

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/24/2025
NAME OF PROVIDER OR SUPPLIER  Bria of River Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE  14500 South Manistee Burnham, IL 60633	

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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102</b></p> <p>Based on interview and record review, the facility failed to conduct a comprehensive assessment for a resident with a new onset of left leg pain. This affected one out of three residents (R1) reviewed for nursing assessments in a total sample of seven. This failure resulted in R1 being delayed treatment and not sent to the hospital for a fractured left hip for four days.</p> <p>Findings Include:</p> <p>R1 is a [AGE] year old with the following diagnosis: epilepsy, Todd's paralysis, dementia, and chronic kidney disease.</p> <p>The Hospital Records dated 2/22/25 document R1 was admitted to the hospital for left hip fracture post fall. R1 reported falling while trying to get in the wheelchair two days ago. R1 is unable to move the left lower extremity and reported achy and tenderness. R1 is guarded and rated the pain a ten out of ten. R1 reported taking pain medication with minimal relief. R1 was admitted for further evaluation. Upon exam, R1 had extremity pain, limited range of motion, and joint swelling to the left hip. The admitting diagnosis was closed intertrochanteric fracture of the left hip. An x-ray of the left hip dated 2/22/25 documents there is an intertrochanteric fracture to the left hip. The exam was extremely limited due to difficulty in positioning.</p> <p>The Facility Investigation Report dated 2/27/25 documents R1 suffered a fracture to the left hip. R1 reported falling when transferring to the wheelchair but did not report the fall to any staff. No roommates were able to give a statement. All staff interviewed denied witnessing a fall. On 2/17/25, R1 complained of left pain. Pain medication was given and an x-ray of the left knee was negative. The nurse practitioner ordered to continue tramadol which was an order from the most recent hospitalization. Another nurse practitioner assessed R1 on 2/18/25 and had no new orders. On 2/19/25, pain medication was given for generalized pain. R1 complained of pain on 2/21/25. The nurse practitioner assessed R1 and ordered a left hip x-ray which showed a fracture of the left femur. R1 was sent to the hospital and had hip surgery to repair the left femur fracture.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/22/25 at 1:23PM, V1 (Nurse) stated V1 first worked with R1 on 2/21/25 and R1 was refusing to eat breakfast so V1 went to assess R1. V1 reported R1 told V1 that R1's left leg hurt very badly and when V1 went to touch the leg R1 screamed out to not touch R1's leg. V1 stated V1 notified the nurse practitioner (V8) and V8 came to the room to assess R1. V1 reported V8 attempted to move R1's left leg but R1 could not move the leg at all on R1's own. V1 stated R1 is a resident who is frequently in the wheelchair self-propelling around the facility so it is abnormal for R1 to stay in bed all day. V1 reported if a resident complains of pain an assessment is completed. V1 stated staff asks where is the pain, when did it start, what it feels like, and what the resident rates the pain if they are alert. V1 reported if a resident isn't alert, V1 will look back in the progress notes to see if there is anything new. V1 denied R1 was able to point or say where the pain was or rate the pain. V1 stated a physical assessment will be completed to touch areas to see where the resident is hurt. V1 reported wherever V1 touches and a resident screams, V1 knows will be the area of most pain. V1 stated V1 will look for any physical difference that are new onset for a resident to make a determination of what is causing the pain.</p> <p>On 3/22/25 at 1:50PM, V3 (Nurse) stated V3 took care of R1 on 2/17/25 and 2/18/25. V3 reported R1 first complaint of pain on 2/17/25 so V3 called the nurse practitioner and an x-ray of the left knee was ordered. V3 stated R1 told V3 the pain was in R1's left leg. V3 denied R1 ever having pain in that area before. V3 reported R1 could not say why the leg was painful. V3 said, I know he has osteoarthritis so I assumed it was that. V3 stated R1 did not get out of bed that day. V3 reported the following day R1 complained of left leg pain and was given pain medication. V3 denied R1 was able to describe the pain. V3 stated when a resident has new onset pain, the nurse is responsible to find out where the pain is at and what the resident rates their pain. V3 reported V3 did not think to ask what caused the pain because the previous hospital stay reported R1 had osteoarthritis. V3 stated R1 never left the bed on either of those days. V3 denied assessing anything other than R1's left knee. V3 reported V3 did not notice R1 not moving the left leg. V3 stated R1 was in pain so V3 thought R1 didn't want to move the leg while it was hurting.