STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065150	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devonshire Care Center	1330 Sidney Ave Sterling, CO 80751

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on record review and interviews, the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (#1 and #2) of three residents out of four sample residents. Specifically, the facility failed to: -Offer person-centered non-pharmacological pain interventions for Resident #2; -Ensure pain medication was administered as ordered and the as needed (PRN) pain medication had parameters for Resident #2 and Resident #1; -Follow-up on documented ineffective pain medication for Resident #2; and, -Appropriately assess Resident #1's pain level. Findings include: I. Professional reference The American Medical Directors Association (AMDA) The Society for Post-Acute and Long-Term Care Medicine Pain in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline. [NAME], MD (2021), retrieved on 5/31/24 from www.paltc.org. It read in pertinent part, When several options for administering analgesics are ordered for a patient, nursing staff need adequately detailed guidance concerning how and when to select a PRN medication from among the several options that have been ordered. II. Facility policy and procedure The Pain Management policy, dated 5/3/23, was provided by the clinical nurse consultant (CNC) on 5/28/24 at 2:23 p.m. It read in pertinent part, Purpose: To accurately assess and achieve pain control. (continued on next page)

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.

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All residents will be evaluated for pain by utilizing a pain evaluation tool in (the electronic medical record). The pain evaluation will be completed on admission, readmission, quarterly, and with any significant change in condition. When a resident complains of pain, ask the resident to rate the level of pain using the Numerical Scale, using a pain level of zero (none) to ten (severe). Cognitively impaired residents have pain evaluated using the Pain Assessment in Advanced Dementia (PAINAD) scale. Do not forget the non-pharmacological interventions such as repositioning, relaxation, aromatherapy, visualization, desensitization, massage, and humor therapy. Non-pharmacological interventions should be documented in progress notes and included on the individual resident care plan. III. Resident #2 A. Resident Status Resident #2, age 71, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included orthopedic aftercare following surgery related to spondylolisthesis (fracture of a vertebra in the spinal column causing it to slip out of place), spinal stenosis (narrowing of the spinal canal), chronic obstructive pulmonary disease, (lung disorder causing breathing difficulty) and unspecified diastolic (congestive) heart failure. The 4/29/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required partial to moderate assistance with transfers and walking. The assessment documented he received routine and as needed (PRN) pain medication. The resident did not receive non-medication interventions for pain during the review period. B. Interview and observation Resident #2 was interviewed on 5/28/24 at 1:05 p.m. Resident #2 was in his room sitting in a wheelchair. He said he had a lot of pain due to recent back surgery. He said he took Tylenol, ibuprofen and Norco (hydrocodone-acetaminophen). He said the Norco was cut back to every 12 hours and sometimes it did not relieve his pain after he took it. He said he could take Tylenol as needed but it really did not help. He said he did get a Lidocaine patch (pain patch) which he said helped. He said sometimes the staff forgot to give it to him. He said it was in a different drawer than his pills and the nurses would forget to give it to him. He said the thing that helped the most with his back pain was a bath. He said he could only have a bath two times per week at the facility. He said on a follow-up doctor's appointment, the doctor did a scan and the screws in his back were loose, which was causing him increased pain. C. Record review The comprehensive pain assessment, completed on 4/22/24, indicated Resident #2 had back pain that interfered with his sleep, activities of daily living (ADL) and limited his physical activity. Resident #2 described the pain as sharp and throbbing. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the May 2024 CPO, Resident #2 had the following physician's orders for pain management: -Celebrex capsule 100 milligrams (mg) two times per day for post-operative pain, ordered 5/24/24; -Norco (hydrocodone-acetaminophen) 10-325 mg one tablet every 12 hours as needed for low back pain, ordered 4/30/24; -Biofreeze External Gel 4 % (menthol topical analgesic) apply to lower back every four hours as needed for pain, ordered 4/29/24; -Ibuprofen tablet 200 mg, give 400 mg three times per day for back pain, ordered 4/23/24; -Tylenol extra strength (acetaminophen) 500 mg, give two tablets every eight hours as needed for back pain, ordered 4/23/24; and, -Lidocaine HCl external patch 4 %, apply to back one time per day and remove per schedule, ordered 4/22/24. According to the May 2024 medication administration record (MAR), the Norco was ineffective for pain rated by Resident #2 as 8 out of 10 on 5/4/24 at 2:35 a.m. and ineffective for pain rated as 7 out of 10 on 5/5/24 at 7:13 pm. -A review of Resident #2's electronic medical record (EMR) did not reveal as needed pain medications were administered when the resident reported ineffective pain follow-up on 5/4/24 and 5/5/24 and there was no documentation indicating non-pharmacological pain interventions were offered. According to the May 2024 MAR (reviewed from 5/1/24 to 5/28/24), the Lidocaine patch was not administered six out of 28 days for the following reasons: -On 5/4/24 the resident declined the patch due to having a bath. There was no documentation that it was applied after the bath. -On 5/8/24 the medication was out of stock. There was no documentation indicating the physician or the pharmacy was notified. -On 5/11/24 the medication was unavailable and the facility was awaiting the order. There was no documentation that the physician or the pharmacy were notified. -On 5/15/24 the medication was not available. There was no documentation that the physician or the pharmacy were notified. -On 5/21/24 the MAR was blank and there was no documentation indicating why the medication was not given. -On 5/23/24 the resident was taking a bath.The charge nurse was notified to apply the patch after the resident finished his bath. There was no documentation indicating the patch was applied after the bath. The MAR was blank. