STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009401	A. BUILDING: _____ B. WING _____	C 04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY AT THE TILLERS	4390 ROUTE 71 OSWEGO, IL 60543

(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) COMPLETE DATE
S 000	Initial Comments Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.3240a) 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 300.1010 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care 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: 6) All necessary precautions shall be taken	S9999		

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S9999	Continued From page 2 to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: These Regulations were not met as evidenced by: Based on record review and interview, the facility failed to implement fall prevention/safety measures for a resident who was high risk for falls. The facility failed to complete a comprehensive pain assessment for a resident injury. The facility failed to notify the physician of x-ray results and obtain timely transfer orders The facility failed to follow their policy for Fall management. This failure resulted in R3 falling and sustaining a fractured wrist.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 3	S9999		

This applies to 1 of 3 residents (R3) reviewed for falls/injuries in a sample of 19.

Findings include:

The facility's Face Sheet for R3 documents that R3 was admitted on March 25, 2017 at the age of 92. The face sheet documents the following diagnoses: history of falling, hypertension left pubic rami fracture, dementia, chronic kidney disease, osteoarthritis, neoplasm of the large intestine, glaucoma, and cataract.

R3's H & P (History and Physical) from the discharging hospital prior to the facility documents: March 22, 2017 History of dementia; Had a fall; Radiographs reveal pubic rami fracture.

The Interim Care Plan for R3 dated March 25, 2017 at 18:26, by E6 (Licensed Practical Nurse/LPN) documents: Potential for fall related to increased weakness; Interventions- Fall protocol.

R3's admission assessment by E6 dated March 25, 2017 at 18:29pm documents: Reason for admission- pelvic fracture, UTI (urinary tract infection); Lower extremity movement-weak; device- wheelchair; Risk alerts- Falls; Impairment- cognitive, vision.

The call light ability screen for R3 dated March 25, 2017 documents that R3 was unable to follow instructions on how to use call light and unable to return demonstration on how to use call light after 5 minutes.

Nursing Notes: March 25, 2017- admitted to

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S9999	Continued From page 4	S9999		

facility at 1440 via stretcher. 1935-Grandson here, aware of fall.

The facility's Event Investigation for R3 dated March 25, 2017 reads: E6 (Licensed Practical Nurse/LPN) - I admitted R3 around 2:40pm. Around 7:30pm, E7 (Certified Nursing Assistant/CNA) stated she heard moaning, so she went to the room and stated she noted pt (patient) on the floor. Post Fall Huddle/Investigation- Alert and Oriented X 1.

The written statement by E6 (Licensed Practical Nurse/LPN) documents: Noted small amount of blood on floor next to res (resident) head, noted small laceration 1cm on eyebrow area. Res complained of (c/o) left wrist and left pelvic pain. Noted bruising to left wrist with no swelling. Left wrist did appear to be slightly deformed in alignment. Z12 (Family Member) entered room. Resident immediately asked Z12 to get resident up.

The Fall Event form dated March 25, 2017 documents: Res said res was trying to get up out of bed and res foot slipped out from underneath res. Resident response to -name and pain. Extremity movement/grasp- weak (all 4 extremities), location of pain- left wrist and pelvic. Positioning of extremities- Rotation/deformity of upper left extremity.

Nursing Progress Notes documents: March 25, 2017 20:10 Z2 (Medical Doctor) aware of fall and res c/o left wrist and pelvic pain w/ new orders for x-rays.
The nurse notes for March 25, 2017 documents that Z2 ordered an x-ray of R3's left wrist. The radiology report reads- Possible displaced

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SYMPHONY AT THE TILLERS	4390 ROUTE 71 OSWEGO, IL 60543

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fracture noted involving distal radius. There was no documentation on this shift that Z2 was notified of the x-ray results The nurse's notes then documents that Z2 gave orders to send R3 to the emergency room Nursing progress notes: March 26, 2017 03:20 POA was called to let him know the x-ray results. No answer. Message was left for POA.