</p> <p>On 3/22/25 at 3:04PM, R1 was lying in bed. R1 stated R1 broke R1's left hip after falling out of a wheelchair. R1 was not able to give a date, time frame, or any other details about the fall due to confusion. R1 was able not able to give any other details regarding when x-rays of the leg were taken and what the time frame was from when R1 fell to when R1 was sent to the hospital. R1's mental status was assessed. R1 is alert and oriented times two. R1 reported the date as March 25, 2003, and the location as Chicago, IL. R1 was also able to accurately state R1's name and birth date. R1 stated R1 went to the hospital and had surgery to have the left hip repaired. R1 reported R1 was taking medicine for R1's pain but did not know the name of the medication or how often R1 was taking the medication. R1 stated R1's pain was a ten out of ten. R1 reported moving or touching the left leg made the pain worse. R1 reported the pain felt like electricity that was in R1's whole leg but the worse pain was near the hip. R1 was not able to answer any questions about the nurses or nurse practitioner's assessment of R1's pain. R1 stated R1's pain level is now a three or five after having the surgery. R1 reported R1 is still being given pain medication. R1 denied knowing why R1 was not sent to the hospital sooner. R1 reported R1 uses a wheelchair to go smoke and move around the facility. R1 stated R1 was not getting out of bed when R1 had pain level at a ten out of ten. R1 said, It was the worst pain in my life. R1 reported the pain medication would lower the pain from a ten to an eight when the pain was at it's worst. R1 stated R1 yelled out more than once when staff tried to touch R1.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/23/25 at 1:45PM, V7 (CNA) stated R1 is an active resident that first reported pain on 2/17 during V7's shift. V7 reported telling the nurse about R1's pain but was not aware of any other actions the nurse took for R1's pain. V7 stated R1 is a resident that enjoys being up in the wheelchair to go to smoke break but on this day R1 did not get out of bed. V7 reported R1 did not want staff to touch R1 because R1 was in so much pain so staff tried to avoid touching R1 to not make the pain worse.</p> <p>On 3/23/25 at 2:29PM, V8 (Nurse Practitioner) stated R1 kept pointing to the knee area when V8 was first notified of R1's pain on 2/17/25 so V8 put in an order a left knee x-ray. V8 reported when R1's knee was touched R1 had increased pain so V8 thought the pain was coming from the knee or could possibly be a pain from frequent episodes of pancreatitis. V8 stated the left knee x-ray was negative but a couple days later staff notified V8 of R1's leg pain again. V8 reported V8 touched R1's hip and groin area during the second assessment and R1 moved away in pain. V8 denied being made aware of an additional times R1 reported pain other than on 2/17/25 and 2/21/25. V8 stated V8 would have come to assess R1 sooner if V8 was aware R2 was still in pain.</p> <p>On 3/24/25 at 9:45 AM, V9 (Rehab Nurse Practitioner) stated when assessing pain, a nurse should ask questions about where the pain is at and what the level of pain is. V9 reported if a resident can't tell you where the pain is at or what happened then when an assessment is being done, then range of motion should be tested and any imaging should be ordered based off of the assessment. V9 stated if a resident is showing signs of facial grimacing or yelling out then they are in pain. V9 was unable to remember assessing R1 on 2/18/25 and was not able answer why no further imaging was ordered on 2/18/25 when V9 assessed R1. V9 reported the left knee imaging was negative and staff assumed that is where the pain was coming from.