R2 was seated at a table in the dining room at this time and observed a "yellow bracelet" to her right wrist. V12 (Activity Aide) said he only knows what the red bracelets mean and not the yellow ones. When asked when the last fall in-service was, V12 could not recall. On 07/12/2023 at 12:54 PM, observed R7 at a table in the main dining room near R2 attempting to stand up from her wheelchair. No staff was present at this time. A male resident was pleading with R7 while speaking in both Spanish and English to "sit down and wait for help, so you don't fall". R7 sat back down at edge of wheelchair but continued multiple times to stand herself up. At 12:58 PM, observed V12 (Activity Aide) walk up to R7 and attempt to wheel her away but R7 continued attempting to stand, began grabbing ahold of the table several times all while seated at the edge of wheelchair. Male resident present in the dining room was able to redirect R7 to stay seated and sit back in chair so V12 could wheel resident out of dining room. At 1:02 PM V12 (Activity Aide) transferred care of R7 to V8 (Certified Nursing Assistant). At 1:05 PM, V12 said normally he and another activity aide monitor the dining room but thinks "she" is on break. V12 then said he was never told by the facility who the fall risk residents are but "knows the anxious ones are". No fall precautions observed in place at this time. On 07/12/2023 at 2:42 PM, V10 (Restorative Director) said she started at the facility on 4/24/23	F 684		

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F 684	Continued From page 6 and is not sure what fall prevention program was in place prior but she "is in the process of implementing a fall prevention program" she had previously used called "falling stars". She added that the goal is to place a star sign on the room door and on the resident's wheelchair of residents at risk for falls as well as posting a resident information card within their closet that will include fall risk and assistance required. V10 then said a resident with a history of falls or multiple falls in a short period of time, or with certain diagnoses such as weakness, anxiety, and/or unsteady gate would indicate they are at risk for falls. V10 (Restorative Director) said the third shift get up list is an unofficial list of residents who are high fall risks, staff often utilize group activities to help monitor these residents and they are frequently monitored while in their rooms. V10 added that the last fall in-service was a few weeks ago where she discussed with nursing about implementing a monitoring schedule between the nurses and aides every other hour so that residents at risk for falls can be monitored every hour. When asked if this hourly monitoring is documented, V10 said it is not being documented and when she is not at the facility, she is relying on nursing that they are doing frequent checks on fall risk residents. When asked what the yellow plastic band/bracelets indicate, V10 said those were in place prior to me starting here. V10 (Restorative Director) also said there seems to be confusion present with the identification of who the fall risk residents are which could cause supervision issues which is the reason why she is implementing the falling stars program because she believes it will be effective in addition to monthly in-services, including one at the end of the month and post falls. At 3:00 PM, V10 (Restorative Director) said	F 684		

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	145879	A. BUILDING _____ B. WING _____	C 07/13/2023

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F 684	Continued From page 7 care plans and interventions should be updated with every fall and she interviews staff post fall to identify interventions. She added if a resident rolled out of bed, the intervention would be bed in low position and fall mats. When asked if a bed at knee level height is appropriate for a resident who is a high risk for falls, V10 said "no". At 3:06 PM, V10 (Restorative Director) said she did not input R3's post fall interventions nor has she inputted the intervention of fall prevention program for any resident because she doesn't currently have an intervention program in place. V10 then said any resident with a fall will be in this fall program and added that R2 qualifies for a fall prevention program. Reviewed fall protocol policy last revised August 2008 that reads in part: if the individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes; based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling; if underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation; staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequence of falling. 3. R1's face sheet indicates resident admitted to the facility on 06/05/2023, went on hospital leave on 06/20/2023 then readmitted to the facility on 07/03/2023. Face sheet also indicates resident has a past medical history not limited to complex	F 684		

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F 684	Continued From page 8 regional pain syndrome, Type 2 diabetes mellitus with hyperglycemia and diabetic neuropathy, Pain in left toe(s), unspecified open wound of left great toe with damage to nail, cellulitis of left toe, peripheral vascular disease. R1's care plan last reviewed 07/05/2023 reads in part, resident is at risk for generalized pain in which he is receiving an opioid pain medication with problem start date of 06/05/2023. Approach showed but not limited to administer pain medications as per physicians' orders, evaluate effectiveness of pain management interventions. On 07/10/2023 at 1:03 PM, R1 said the previous night, a male nurse left his oxycodone (narcotic pain medication) on his tray table and told him to take it at 12:00 AM. R1 added that the nurse told him due to the floors being buffed that night, he wouldn't be able to return for several hours. On 07/11/2023 at 1:47 PM to 1:54 PM V6 (Licensed Practical Nurse) said medications are not left at the bedside due to safety concerns and to ensure the correct resident is taking the medications. On 07/11/2023 at 2:52 PM, V9 (Registered Nurse) said a few days ago, he had brought R1 his oxycodone at 11:00 PM and asked the resident if he wanted to take it at that time which was an hour early but R1 said he wanted to take the med at midnight. V9 told R1 the floors were to be buffed that night so he (V9) wouldn't be able to return until 2:00 to 3:00 AM. R1 told V9 that he would take the medication at midnight, so V9 left the medication (oxycodone) and a glass of water on R1's bedside table then left the room. V9 (Registered Nurse) then said an aide came up to	F 684		