On March 31, 2017 at 10:28am, E7 (Certified Nursing Assistant/CNA) stated she was assigned to care for R3 on March 25, 2017. E7 stated "she was confused. She didn't know where she was. She wanted to get a hold of her husband." E7 stated she noticed R3 lying on the floor, away from her bed, by the T.V. and dresser. E7 stated "apparently she was ambulatory." E7 stated she thinks R3 had a wheelchair. E7 stated she had no information related to R3 being a fall risk prior to the fall. E7 added "there were no fall interventions prior to then that I know of. I saw R3 laying [sic] on the floor. E7 stated she went and got E6 and they rolled R3 over and there was blood on the floor. E7 stated "R3's arm was behind R3. R3 said R3's arm hurts. R3 was laying on it." E7 stated when staff knows residents are a fall risk, they will place an alarm. E7 stated "we put the alarm on the bed after the fall."

On March 31, 2017, E6 stated she admitted R3 around 2:40pm. E6 stated at 7:30pm, E7 called her to the room and R3 was lying on R3's left side near the foot of the bed. E6 stated "R3's left arm was bent behind R3 and R3 was lying on it. Blood was on the left side of R3's head, on the floor." E6 stated R3 sustained a laceration. E6 stated that R3 requires assistance with ambulating. E6 stated she was not aware of R3 being a fall risk. E6 stated there were "no fall

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S9999	Continued From page 6	S9999		

prevention measures prior to the fall. R3 complained of left wrist pain, head ache and left pelvic." E6 stated R3 was admitted to the facility because she fell and sustained a fractured pelvis. E6 stated the fall protocol is "If I know they are fall risk, they get an alarm. If they are confused, they would get an alarm."

R3's Fall Risk Screen dated March 25, 2017 at 18:40 (approximately 1 hour prior to the fall) completed by E6 documents that she scored 23, category: high risk. History of falls within last six months- 1-2 times, Vision pattern- inadequate; unable to independently come to a standing position, requires hand-on assistance to move from place to place, uses an assistive device, decrease in muscle coordination.

On March 31, 2017 at 1:10pm, E4 (Falls Coordinator/Quality Assurance Registered Nurse/RN) stated the fall protocol is "If we know they are high risk for falls, we give alarms. We didn't know R3 was high risk until the grandson said something after the fall. I didn't realize R3 had fallen at home until after the fall. Staff are supposed to do fall risk assessments on admission. R3 didn't trigger high on fall risk assessment. We didn't know R3's history. If we had known, R3 would've been closer to the front of the hall. That's protocol if high risk. R3 has dementia, but with what was documented and what the CNA said, R3 didn't seem confused."
On March 31, 2017 at 1:10pm, E4 (Quality Assurance Coordinator/Falls Coordinator) stated that she worked the night of March 25-26, 2017. E4 stated that she received x-ray results for R3 around 3:00am March 26, 2017. E4 stated she did not call Z1 (Medical Doctor/MD) or E2 (Director of Nursing). E4 stated she instead sent them a text message. E4 stated I didn't want to

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S9999	Continued From page 7	S9999		

wake E2 because she had been at the facility all afternoon. E4 stated that R3's x-ray showed a possible fracture. E4 stated she did not do any pain assessment for R3. E4 stated she did not speak to Z1 or relay the x-ray results.

On March 31, 2017 at 8:17am, E2 (Director of Nursing) stated the nurses are not used to the term "high fall risk."

On April 5, 2017 at 2:11pm, E2 stated "E6 completed R3's fall assessment prior to her having a fall." The fall assessment score read 23, high risk. At 4:09pm, E2 stated "fall interventions are added for all residents at risk for falls. If they come in and they had a fall, we give interventions. E4 and the corporate nurse are working on our fall program. I will have to look closely at our falls."

On April 6, 2017 at 12:36pm, Z2 (Medical Doctor) stated he was not R3's primary MD, and did not get to see her because everything happened in one day. Z2 stated the facility notified him that R3 fell. Z2 stated "and I sent R3 to the emergency room for x-rays." Z2 stated he was made aware that R3 sustained a fractured wrist.

On April 6, 2017 at 2:11pm, E2 stated the policy for change in condition is to call the physician. E2 stated "no specific time frame but as soon as possible. When you get the radiology report. Once you get hold of the results, call the doctor." E2 also stated the "Comprehensive pain assessment is done on admission and after the fall." E2 stated "R3 triggered for pain, so she has a comprehensive pain assessment. That's why she got an order for x-ray. She should have one after the fall." When asked to provide the post

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SYMPHONY AT THE TILLERS	4390 ROUTE 71 OSWEGO, IL 60543

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fall pain assessment, E2 said "R3 only has one assessment which E6 started at 6:05pm before the fall. She finished it at 11:07pm (hours after the fall). She left it open." E2 stated E6 left the assessment open because she had to pass medications. E2 stated the nurses have to do a pain assessment each shift and document on the MAR (Medication Administration Record).