</p> <p>On 3/24/25 at 12:54PM, V10 (DON) stated R1 began complaining of pain to the left knee so an x-ray was taken that was negative. V10 reported two or three days later R1 still complained of pain so an x-ray of the hip was completed and showed a fracture to the femur. V10 stated staff should do a complete assessment for a resident to rule out as many causes as possible when there are complaints of new pain. V10 reported staff need to check the pain level and where the pain is at and what the pain feels like during the assessment. V10 stated if pain keeps returning then the physician or nurse practitioner needs to be notified again. V10 reported a hip x-ray was not done at the same time as the knee x-ray because the nurse practitioner said they had to work their way up the leg before they order all the images.</p> <p>On 3/24/25 at 1:49PM, V11 (Primary Physician) stated if a resident is complaining of pain in the leg then V10's concern is an injury to the hip so V11 always orders an x-ray to the hip. V11 reported pain is subjective so staff must go off what the resident is reporting and treat it that way. V11 said, I have seen people who stub their toe and rate the pain a 10 and other people who have a fracture who say the pain is not that bad. You have to get to an answer of what is cause a new onset of pain if possible. V11 stated if the resident can't tell staff where the pain is but there are signs of pain then a full assessment must be done to identify as best as possible where the pain is and what caused the pain.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Hospital Records dated 2/7/25 document R1 admitted to the hospital for increased confusion and was complaining of left hip pain. R1 was unable to state a reason for the pain. On physical exam, R1 had normal extremities. An x-ray of the pelvis was taken to rule out any injuries. The hospital x-ray report dated 2/8/25 documents the left hip had no evidence of fracture but had mild osteoarthritis in both hips. R1 was discharged back to the facility on [DATE].</p> <p>A Nursing note dated 2/16/25 documents R1 is in stable condition and denied any pain or discomfort this shift.</p> <p>A Nursing note dated 2/17/25 at 1:26PM documents R1 complained of an increase of pain. The nurse practitioner ordered ibuprofen as needed and an x-ray of the left knee.</p> <p>A Nursing note dated 2/17/25 at 7:23PM documents R1 is alert and oriented time two and able to make needs known. One view of the left knee was unable to be completed because the left knee could not straighten out all the way.</p> <p>A Nursing note dated 2/17/25 at 8:49PM documents R1 is alert but confused. The left knee x-ray results indicate the left knee has moderate osteoarthritis with joint space narrowing from chondromalacia. Knee bones with osteopenia suggest early demineralization of bone mass. There is no evidence of osseous destruction or acute pathological fracture. The physician was notified of the results.</p> <p>The X-ray Report of the left knee dated 2/17/25 documents the left knee has moderate osteoarthritis with osteopenia. There is no evidence of osseous destruction or acute pathological fracture.</p> <p>A Nurse Practitioner note dated 2/18/25 documents R1 recently returned from the hospital for altered mental status. R1 reported pain to the left leg which appeared to have left knee flexion and contracture present. The x-ray to the left knee showed moderate arthritis present. The nurse practitioner attempted to gently stretch the left lower extremity but R1 yelled out when the nurse practitioner touched R1's left lower limb. Three different pain medications are ordered as needed.</p> <p>A Nursing note dated 2/19/25 documents R1 complained of generalized body pain. Pain medication was administered. Continue plan of care.</p> <p>A Nursing note dated 2/21/25 at 12:17PM documents R1 complained of pain to the left leg and difficulty moving the left leg. R1 was unable to state the level of pain on a pain scale or the exact onset of the pain at this time. R1 only said, It hurts. Don't touch it. Pain medication was administered and the in house nurse practitioner was notified. The nurse practitioner examined R1 and ordered for an x-ray of the left trochanter.</p> <p>A Nursing note dated 2/21/25 at 5:35PM documents R1 complained of pain to the left and right leg and both feet.</p> <p>The X-ray Report of the left hip dated 2/21/25 documents a fracture at the neck of the left femur is seen with displaced distal fragments. Mild osteoarthritis of the hip is also present.</p> <p>A Nursing note dated 2/21/25 at 6:39PM documents the left trochanter x-ray was positive for a fracture to the neck of the left femur and displaced distal fragments. The physician was notified and ordered to send R1 to the hospital. An ambulance was called and was scheduled to arrive in 90 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A Nursing note dated 2/22/25 documents R1's admitting diagnosis as left intertrochanter fracture with displacement.