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	IL6001028	A. BUILDING: _____ B. WING _____	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S 000	Initial Comments Compaint 1743678 / IL94831 Licensure Findings	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 d) 1) 300.1210 d) 2) 300.1210 d) 5) 300.3240 a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

2) All treatments and procedures shall be administered as ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

Based on interview and record review, the facility failed to provide pain management for 2 of 4 residents (R3 and R4) reviewed for pain

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management in the sample of five. This failure resulted in R4 experiencing severe pain exhibited by him crying and having an increased level of anxiety following admission to the facility from the hospital.

Findings include:

1. The Admission Record documented R4 as a 56 year old male admitted to the facility on 4/26/17 following hospitalization and surgery for Fournier's Gangrene. Fournier's Gangrene is documented by Medscape as "a rapidly progressive gangrene, necrotizing fascititis of the perineal, perianal, or genital areas" which requires surgical excision of the necrotic tissue.

R4's Minimum Data Sheet (MDS) dated 5/9/17 documented R4 to be cognitively intact.

Hospital Discharge Orders, dated 4/26/17, include pain medication as follows: Hydromorphone 2 milligrams (mg), 1-2 tabs by mouth every 4 hours as needed (PRN), Morphine 30 mg, 1 tab by mouth every 12 hours for 30 days, Acetaminophen 325 mg, 1 tab by mouth every 6 hours as needed for pain or fever, Hydrocodone-acetaminophen 10-325, 1 tab by mouth every 6 hours as needed for pain and Tramadol 50 mg ,1 tablet by mouth every 8 hours as needed for pain.

Hospital Discharge records, dated 4/26/17, documented the last dose of pain medication R4 received prior to his transfer to the facility was Morphine 30 mg at 9:02AM and Norco given at 11:17 AM.

The Resident Data Collection sheet documented R4 arrived at the facility on 4/26/17 at 6:00 PM.

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The sheet documented "yes" with reference to pain on admission with description written as "pain to coccyx." Documentation under comments is written "Surgical wound to coccyx." The form was not signed by staff.

On 6/20/17 at 2:13 PM, R4 stated he did not get any pain medication after being admitted to the facility until the next day. When R4 was asked to score his pain, R4 described it as "horrible" and added that he was crying he was in so much pain. R4 stated he was told by the admitting nurse that none of his medication, including his pain medication, would be in until the next day as it came from a pharmacy in (Southern Illinois City). R4 stated he lay in pain all night. When asked to score his pain the night of his admission, R4 stated it would have been a "10" all night.

The first Progress Note written following admission was dated 4/27/17 at 2:17 AM by E8, Registered Nurse (RN), and documented, "resident arrived by ambulance in stable condition. DX (diagnoses) sepsis, r/t (related to) gangrene surgical opening of the coccyx for debridement. Open area 35 cm (centimeter) in length, 9.5 cm in width and 4.5 cm deep, wound vac (vacuum) placed." There was no assessment of pain documented on the day R4 was admitted from the day shift through to 6:00 AM on 4/27/17.

The next Progress Note, dated 4/27/17 at 16:01 (4:01 PM), written by E9, License Practical Nurse (LPN), documented "Resident is alert and oriented x 3, he is able to make his needs known" and "He c/o (complaints of) pain even after the dose of Morphine."

On 6/21/17 at 12:25 pm, E9 stated she gave R4

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his 9:00 AM dose of Morphine 30 mg around 8:00 AM on 4/27/17 stating she had pulled it from the emergency box (E-box). E9 stated R4 scored his level of pain at that time as a "10." E9 stated she recalled R4 to have a "horrible wound that went from the top of his coccyx down through his buttocks into his scrotum" and that he had to have a colostomy due to the gangrene.

On 6/21/17 at 2:00 PM, E2, Corporate Registered Nurse stated E8, Registered Nurse (RN) was the admitted nurse and worked second shift 4/26/17 until 6am on 4/27/17. E2 stated E8 is no longer employed by the facility.