The pain assessment for R3 by E6 reads: March 25, 2017 18:05, Do you have pain? No; Have you recently been medicated for pain? No; Have you experienced pain in the last 3 months? No; Are you receiving routine or PRN (as needed) pain medications? Yes. Pain location- Groin. Complete pain assessment quarterly, with significant change, resident self reports of pain, and/or day of discharge. This was the only comprehensive pain assessment in R3's medical record. There was no comprehensive assessment for R3's wrist.

On April 6, 2017 at 2:50pm, E1 (Administrator) stated E4 did not call the physician with the x-ray results because it read possible fracture. E1 stated R3 did not complain of pain. E1 also stated E4 did not complete a pain assessment. When asked about the policy for pain assessments, E1 replied "I don't have all of them memorized." E1 stated the policy for physician notification with acute change in condition is to "email, text or phone him. Z2 keeps his phone right next to him. That's what I was told. I don't sleep with him so I don't know for sure."

On April 6, 2017 at 5:13pm, Z12 (Family Member) stated he was at the facility on March 25, 2017 (7:30pm) and saw R3 on the floor. Z12 stated R3 was screaming in pain, stating her wrist was

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broken and was asking him to get her up.
The Nursing Progress Notes March 26, 2017 10:09am reads: Z2 notified of x-ray results of left wrist with possible mildly fracture. Patient with swelling, bruising and moderate to severe pain with movement/touch to left wrist. Also pt with BP's in the 180's. Send to ER for further eval.

The Nursing Progress Notes dated March 26, 2017 documents: Resident taken at 11:00 by ambulance to local hospital for further evaluation on left wrist. The resident is AO X 1, weak. Pain on left wrist 8/10, ice pack used and Tylenol given, not effective. BP 180/85 early morning.

E4 did not notify Z2 when she received the portable x-ray results. Z2 was notified on the next shift after the blood pressure is 180s, wrist with bruising and pain severity increasing (nearly 15 hours after the fall/injury).

R3's discharge summary dated March 26, 2017 at 18:14 documents: Admitted to local Medical Center. Hospital admission diagnoses: altered mental status, wrist fracture and head injury.

The facility's policy for Falls documents:
Fall Prevention Guidelines for all residents upon Admission/Re-Admission:
-A Fall Risk will be completed on admission, readmission, quarterly, with each significant change and after each fall.
-Residents at fall risk will be identified for staff awareness.
-Residents at risk for falls will have Fall Risk identified on the interim plan of Care with interventions implemented to minimize fall risk.

The facility's policy titled Physician Notification documents: In a non-emergent, but acute

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S9999	Continued From page 10 medical situation the physician will be paged and if there is no return call in 15minutes, the physician will be notified again. If there is no return call in 5 minutes, the Medical Director will be notified. The facility's policy for Pain Management documents: Pain management is a multidisciplinary care process that includes the following- Observing for the potential for pain Effectively recognizing the presence of pain Addressing the underlying causes of the residents pain (B)	S9999		

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

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	146034	A. BUILDING _____ B. WING _____	C 04/06/2017

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F 000	INITIAL COMMENTS	F 000		

Complaint Investigation:

1771866/IL92877- F309, F323
1771999/IL93021- F333

F 309 SS=G 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING — F 309

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

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, including but not limited to the following:

(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.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such

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

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F 309	Continued From page 1	F 309		

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 record review and interview, the facility failed to complete a comprehensive pain assessment for a resident injury. The facility failed to notify the physician of x-ray results and obtain timely transfer orders. This failure resulted in R3 receiving a delay in treatment after falling in the facility and sustaining a fractured left wrist.

This applies to 1 of 3 (R3) residents reviewed for falls with injury in a sample of 19.

Findings include:

The facility's Face Sheet for R3 documents R3 was admitted March 25, 2017 at the age of 92. The Face Sheet lists the following diagnoses: history of falling, hypertension left pubic rami fracture, dementia, chronic kidney disease, osteoarthritis, neoplasm of the large intestine, glaucoma, and cataract.