</p> <p>A Nursing note dated 2/26/25 documents R1 readmitted to the facility post left hip surgery.</p> <p>The Medication Administration Record dated 02/2025 documents there is an order to monitor and record pain score every shift. The ordered was discontinued on 2/8/25 when R1 went to the hospital and was not reordered again until 2/26/25. From 2/11/25 through 2/21/25, pain scores were not being assessed and recorded every shift for R1.</p> <p>The Comprehensive Pain assessment dated [DATE] documents R1 denied any reports of pain. R1 did not verbally admit to having any pain and does not show any nonverbal signs of pain such as facial grimacing, restlessness, rubbing, or bracing. The facial pain scale documents the pain score at a zero out of ten.</p> <p>The Comprehensive Pain assessment dated [DATE] documents R1 reported pain to the left knee. R1 has generalized osteoarthritis which could be a reason for the pain. R1 has also had a decrease in physical activity. Pain is relieved by position change and medication. R1 shows facial grimacing and vocalizes reports of pain. R1 described the pain as aching. The facial pain scale documents the pain hurts even more (four out of ten on the numerical pain scale). AN x-ray of the knee was ordered and an order for ibuprofen 600 mg every six hours as needed as put in by the nurse practitioner.</p> <p>The Comprehensive Pain assessment dated [DATE] documents R1 did not have any reports of pain. R1 did not verbally admit to having any pain and does not show any nonverbal signs of pain such as facial grimacing, restlessness, rubbing, or bracing. The facial pain scale documents the pain score at a zero out of ten.</p> <p>There is no documentation that a Comprehensive Pain Assessment was completed on 2/19/25 or 2/20/25.</p> <p>The Comprehensive Pain assessment dated [DATE] documents R1 reported pain to the left hip. R1 has generalized osteoarthritis which could be a reason for the pain. R1 was withdrawn from activities on this day and pain was increased with repositioning. Pain is relieved with medication. R1 shows facial grimacing, bracing, and vocal complaints to not touch the area that is painful. R1 described the area as aching and discomfort. The facial pain scale documents the pain hurts a whole lot. The numerical pain scale rate the pain a ten out of ten.</p> <p>The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as 11 (moderate cognitive impairment). Section GG of the MDS documents R1 uses a wheelchair for a mobility device. R1 needs partial to moderate assistance with bed mobility and substantial to maximal assistance with transfers. R1 is able to self propel in the wheelchair with supervision or touching assistance. Section J of the MDS documents R1 has not received any scheduled or as needed pain medication in the last five days and denied having any pain within the last five days.</p> <p>The Care Plan revised on 2/27/25 documents R1 is at risk for an alteration in comfort related to fracture of femur, arthritis, history of falls, and seizures. Interventions include: assess pain characteristics by duration, location, and quality; and monitor for non-verbal indicators of pain (moaning, crying, grimacing, wincing).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>There is no documentation that nursing staff did any range of motion testing or any further investigation of R1's cause root cause of the pain until 2/21/25 when an additional x-ray was ordered.</p> <p>The policy titled, Pain Management, dated 10/2024 documents, General: To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. Guideline: the pain management program is based on a facility wide commitment to resident comfort. Pain is defined as whatever. The experiencing person says it is and exists whenever he or she says it does. Pain Management is defined as the process of alleviating the residence pain to a level that is acceptable to the resident is based on his or her clinical condition and establish treatment goal. Pain management is a multidisciplinary care process that includes the following: observing for the potential for pain, effectively, recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of the residence pain, developing in implementing approaches to pain management, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions; and modifying approaches as necessary. It is important to recognize cognitive, cultural, familial, or gender specific influences on the resident's ability or willingness to verbalize pain .Policy: 1. Pain is assessed using the comprehensive pain assessment form: upon admission, quarterly, with significant change, following a fall, when new pain is identified, and when existing pain worsens. 