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the May 2024 MAR (reviewed from 5/1/24 to 5/28/24), Celebrex Capsule 100 mg was not documented as administered on two out of 24 days. The MAR did not indicate the resident received the Celebrex on 5/6/24 and 5/12/24 at 6:00 p.m. According to the May 2024 CPO, Resident #2 had a physician's order for Tylenol 500 mg two tablets every eight hours as needed, Norco 10-325 mg one tablet every 12 hours as needed and Biofreeze external gel every four hours as needed. -The physician's order did not specify when to give the Tylenol 500 mg versus the Norco 10-325 mg. A review of Resident #2's May 2024 MAR (from 5/1/24 to 5/28/24) documented the resident was administered Norco 10-325 mg when Resident #2 reported his pain level at a 3 out of 10 two times. The resident was administered Norco 10-325 mg when Resident #2 reported a pain level at a 4 out of 10 two times. The resident was administered Norco 10-325 mg when Resident #2 reported a pain level at a 5 out of 10 four times. The resident was administered Norco 10-325 mg when Resident #2 reported a pain level at a 6 out of 10 seven times. The resident was administered Norco 10-325 mg when Resident #2 reported a pain level at a 7 out of 10 nine times. The resident was administered Norco 10-325 mg when Resident #2 reported a pain level at an 8 out of 10 fourteen times. The resident was administered Norco 10-325 mg when Resident #2 reported a pain level at a 9 out of 10 one time. The resident was administered Tylenol 500 mg when Resident #2 reported his pain level at a 9 out of 10 on 5/1/24. The resident was administered Tylenol 500 mg when Resident #2 reported his pain level at an 8 out of 10 on 5/4/24. The resident was administered Tylenol 500 mg when Resident #2 reported his pain level at a 6 out of 10 on 5/7/24 and 5/17/24. The resident was administered Tylenol 500 mg when Resident #2 reported his pain level at a 7 out of 10 on 5/14/24. The Biofreeze was applied as needed on 5/2/24, 5/3/24, 5/8/24 and 5/9/24. -However, a review of the EMR did not reveal a pain level was assessed or documented when the resident was administered the Biofreeze external gel. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pain care plan, initiated on 4/22/24, indicated the resident had pain. Interventions included administering medication per orders, reporting to the nurse any complaints of pain, evaluating the effectiveness of the pain interventions and notifying the physician if the interventions were unsuccessful. -A review of the Resident #2's EMR did not reveal documentation of person-centered non-pharmacological pain interventions or documentation that non-pharmacological pain interventions were attempted. D. Interviews Licensed practical nurse (LPN) #1 was interviewed on 5/28/24 at 11:25 a.m. LPN #1 said if a medication was not in the medication cart she would check the medication room where extra medications were stored. She said if the medication was not there she would double check the cart. She said if she could not find the medication in the medication cart she would get it from the medication dispensing machine that contained back-up medications. She said she would order the medication from the pharmacy right away. She said the pharmacy delivered medications to the facility daily at 7:00 p.m. and 1:00 a.m. She said the pharmacy would deliver up to four times per day if needed. She said if a medication was not available in the medication dispensing machine, she would notify the provider to put the medication on hold until it arrived. LPN #2 was interviewed on 5/28/24 at 1:15 p.m. LPN #2 said if a pain medication was not effective, she would do a full pain assessment. She said she would check to see when pain medication was last given to the resident and check to see if the resident had any PRN pain medications that could be administered.She said if there were no physician's orders or if the medication could not be given yet, she would call the on-call provider to ask for additional medication. She said she also offered non-pharmacological interventions such as relaxation, music, massage or asked the resident what worked for them. IV. Resident #1 A. Resident status Resident #1, age 80, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included multiple sclerosis (disease that affects the nervous system), Alzheimer's dementia and chronic pain. The 3/29/24 minimum data set (MDS) assessment revealed Resident #1 had severe cognitive impairment with a BIMS score of two out of 15. He required total assistance with transfers and did not walk. He was independent with wheelchair mobility. B. Resident representative interview The representative for Resident #1 was interviewed on 5/28/24 at 10:20 a.m. Resident #1's representative said his pain medication was recently changed from Fentanyl patches to pills. She said he had missed some doses of the new medication because the pharmacy did not deliver it right away. C. Record review (continued on next page)

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