R3's H & P (History and Physical) from the discharging hospital documented: history of dementia. Had a fall. Radiographs reveal pubic rami fracture.

The facility's Event Investigation for R3 dated March 25, 2017 reads: E6 (Licensed Practical Nurse/LPN) - I admitted her around 2:40pm. Around 7:30pm, E7 (Certified Nursing Assistant/CNA) stated she heard moaning, so she went to the room and stated she noted pt (patient) on the floor.

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F 309	Continued From page 2	F 309		

The written statement by E6 (Licensed Practical Nurse/LPN) documents: Noted small amount of blood on floor next to res (resident) head, noted small laceration 1cm on eyebrow area. Res complained of (c/o) left wrist and left pelvic pain. Noted bruising to left wrist with no swelling. Left wrist did appear to be slightly deformed in alignment. Z12 (Family Member) entered room. Resident immediately asked Z12 to get resident up.

The Fall Event form dated March 25, 2017 documents: Resident response to name and pain. Extremity movement/grasp- weak (all 4 extremities), location of pain- left wrist and pelvic. Positioning of extremities- Rotation/deformity of upper left extremity.
Nursing Progress Notes documents: March 25, 2017 20:10 Z2 (Medical Doctor) aware of fall and res c/o left wrist and pelvic pain w/ new orders for x-rays.

Portable x-ray report: March 26, 2017 2:32am Possible displaced fracture noted involving distal radius.
Nursing progress notes: March 26, 2017 03:20 POA was called to let him know the x-ray results. No answer. Message was left for POA. There was no documentation on this shift that Z2 was notified of the x-ray results.

On March 31, 2017 at 1:10pm, E4 (Quality Assurance Coordinator/Falls Coordinator) stated that she worked the night of March 25-26, 2017. E4 stated that she received x-ray results for R3 around 3:00am March 26, 2017. E4 stated she did not call Z1 (Medical Doctor/MD) or E2 (Director of Nursing). E4 stated she instead sent

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them a text message. E4 stated I didn't want to wake E2 because she had been at the facility all afternoon. E4 stated that R3's x-ray showed a possible fracture. E4 stated she did not do any pain assessment for R3. E4 stated she did not speak to Z1 or relay the x-ray results.

On April 6, 2017 at 2:11pm, E2 stated the policy for change in condition is to call the physician. E2 stated "no specific time frame but as soon as possible. When you get the radiology report. Once you get hold of the results, call the doctor." E2 also stated the "Comprehensive pain assessment is done on admission and after the fall." E2 stated "R3 triggered for pain, so she has a comprehensive pain assessment. That's why she got an order for x-ray. She should have one after the fall." When asked to provide the post fall pain assessment, E2 said "R3 only has one assessment which E6 started at 6:05pm before the fall. She finished it at 11:07pm (hours after the fall). She left it open." E2 stated E6 left the assessment open because she had to pass medications. E2 stated the nurses have to do a pain assessment each shift and document on the MAR (Medication Administration Record).

The pain assessment for R3 by E6 reads: March 25, 2017 18:05, Do you have pain? No; Have you recently been medicated for pain? No; Have you experienced pain in the last 3 months? No; Are you receiving routine or PRN (as needed) pain medications? Yes. Pain location- Groin. Complete pain assessment quarterly, with significant change, resident self reports of pain, and/or day of discharge. This was the only comprehensive pain assessment in R3's medical record. There was no comprehensive assessment for R3's wrist.

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On April 6, 2017 at 12:36pm, Z2 (Medical Doctor) stated the facility notified him that R3 had fallen. Z2 stated "I sent her to the emergency room for x-rays."

On April 6, 2017 at 2:50pm, E1 (Administrator) stated E4 did not call the physician with the x-ray results because it read possible fracture. E1 stated R3 did not complain of pain. E1 also stated E4 did not complete a pain assessment. When asked about the policy for pain assessments, E1 replied "I don't have all of them memorized." E1 stated the policy for physician notification with acute change in condition is to "email, text or phone him. Z2 keeps his phone right next to him. That's what I was told. I don't sleep with him so I don't know for sure."