2. Pain will be assessed at least once a every shift and documented in the EMAR using the pain scale appropriate for the patient. The following pain scales are available for use: numerical scale and PAINAND scale for the cognitively impaired .6. If pain has not been managed, consistent with the residence goals and needs, the interdisciplinary team may need to reconsider current interventions and revise those interventions as needed; or if pain has been maintained and/or resolved, the nursing staff will work with the physician to taper or discontinue analgesics.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40102</p> <p>Based on interview and record review, the facility failed to assess and identify the underlying cause of a resident's (R1) new onset of pain in the left leg, and failed to inform the primary care provider of continued pain after being administered tramadol 50mg. This affected one out of three (R1) residents reviewed for pain management in a total sample of seven. This failure resulted in R1 having increased pain levels for four days before R1 was sent to the hospital for treatment of a left hip fracture.</p> <p>Findings Include:</p> <p>R1 is a [AGE] year old with the following diagnosis: epilepsy, Todd's paralysis, dementia, and chronic kidney disease.</p> <p>The Hospital Records dated 2/22/25 document R1 was admitted to the hospital for left hip fracture post fall. R1 reported falling while trying to get in the wheelchair two days ago. R1 is unable to move the left lower extremity and reported achy and tenderness. R1 is guarded and rated the pain a ten out of ten. R1 reported taking pain medication with minimal relief. R1 was admitted for further evaluation. Upon exam, R1 had extremity pain, limited range of motion, and joint swelling to the left hip. The admitting diagnosis was closed intertrochanteric fracture of the left hip. An x-ray of the left hip dated 2/22/25 documents there is an intertrochanteric fracture to the left hip. The exam was extremely limited due to difficulty in positioning.</p> <p>The Facility Investigation Report dated 2/27/25 documents R1 suffered a fracture to the left hip. R1 reported falling when transferring to the wheelchair but did not report the fall to any staff. No roommates were able to give a statement. All staff interviewed denied witnessing a fall. On 2/17/25, R1 complained of left pain. Pain medication was given and an x-ray of the left knee was negative. The nurse practitioner ordered to continue tramadol which was an order from the most recent hospitalization. Another nurse practitioner assessed R1 on 2/18/25 and had no new orders. On 2/19/25, pain medication was given for generalized pain. R1 complained of pain on 2/21/25. The nurse practitioner assessed R1 and ordered a left hip x-ray which showed a fracture of the left femur. R1 was sent to the hospital and had hip surgery to repair the left femur fracture.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/22/25 at 3:04PM, R1 was lying in bed. R1 stated R1 broke R1's left hip after falling out of a wheelchair. R1 was not able to give a date, time frame, or any other details about the fall due to confusion. R1 was able not able to give any other details regarding when x-rays of the leg were taken and what the time frame was from when R1 fell to when R1 was sent to the hospital. R1's mental status was assessed. R1 is alert and oriented times two. R1 reported the date as March 25, 2003, and the location as Chicago, IL. R1 was also able to accurately state R1's name and birth date. R1 stated R1 went to the hospital and had surgery to have the left hip repaired. R1 reported R1 was taking medicine for R1's pain but did not know the name of the medication or how often R1 was taking the medication. R1 stated R1's pain was a ten out of ten. R1 reported moving or touching the left leg made the pain worse. R1 reported the pain felt like electricity that was in R1's whole leg but the worse pain was near the hip. R1 was not able to answer any questions about the nurses or nurse practitioner's assessment of R1's pain. R1 stated R1's pain level is now a three or five after having the surgery. R1 reported R1 is still being given pain medication. R1 denied knowing why R1 was not sent to the hospital sooner. R1 reported R1 uses a wheelchair to go smoke and move around the facility. R1 stated R1 was not getting out of bed when R1 had pain level at a ten out of ten. R1 said, It was the worst pain in my life. R1 reported the pain medication would lower the pain from a ten to an eight when the pain was at it's worst. R1 stated R1 yelled out more than once when staff tried to touch R1.