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F 684	Continued From page 9 him and said that R1 didn't know what pill was left on his bedside table. V9 said he went back to R1's room to talk to him again about the pill and told R1 he was going to take the pill away but R1 said he'd take it at this time. V9 said R1 took the pill then he left the room and indicated the time was approximately 11:10 PM. When asked if R1 has an order to leave meds at bedside, V9 said "no". At 3:00 PM, V9 (Registered Nurse) said "we don't leave pills at the bedside at all, staff stay and watch the resident take the medication(s)" then said "we have residents who wander and are confused that could ingest the medications, and we want to ensure the correct resident is taking the correct prescribed med at the correct time as ordered by their physician". Reviewed R1's current physician orders that reads in part, "oxycodone-acetaminophen 10-325 mg one tablet by mouth every 12 hours at 10 AM and 10 PM for optimum performance at therapy and bedtime rest with start date of 06/18/2023". No current order in place for R1 to self-administer medications. On 07/12/2023 at 2:32 PM, V2 (Assistant Director of Nursing/ADON) said her expectations regarding medication administration are for nursing to follow physician orders, properly assess residents and to administer medications or treatments as ordered. V2 added that medications are not to be left at the On 07/12/2023, V1 (Administrator) provided completed medication administration in-service record dated 07/11/2023 that reads in part, "nurses are to administer medications according to policy IIA2".	F 684		

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F 684	Continued From page 10 Reviewed "IIA2 Medication Administration policy with effective date of 10/25/2014 that reads in part: when medications are administered by mobile cart taken to the resident's location, medications are administered at the time they are prepared; the person who prepares the dose for administration is the person who administers the dose; residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications; the resident is always observed after administration to ensure that the dose was completely ingested. On 07/12/2023 at 2:32 PM, V2 (Assistant Director of Nursing/ADON) said her expectations regarding medication administration are for nursing to follow physician orders and to administer medications or treatments as ordered.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to effectively assess, treat, and manage pain for a resident at risk for pain due to multiple medical diagnoses and factors; and failed to follow their pain management policy for one (R1) of three residents reviewed for pain management. R1 was	F 697		8/6/23

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F 697	Continued From page 11 frustrated and experiencing psycho-social distress related to not receiving pain medication in a timely manner. Findings include: On 07/10/2023 at 12:47 PM, observed R1 lying in bed who said he had just finished eating lunch. R1 reported medication issues at times on the evening shift. R1 said he knows the oxycodone (narcotic pain medication) is not scheduled and is prescribed "as needed". R1 then said he "should get it when needed or wanted". R1 added that his last dose was this morning around 8:00 or 9:00 AM. R1 reports having "some pain" at this time and that staff have never offered non-medicated pain relief measures and wants to take the oxycodone every 12 hours. Observed R1 to be visibly distraught and emotional. On 07/11/2023 at 1:28 PM, observed R1 lying in bed who said his current pain level was "9/10" and doesn't recall the last time that he received pain medication. R1 added that the nurse said he will get a pain pill at "1:00 PM to get him back on schedule". R1 then said it is "unbearable and frustrating" to not have his pain under control. Again, observed R1 to be visibly distraught and emotional. At 1:37 PM, V4 LPN (Licensed Practical Nurse) said R1 just received a pain pill and the last time he received one was at 1:00 AM. R1's face sheet indicates resident admitted to the facility on 06/05/2023, went on hospital leave on 06/20/2023 then re-admitted to the facility on 07/03/2023. Face sheet also indicates resident has a past medical history not limited to complex regional pain syndrome, Type 2 diabetes mellitus	F 697		