The Nursing Progress Notes March 26, 2017 10:09am reads: Z2 notified of x-ray results of left wrist with possible mildly fracture. Patient with swelling, bruising and moderate to severe pain with movement/touch to left wrist. Also pt with BP's in the 180's. Send to ER for further eval.

The Nursing Progress Notes dated March 26, 2017 documents: Resident taken at 11:00 by ambulance to local hospital for further evaluation on left wrist. The resident is AO X 1, weak. Pain on left wrist 8/10, ice pack used and Tylenol given, not effective. BP 180/85 early morning.

E4 did not notify Z2 when she received the portable x-ray results. Z2 was notified on the next shift after the blood pressure is 180s, wrist with bruising and pain severity increasing (nearly 15 hours after the fall/injury).

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F 309	Continued From page 5 On April 6, 2017 at 5:13pm, Z12 (Family Member) stated he was at the facility on March 25, 2017 (7:30pm) and saw R3 on the floor. Z12 stated R3 was screaming in pain, stating her wrist was broken and was asking him to get her up. R3's discharge summary dated March 26, 2017 at 18:14 documents: Admitted to local Medical Center. Hospital admission diagnoses: altered mental status, wrist fracture and head injury. The facility's policy titled Physician Notification documents: In a non-emergent, but acute medical situation the physician will be paged and if there is no return call in 15minutes, the physician will be notified again. If there is no return call in 5 minutes, the Medical Director will be notified. The facility's policy for Pain Management documents: Pain management is a multidisciplinary care process that includes the following- Observing for the potential for pain Effectively recognizing the presence of pain Addressing the underlying causes of the residents pain	F 309		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to implement fall prevention/safety measures for a resident who was high risk for falls. The facility failed to follow their policy for Fall management. This failure resulted in R3 falling and sustaining a fractured wrist.

This applies to 1 of 3 residents (R3) reviewed for falls/injuries in a sample of 19.

Findings include:

The facility's Face Sheet for R3 documents that R3 was admitted on March 25, 2017 at the age of 92. The face sheet documents the following diagnoses: history of falling, hypertension left pubic rami fracture, dementia, chronic kidney disease, osteoarthritis, neoplasm of the large intestine, glaucoma, and cataract.

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R3's H & P (History and Physical) from the discharging hospital prior to the facility documents: March 22, 2017 History of dementia; Had a fall; Radiographs reveal pubic rami fracture.

The Interim Care Plan for R3 dated March 25, 2017 at 18:26, by E6 (Licensed Practical Nurse/LPN) documents: Potential for fall related to increased weakness; Interventions- Fall protocol.

R3's admission assessment by E6 dated March 25, 2017 at 18:29pm documents: Reason for admission- pelvic fracture, UTI (urinary tract infection); Lower extremity movement-weak; device- wheelchair; Risk alerts- Falls; Impairment- cognitive, vision.

The call light ability screen for R3 dated March 25, 2017 documents that R3 was unable to follow instructions on how to use call light and unable to return demonstration on how to use call light after 5 minutes.

Nursing Notes: March 25, 2017- admitted to facility at 1440 via stretcher. 1935-Grandson here, aware of fall.

The facility's Event Investigation for R3 dated March 25, 2017 reads: E6 (Licensed Practical Nurse/LPN) - I admitted R3 around 2:40pm. Around 7:30pm, E7 (Certified Nursing Assistant/CNA) stated she heard moaning, so she went to the room and stated she noted pt (patient) on the floor. Post Fall Huddle/Investigation- Alert and Oriented X 1.

The written statement by E6 (Licensed Practical

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Nurse/LPN) documents: Noted small amount of blood on floor next to res (resident) head, noted small laceration 1cm on eyebrow area. Res complained of (c/o) left wrist and left pelvic pain. Noted bruising to left wrist with no swelling. Left wrist did appear to be slightly deformed in alignment.

The Fall Event form dated March 25, 2017 documents: Res said res was trying to get up out of bed and res foot slipped out from underneath res. Resident response to -name and pain. Extremity movement/grasp- weak (all 4 extremities), location of pain- left wrist and pelvic. Positioning of extremities- Rotation/deformity of upper left extremity.

The nurse notes for March 25, 2017 documents that Z2 ordered an x-ray of R3's left wrist. The radiology report reads- Possible displaced fracture noted involving distal radius. The nurse's notes then documents that Z2 gave orders to send R3 to the emergency room.