</p> <p>On 3/23/25 at 1:45PM, V7 (CNA) stated R1 is an active resident that first reported pain on 2/17 during V7's shift. V7 reported telling the nurse about R1's pain but was not aware of any other actions the nurse took for R1's pain. V7 stated R1 is a resident that enjoys being up in the wheelchair to go to smoke break but on this day R1 did not get out of bed. V7 reported R1 did not want staff to touch R1 because R1 was in so much pain so staff tried to avoid touching R1 to not make the pain worse. V7 stated R1 had pain all during V7's shift.</p> <p>On 3/23/25 at 2:29PM, V8 (Nurse Practitioner) stated R1 kept pointing to the knee area when V8 was first notified of R1's pain on 2/17/25 so V8 put in an order a left knee x-ray. V8 reported when R1's knee was touched R1 had increased pain so V8 thought the pain was coming from the knee or could possibly be a pain from frequent episodes of pancreatitis. V8 stated the left knee x-ray was negative but a couple days later staff notified V8 of R1's leg pain again. V8 reported V8 touched R1's hip and groin area during the second assessment and R1 moved away in pain. V8 denied being made aware of an additional times R1 reported pain other than on 2/17/25 and 2/21/25. V8 stated V8 would have come to assess R1 sooner if V8 was aware R2 was still in pain. V8 reported V8 continued the tramadol order from the hospital for pain but V8 was not aware that the medication had only a little affect in lower R1's pain.</p> <p>On 3/24/25 at 9:45 AM, V9 (Rehab Nurse Practitioner) stated when assessing pain, a nurse should ask questions about where the pain is at and what the level of pain is. V9 reported if a resident can't tell you where the pain is at or what happened then when an assessment is being done, then range of motion should be tested and any imaging should be ordered based off of the assessment. V9 stated if a resident is showing signs of facial grimacing or yelling out then they are in pain. V9 was unable to remember assessing R1 on 2/18/25 and was not able answer why no further imaging was ordered on 2/18/25 when V9 assessed R1. V9 reported the left knee imaging was negative and staff assumed that is where the pain was coming from.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Bria of River Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE  14500 South Manistee Burnham, IL 60633	
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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/24/25 at 12:54PM, V10 (DON) stated R1 began complaining of pain to the left knee so an x-ray was taken that was negative. V10 reported two or three days later R1 still complained of pain so an x-ray of the hip was completed and showed a fracture to the femur. V10 stated staff should do a complete assessment for a resident to rule out as many causes as possible when there are complaints of new pain. V10 reported staff need to check the pain level and where the pain is at and what the pain feels like during the assessment. V10 stated if pain keeps returning then the physician or nurse practitioner needs to be notified again. V10 reported pain scores need to be documented in the MAR every shift and every time a pain medication is administered. V10 reported documenting the pain scores allows staff to see if the current plan of treatment is working. V10 stated if the pain continues then the nurse practitioner or physician needs to be notified again until the pain is under control.</p> <p>On 3/24/25 at 1:49PM, V11 (Primary Physician) stated if a resident is complaining of pain in the leg then V10's concern is an injury to the hip so V11 always orders an x-ray to the hip. V11 reported pain is subjective so staff must go off what the resident is reporting and treat it that way. V11 said, I have seen people who stub their toe and rate the pain a 10 and other people who have a fracture who say the pain is not that bad. You have to get to an answer of what is cause a new onset of pain if possible. V11 stated if the resident can't tell staff where the pain is but there are signs of pain then a full assessment must be done to identify as best as possible where the pain is and what caused the pain.