The April 2017 Medication Administration Records (MAR) confirm R4 received no pain medication from 6:00 PM 4/26/17 when he was admitted until 9:00 AM on 4/27/17 when E9 pulled Morphine from the E-box. R4's MAR also documented that R4's Morphine ordered every 12 hours was not documented as given for the evening dose of 4/27/17 by E8 either. There is no documentation of the effectiveness of the Morphine given R4 at 8am on 4/27/17 or any follow-up recorded in the progress notes on the status of R4's pain throughout the day on 4/27/17 while he waited on his medication to arrive.

On 6/20/17 at 2:32pm, Z1, Pharmacy Manager, stated that the facility has an emergency box with controlled substance in it that is accessible for the nurses to use when the pain medication has not been delivered yet. Z1 confirmed that E9 took Morphine 30mg from the emergency box at 8am on 4/27/17 but stated no other pain medication was used from the box before that time even though the Tramadol and Norco would have also been available. Z1 also stated the box contained oral Morphine that could have been substituted

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with a call to the physician until R4's medications arrived from the pharmacy.

On 6/21/17 at 2:25pm, Z2, R4's Primary Physician, stated R4 would have had severe pain due to the extent and size of the wound describing it as "massive." Z2 stated R4 had the colostomy done when they debrided the gangrene due to it extending from just below his coccyx, down including his rectum and into the scrotum. Z2 stated the nurse should have pulled from the E-box (emergency box) and/or called him as this resident would have needed his pain medication. Z2 stated it would have been appropriate for them to get it from a local pharmacy as a "STAT" order which they can do through their pharmacy services.

The Emergency Box contents list was reviewed and noted to contain Tramadol 50 mg, Hydrocodone 5/325 and Morphine in oral and liquid form.

The facility's policy/procedure entitled "Pain Management" dated 2015 documents its purpose as "To facilitate resident independence, promote resident comfort and preserve resident dignity" by provide an effective pain management program. Under general guidelines, the facility documents it will: promptly and accurately assessing and managing pain to the greatest extent possible, encouraging residents to self report pain, aggressively assessing pain in non-verbal and cognitively impaired residents, increasing comfort and reducing depression and anxiety in residents, optimizing the residents ability to perform activities of daily living and monitoring treatment and efficacy and side effects. The policy continues to document that pain will be assessed and managed in a timely manner, especially if it is

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of recent onset.

The policy entitled "Pharmacy Hours and Delivery Schedule" dated 1/27/14 documents "New orders communicated to the (Pharmacy) after the fax cut-off time will automatically go into the next regular delivery for the facility" and "The medication therapy should be initiated promptly if the new order is a medication contained in the convenience box or emergency box supply." The policy also documents "An emergency delivery can be requested by faxing the pharmacy, writing the word "STAT" in large bold lettering in the upper right-hand corner of the order sheet. After faxing the order, please contact the pharmacy by phone to alert them that you faxed a STAT order."

2. The Admission Record identifies R3 as an 84 year old female admitted to the facility on 5/16/17 from the hospital following a surgical repair of a fracture left hip. The MDS dated 5/23/17 documents R3 to have no cognitive impairment.

The Hospital Discharge Records dated 5/16/17 document orders for Tramadol 50 mg, 1 tab every 6 hours PRN and Tylenol 325 mg tabs 2 every 4 hours PRN for mild pain.

Comprehensive Pain Assessment (undated) identifies R3's pain at the left hip fracture, describes it as "aching" and "throbbing" and requires pain management intervention.

On 6/21/17 at 11:55 AM, R3 was sitting quietly in a chair beside her bed. R3 recalled the night she arrived at the facility stating it was "terrible" that night as they did not have her pain medication available until the next day. R3 stated she has moderate pain in her left thigh area and rubbed it

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as she spoke. R3 stated she did get Tylenol the next day but had to wait for the Tramadol. R3 stated she usually takes a Tramadol around 5:00 AM to get her through the day and again around 9:00 PM to help her sleep since she sustained a hip fracture.

R3's Progress notes dated 5/17/17 show R3 received a dose of Tylenol at 5:47 AM although the May 2017 MAR did not document she received the medication. The next pain medication R3 was documented as receiving was documented in the Progress note to be given at 19:47 (6:47pm.) The MAR has initials as the Tramadol given but fails to reflect the time, score of pain and/if it was effective or not.

On 6/21/17 at 2:25pm, Z2, R4's Primary Physician stated the nurses should have utilized the E-Box for R3's pain medication.

(A)