On March 31, 2017 at 10:28am, E7 (Certified Nursing Assistant/CNA) stated she was assigned to care for R3 on March 25, 2017. E7 stated "she was confused. She didn't know where she was. She wanted to get a hold of her husband." E7 stated she noticed R3 lying on the floor, away from her bed, by the T.V. and dresser. E7 stated "apparently she was ambulatory." E7 stated she thinks R3 had a wheelchair. E7 stated she had no information related to R3 being a fall risk prior to the fall. E7 added "there were no fall interventions prior to then that I know of. I saw R3 laying [sic] on the floor. E7 stated she went and got E6 and they rolled R3 over and there was blood on the floor. E7 stated "R3's arm was

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behind R3. R3 said R3's arm hurts. R3 was laying on it." E7 stated when staff knows residents are a fall risk, they will place an alarm. E7 stated "we put the alarm on the bed after the fall."

On March 31, 2017, E6 stated she admitted R3 around 2:40pm. E6 stated at 7:30pm, E7 called her to the room and R3 was lying on R3's left side near the foot of the bed. E6 stated "R3's left arm was bent behind R3 and R3 was lying on it. Blood was on the left side of R3's head, on the floor." E6 stated R3 sustained a laceration. E6 stated that R3 requires assistance with ambulating. E6 stated she was not aware of R3 being a fall risk. E6 stated there were "no fall prevention measures prior to the fall. R3 complained of left wrist pain, head ache and left pelvic." E6 stated R3 was admitted to the facility because she fell and sustained a fractured pelvis. E6 stated the fall protocol is "If I know they are fall risk, they get an alarm. If they are confused, they would get an alarm."

R3's Fall Risk Screen dated March 25, 2017 at 18:40 (approximately 1 hour prior to the fall) completed by E6 documents that she scored 23, category: high risk. History of falls within last six months- 1-2 times, Vision pattern- inadequate; unable to independently come to a standing position, requires hand-on assistance to move from place to place, uses an assistive device, decrease in muscle coordination.

On March 31, 2017 at 1:10pm, E4 (Falls Coordinator/Quality Assurance Registered Nurse/RN) stated the fall protocol is "If we know they are high risk for falls, we give alarms. We didn't know R3 was high risk until the grandson

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said something after the fall. I didn't realize R3 had fallen at home until after the fall. Staff are supposed to do fall risk assessments on admission. R3 didn't trigger high on fall risk assessment. We didn't know R3's history. If we had known, R3 would've been closer to the front of the hall. That's protocol if high risk. R3 has dementia, but with what was documented and what the CNA said, R3 didn't seem confused."

On March 31, 2017 at 8:17am, E2 (Director of Nursing) stated the nurses are not used to the term "high fall risk."

On April 5, 2017 at 2:11pm, E2 stated "E6 completed R3's fall assessment prior to her having a fall." The fall assessment score read 23, high risk. At 4:09pm, E2 stated "fall interventions are added for all residents at risk for falls. If they come in and they had a fall, we give interventions. E4 and the corporate nurse are working on our fall program. I will have to look closely at our falls."

On April 6, 2017 at 12:36pm, Z2 (Medical Doctor) stated he was not R3's primary MD, and did not get to see her because everything happened in one day. Z2 stated the facility notified him that R3 fell. Z2 stated "and I sent R3 to the emergency room for x-rays." Z2 stated he was made aware that R3 sustained a fractured wrist.

On April 6, 2017 at 5:13pm, Z12 (Family Member) stated he was at the facility on March 25, 2017 (7:30pm) and saw R3 on the floor. Z12 stated R3 was screaming in pain, stating her wrist was broken and was asking him to get her up.