</p> <p>The Hospital Records dated 2/7/25 document R1 admitted to the hospital for increased confusion and was complaining of left hip pain. R1 was unable to state a reason for the pain. On physical exam, R1 had normal extremities. An x-ray of the pelvis was taken to rule out any injuries. The hospital x-ray report dated 2/8/25 documents the left hip had no evidence of fracture but had mild osteoarthritis in both hips. R1 was discharged back to the facility on [DATE].</p> <p>A Nursing note dated 2/16/25 documents R1 is in stable condition and denied any pain or discomfort this shift.</p> <p>A Nursing note dated 2/17/25 at 1:26PM documents R1 complained of an increase of pain. The nurse practitioner ordered ibuprofen as needed and an x-ray of the left knee.</p> <p>A Nursing note dated 2/17/25 at 7:23PM documents R1 is alert and oriented time two and able to make needs known. One view of the left knee was unable to be completed because the left knee could not straighten out all the way.</p> <p>A Nursing note dated 2/17/25 at 8:49PM documents R1 is alert but confused. The left knee x-ray results indicate the left knee has moderate osteoarthritis with joint space narrowing from chondromalacia. Knee bones with osteopenia suggest early demineralization of bone mass. There is no evidence of osseous destruction or acute pathological fracture. The physician was notified of the results.</p> <p>The X-ray Report of the left knee dated 2/17/25 documents the left knee has moderate osteoarthritis with osteopenia. There is no evidence of osseous destruction or acute pathological fracture.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A Nurse Practitioner note dated 2/18/25 documents R1 recently returned from the hospital for altered mental status. R1 reported pain to the left leg which appeared to have left knee flexion and contracture present. The x-ray to the left knee showed moderate arthritis present. The nurse practitioner attempted to gently stretch the left lower extremity but R1 yelled out when the nurse practitioner touched R1's left lower limb. Three different pain medications are ordered as needed.</p> <p>A Nursing note dated 2/19/25 documents R1 complained of generalized body pain. Pain medication was administered. Continue plan of care.</p> <p>A Nursing note dated 2/21/25 at 12:17PM documents R1 complained of pain to the left leg and difficulty moving the left leg. R1 was unable to state the level of pain on a pain scale or the exact onset of the pain at this time. R1 only said, It hurts. Don't touch it. Pain medication was administered and the in house nurse practitioner was notified. The nurse practitioner examined R1 and ordered for an x-ray of the left trochanter.</p> <p>A Nursing note dated 2/21/25 at 5:35PM documents R1 complained of pain to the left and right leg and both feet.</p> <p>The X-ray Report of the left hip dated 2/21/25 documents a fracture at the neck of the left femur is seen with displaced distal fragments. Mild osteoarthritis of the hip is also present.</p> <p>A Nursing note dated 2/21/25 at 6:39PM documents the left trochanter x-ray was positive for a fracture to the neck of the left femur and displaced distal fragments. The physician was notified and ordered to send R1 to the hospital. An ambulance was called and was scheduled to arrive in 90 minutes.</p> <p>A Nursing note dated 2/22/25 documents R1's admitting diagnosis as left intertrochanter fracture with displacement.</p> <p>A Nursing note dated 2/26/25 documents R1 readmitted to the facility post left hip surgery.</p> <p>The Medication Administration Record dated 02/2025 documents R1 was given scheduled tramadol 50 mg at 9AM and 5PM as ordered. A pain score is documented with each administration of tramadol. The documented pain scores range from zero to eight out of ten. The first documentation of a score higher than zero was on 2/14/25 at the 5PM dose when R1 rated the pain a five out of ten. There is an order to monitor and record pain score every shift. The ordered was discontinued on 2/8/25 when R1 went to the hospital and was not reordered again until 2/26/25. From 2/11/25 through 2/21/25, pain scores were not being assessed and recorded every shift for R1. An order for ibuprofen 600mg every six hours as needed was placed on 2/17/25. The documentation shows R1 only received ibuprofen on 2/21/25 at 9:37AM. There is no pain scored documented with the administration of this medication.</p> <p>The Comprehensive Pain assessment dated [DATE] documents R1 denied any reports of pain. R1 did not verbally admit to having any pain and does not show any nonverbal signs of pain such as facial grimacing, restlessness, rubbing, or bracing. The facial pain scale documents the pain score at a zero out of ten.</p> <p>(continued on next page)</p>		