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F 697	Continued From page 12 with hyperglycemia and diabetic neuropathy, other gram-negative sepsis, pain in left toe(s), unspecified open wound of left great toe with damage to nail, cellulitis of left toe, hypertensive heart disease with heart failure, peripheral vascular disease, acquired absence of other right toe(s), and difficulty in walking. R1's care plan last reviewed 07/05/2023 reads in part, resident is at risk for generalized pain in which he is receiving an opioid pain medication with problem start date of 06/05/2023. Approach showed to administer pain medications as per physicians' orders, evaluate effectiveness of pain management interventions, and use non-medicated pain relief measures. Reviewed R1's current physician orders that showed the following pain medication orders for: acetaminophen 325 milligrams (mg) take 2 tablets by mouth every 6 hours as needed for pain, apply one lidocaine adhesive medicated 4% patch to affected areas once daily, oxycodone-acetaminophen 10-325 mg one tablet by mouth every 12 hours at 10AM and 10PM for optimum performance at therapy and bedtime rest with start date of 06/18/2023; diclofenac sodium 1% topical gel apply 4 grams topically to lower back at bedtime. Reviewed R1's readmission pain observation assessment with completion date of 07/07/2023 at 12:20 AM and noted assessment to be blank and not completed. Reviewed R1's medication administration record for June 2023 that showed R1's daily pain assessments were inadequately documented throughout the month for 1 of 3 shifts; his lidocaine medicated patch administrations were	F 697		

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F 697	Continued From page 13 "circled" on the 17th, 18th, and 20th (no documentation that R1 refused meds or it was withheld); acetaminophen and oxycodone were minimally documented as being administered throughout entire month; diclofenac sodium 1% topical gel administration was "circled" on the 8th; acetaminophen 500 milligrams (mg) 2 tablets by mouth every 8 hours as needed for breakthrough pain showed no documented administrations (unsure of start and/or stop date, not included in active physician's orders). No documentation provided indicating R1 refused any medication administrations for month of June 2023. Reviewed R1's "PRN Medications Notes" showed resident received oxycodone-acetaminophen 10-325 mg one tablet on 6/18/2023 for pain rated at "7/10" and 6/20/2023 for pain rated at "8/10". Reviewed R1's medication administration record for July 2023 that showed R1's lidocaine medicated patch administrations were "circled" on the 7th, 10th, and 11th; acetaminophen and oxycodone were minimally documented as being administered throughout entire month. Reviewed R1's-controlled drug administration record that indicates R1 is to receive oxycodone-acetaminophen 10-325 mg one tablet as needed every 12 hours. The record shows R1 received one dose on unknown date at 6:00 PM, received one dose on 06/10/2023 at 10:00 AM then did not receive the medication again until 06/14/2023. The record also shows that R1 received 3 doses on 06/17/2023 and only one dose on July 5th and July 10th. On 07/11/2023, V1 (Administrator) provided June 2023 medication administration records for R1	F 697		

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F 697	Continued From page 14 that showed administration times for oxycodone-acetaminophen 10-325 mg scheduled for 5:00 AM and 5:00 PM from 06/16/2023 through 06/17/2023: at 10:00 AM and 10:00 PM from 06/18/2023 to current. On 07/12/2023 at 2:32 PM, V2 (Assistant Director of Nursing/ADON) said her expectations regarding medication administration are for nursing to follow physician orders, properly assess residents and to administer medications or treatments as ordered. When asked why it is important to administer pain medications as ordered by a physician, V2 (ADON) said because the physician prescribes what's best for the resident and implements orders that are needed for the resident. V2 added that pain medications should be administered as ordered to keep residents' pain free and to allow resident's the ability to function throughout the day. V2 then said nurses primarily document care provided within a resident's administration record by documenting with their initials and should document any missed administrations in the resident's medical record and/or progress note. V2 added that if an administration box is left blank or is circled, that could mean it was not administered, the resident was not available or the resident refused and should be documented in the resident's record/progress note. On 07/12/2023, V1 (Administrator) provided completed medication administration in-service record dated 07/11/2023 that reads is part, "nurses are to administer medications according to policy IIA2". Reviewed "IIA2 Medication Administration policy with effective date of 10/25/2014 that reads in part: Medications are administered in accordance	F 697		

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F 697	Continued From page 15 with written orders of the prescriber, administered without unnecessary interruptions, and a schedule of routine dose administration times is established by the facility and utilized on the administration records. Reviewed pain policy last revised August 2008 that reads in part: to identify individuals who have pain or at risk for pain; assessments should occur upon admission to facility, at each quarterly review, with any significant change and when pain is suspected; identify the nature and severity of pain with use of a standardized pain assessment appropriate to resident's cognition level; evaluate how pain is affecting mood, activities of daily living, sleep and selected quality of life measures; with the input from resident, establish goals of pain treatment; physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain; if there are more than occasional analgesic requests, the physician will consider changing to regular administration of at least one analgesic with another medication for as needed use, increasing the standard dose of the existing analgesic, or switching to another analgesic.	F 697		