R3's discharge summary dated March 26, 2017

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F 323	Continued From page 11 at 18:14 documents: Admitted to local Medical Center. Hospital admission diagnoses: altered mental status, wrist fracture and head injury. The facility's policy for Falls documents: Fall Prevention Guidelines for all residents upon Admission/Re-Admission: -A Fall Risk will be completed on admission, readmission, quarterly, with each significant change and after each fall. -Residents at fall risk will be identified for staff awareness. -Residents at risk for falls will have Fall Risk identified on the interim plan of Care with interventions implemented to minimize fall risk.	F 323		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure removal of a transdermal patch prior to applying a new patch. This failure led to R4 receiving an excessive amount of the narcotic Fentanyl and having decrease respirations and lethargy. This applies to 1 of 4 residents (R4) reviewed for narcotics in a sample of 19. Findings include: The facility's Face Sheet for R4 documents that	F 333		

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R4 is 97 years old and has the following diagnoses: osteoporosis, dementia, TIA, anemia, GERD, constipation, urinary incontinence, gait abnormality, falls and palliative care.

The POS (Physicians Order Sheet) and MAR (Medication Administration Record) documents the following orders:
Duragesic -50 Patch 72hour 50mcg/hr (Fentanyl), apply 1 patch transdermally one time a day every 3 days for pain and remove per schedule, start date December 15, 2016- D/C date January 12, 2017;

Duragesic- 75 Patch 72hour 75 mcg/hr (Fentanyl) apply 1 patch transdermally one time a day every 3 days for pain and remove per schedule, start date January 12, 2017;

Dilaudid tablet 2mg (Hydromorphone HCL) give 1.5 tablets by mouth every 3 hours for pain start date January 12, 2017, D/C January 13, 2017.

The Physician's Progress Notes by Z1 dated January 12, 2017 documents: recommend increasing Duragesic from 50-75mcg every 3 days and scheduled Dilaudid to 3mg every 3 hours. The Nurse's Progress Notes documents that R4 received the Dilaudid.

The MAR documents that R4 received the Dilaudid every 3 hours January 12-13, 2017.

The Nurse's progress notes dated January 11, 2017 at 16:42 documents: "patient up in w/c (wheelchair) comfortable, no sign of distress, patient no sign of pain, schedule medication given, fluids encourage, [sic]"

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The Nurse's progress notes dated January 13, 2017 documents: resident unable to swallow pills, lethargic and gurgly sound noted.

The Nurse's progress notes dated January 16, 2017 documents: "Z1 notified of resident's daughter request regarding ABT (anti-biotic) and updated her of resident's condition regarding Fentanyl patch discrepancy."

On April 5, 2017 at 9:55am, E5 (Licensed Practical Nurse/LPN) stated that R4 was on a lot of Dilaudid and Z1 came and increased her Fentanyl dose. E5 stated "the afternoon nurse placed a new dose, but didn't remove the current dose." E5 stated the 50mcg patch was applied Wednesday and the 75mcg patch was applied Thursday. E5 added "the family noted the (2) patches Saturday and called me to the room. Her respirations were 6 and she was still getting Dilaudid. On Friday evening to Saturday her respirations were decreasing." E5 stated R4 got a total of 125mcg of Fentanyl. E5 stated that E4 (Quality Assurance Nurse) is in charge of handling medication errors.

On April 5, 2017 at 10:33am, E4 stated there's no protocol for medication errors other than contacting the physician and family. E4 stated there is "no specific policy."

On April 5, 2017 at 11:52am, E2 (Director of Nursing) stated that E5 informed her that R4 had on 2 Duragesic patches 50mcg and 75mcg. E2 stated the facility does not have a policy for medication errors. E2 stated the protocol for Duragesic patches is "they need to remove the previous one. E3 (LPN) was the nurse. E3 said she couldn't find the patch because it was dark."

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E2 stated the facility does not have a policy for applying transdermal patches.

On April 5, 2017 at 12:44pm, E3 stated she was the nurse who applied the 75mcg Fentanyl patch to R4. E3 stated "when I put the patch, I didn't see an old Fentanyl. It was dark in the room." E3 also stated "Policy should be every time we put a new patch, we have to remove the old one. That's the policy."

On April 6, 2017 at 8:47am, Z1 (Medical Doctor/Medical Director) stated he increased R4's Fentanyl Patch from 50mcg to 75mcg because of pain. Z1 stated "the important effort was to ensure she was comfortable, to increase the Duragesic (Fentanyl) and give the Dilaudid regular. There's a fine line between comfort and side effects of lethargy. Results of too much narcotics is lethargy and decreased respirations which was noted. They crossed the boundary where a little bit too much was given. I agree it's a system issue, there has to be a better system to trigger the nurse to remove the patch and place the new one."