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F 0697  Level of Harm - Actual harm  Residents Affected - Few	<p>The Comprehensive Pain assessment dated [DATE] documents R1 reported pain to the left knee. R1 has generalized osteoarthritis which could be a reason for the pain. R1 has also had a decrease in physical activity. Pain is relieved by position change and mediation. R1 shows facial grimacing and vocalizes reports of pain. R1 described the pain as aching. The facial pain scale documents the pain hurts even more (four out of ten on the numerical pain scale). AN x-ray of the knee was ordered and an order for ibuprofen 600 mg every six hours as needed as put in by the nurse practitioner.</p> <p>The Comprehensive Pain assessment dated [DATE] documents R1 did not have any reports of pain. R1 did not verbally admit to having any pain and does not show any nonverbal signs of pain such as facial grimacing, restlessness, rubbing, or bracing. The facial pain scale documents the pain score at a zero out of ten.</p> <p>There is no documentation that a Comprehensive Pain Assessment was completed on 2/19/25 or 2/20/25.</p> <p>The Comprehensive Pain assessment dated [DATE] documents R1 reported pain to the left hip. R1 has generalized osteoarthritis which could be a reason for the pain. R1 was withdrawn from activities on this day and pain was increased with repositioning. Pain is relieved with medication. R1 shows facial grimacing, bracing, and vocal complaints to not touch the area that is painful. R1 described the area as aching and discomfort. The facial pain scale documents the pain hurts a whole lot. The numerical pain scale rate the pain a ten out of ten.</p> <p>The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as 11 (moderate cognitive impairment). Section GG of the MDS documents R1 uses a wheelchair for a mobility device. R1 needs partial to moderate assistance with bed mobility and substantial to maximal assistance with transfers. R1 is able to self propel in the wheelchair with supervision or touching assistance. Section J of the MDS documents R1 has not received any scheduled or as needed pain medication in the last five days and denied having any pain within the last five days.</p> <p>The Care Plan revised on 2/27/25 documents R1 is at risk for an alteration in comfort related to fracture of femur, arthritis, history of falls, and seizures. Interventions include: assess pain characteristics by duration, location, and quality; and monitor for non-verbal indicators of pain (moaning, crying, grimacing, wincing).</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The policy titled, Pain Management, dated 10/2024 documents, General: To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. Guideline: the pain management program is based on a facility wide commitment to resident comfort. Pain is defined as whatever. The experiencing person says it is and exists whenever he or she says it does. Pain Management is defined as the process of alleviating the residence pain to a level that is acceptable to the resident is based on his or her clinical condition and establish treatment goal. Pain management is a multidisciplinary care process that includes the following: observing for the potential for pain, effectively, recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of the residence pain, developing in implementing approaches to pain management, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions; and modifying approaches as necessary. It is important to recognize cognitive, cultural, familial, or gender specific influences on the resident's ability or willingness to verbalize pain .Policy: 1. Pain is assessed using the comprehensive pain assessment form: upon admission, quarterly, with significant change, following a fall, when new pain is identified, and when existing pain worsens. 2. Pain will be assessed at least once a every shift and documented in the EMAR using the pain scale appropriate for the patient. The following pain scales are available for use: numerical scale and PAINAND scale for the cognitively impaired .6. If pain has not been managed, consistent with the residence goals and needs, the interdisciplinary team may need to reconsider current interventions and revise those interventions as needed; or if pain has been maintained and/or resolved, the nursing staff will work with the physician to taper or discontinue analgesics.</p>		