| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355077 | A. BUILDING _____ B. WING _____ | C 02/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SMP HEALTH - ST RAPHAEL | 979 CENTRAL AVE N VALLEY CITY, ND 58072 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced on-site complaint investigation survey was completed on 02/16/24. During the complaint investigation, the facility was found noncompliant with the regulatory requirements. | F 000 | | |
| F 697 SS=G | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable level of well-being and to prevent and/or manage pain for 1 of 1 sampled resident (Resident #1) who experienced a fall with major injury. Failure to identify circumstances when pain could be anticipated and recognize when the resident experienced pain resulted in Resident #1 experiencing uncontrollable pain related to his untreated hip fracture.<br><br>Findings include:<br><br>Information provided by the complainant indicated facility staff failed to identify and respond to changes in the physical status of a resident who experienced uncontrollable pain from a hip fracture sustained during a fall. The | F 697 | F 697 Pain Management<br>1. Resident identified was transported to the hospital via ambulance when his pain increased and was noted to be unmanaged. Nurses working with resident were educated on pain management, documentation, and clinical assessment of residents. They were also re-educated on criteria that require physician notification.<br><br>2. The facility identified that all residents can be affected by this practice. All nursing staff have been re-educated on pain management and Care Planning (2/13/2024). New nurse orientation checklist information updated regarding pain management and how the information is provided to new staff; the updated "Nurse Cheat Sheet" was distributed to all nursing staff as a | 3/8/24 |

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

Electronically Signed | 03/08/2024

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| F 697 | Continued From page 1<br>complainant also indicated Emergency Medical Services (EMS) staff administered Fentanyl (a medication given for severe pain) during the ambulance ride to the hospital in an effort to alleviate the resident's pain.<br><br>Review of the facility policy titled "Pain Management" occurred on 02/16/24. This policy, revised December 2023, stated, ". . . Nurses will assess the resident's pain level . . . Nurse will complete the following: . . . Pain assessment, identifying the . . . factors which increase or decrease pain, nonverbal signs that indicate possible pain, and effect of pain on ADL's. . . "<br><br>Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, vascular dementia, psychotic disorder with delusions, osteoarthritis, repeated falls, and history of left lower leg and right femur fractures. The care plan, dated 12/16/23, identified, ". . . I transfer independently. I need supervision to get to desired locations. . . . Assist me to the bathroom routinely. . . . I take myself to the bathroom and am unable to remember to report having a BM [bowel movement] to staff. . . . ."<br><br>A progress note, dated 01/20/24 at 8:15 a.m., identified, ". . . On coming nurse was walking onto the unit and resident was laying on the floor . . . Resident is unable to tell nursing staff what happened. Evaluation was completed and resident was assisted to feet . . . vitals were obtained . . . 0/10 pain [0 pain on 10 point scale], POA [Power of Attorney] was notified . . . and provider was faxed. . . ." The resident experienced a second fall later in the day on | F 697 | reference guide (2/15/2024). All nursing staff were educated on emailing the team leaders after a fall so that they can be tracked and followed up on in a timelier manner and fall audit process updated to be fully reviewed during risk management every morning with nurse follow-up and further education of the specific nursing staff done at this time when needed (2/16/2024). All nursing staff have been re-educated on pain management and proper clinical assessment following a fall and change of status that requires physician notification (2/20/2024). Education on proper documentation in the clinical chart (2/15/2024 and 2/20/2024). All nursing staff have been re-educated regarding Fall policy and procedure and Pain management policy and procedure (2/20/2024). Pain management and Fall Prevention policy and procedure reviewed and revised (2/15/2024).<br><br>3. An audit tool has been developed to ensure all falls are reviewed and staff followed policy and procedures after fall. Audit tool will be completed by Director of Nursing or designee 2 X week for one month, 1 X a week for two months, 1 X week for 3 months and then quarterly for one year.<br>a. A summary of completed audits will be provided monthly to the quality assurance committee to confirm compliance and is maintained.<br>b. Falls will be reviewed daily in risk management and pain will be addressed weekly in IDT. | |

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| F 697 | Continued From page 2<br>01/20/24.<br><br>A post-fall huddle tool, dated 01/20/24, identified the following:<br>* Time of Fall 2:50 p.m.<br>* 2:50 p.m., ". . . laying on back . . . weakness - flu . . . bruise coccyx . . . on-call called - push fluids, monitor 4 [for] head injury, give prn [as needed] [medication] for pain for bruising . . . RLE [right lower extremity] pain . . ."<br>* 3:10 p.m., ". . . Pain 6/10 . . . RLE WNL [within normal limits] Pain . . ."<br><br>A progress note pertaining to the second fall identified the following:<br>* 01/20/24 at 4:32 p.m., ". . . Date/Time of Fall . . . 1-20-24 1350 [1:50 p.m.] [The time entered contradicts the entry the nurse made on the post-fall huddle tool.] Heard a loud noise, Resident found laying [sic] on back with head against the doorframe . . . Resident has been restless since falling this morning, continues to have flu-like symptoms. . . . Resident assisted up into wheelchair. Resident c/o [complained of] pain to right hip/pelvic area. On-Call provider notified by phone, due to resident hitting head, and being on anti-coagulants [blood thinners]. Provider also notified of increased weakness and pain related to fall. Provider instructed writer to administer PRN pain medication and monitor resident for s/s [signs/symptoms] of head injury. . . . [POA]-Phone call . . . [Physician] Faxed . . ."<br>* 01/21/24 at 2:33 a.m., ". . . bruising to tailbone area, pain in pelvic/hip area . . . yells when moved d/t [due to] pain in pelvic/hip area. Bruise noted to tailbone region. Gets very frustrated and angry when trying to help him when needing to change him . . ." | F 697 | | |

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| F 697 | Continued From page 3<br>* 01/21/24 at 2:50 a.m., ". . . frustrated and irritated when moved . . ."<br>* 01/21/24 at 5:26 a.m., ". . . Staff saying when staff moves him from side to side, he yells out in pain, when he is laying still on his bed or when he moves himself, he denies having any pain. . . ."<br>* 01/21/24 at 10:31 a.m., ". . . C/o pain but unable to express where. . . . Resident is still unable to stand without assistance of stand lift. . . . Resident does become agitated and aggressive when staff is assisting. . . ."<br>* 01/21/24 at 10:30 p.m., ". . . c/o pain to right pelvic/hip region . . . continues to c/o of pain to right pelvic/hip region when moving, ROM [range of motion] is limited d/t the pain to the RLE. yells out and gets upset with staff when he is moved . . ."<br>* 01/22/24 at 5:19 a.m., ". . . Reported from day [sic] staff, resident is agitated when being moved or assisted with cares. Resident is able to move RLE on own but ROM is limited when staff is helping him do this. Resident did not receive any pain medication PRN throughout the day. . . .<br>* 01/22/24 at 10:29 a.m., ". . . (R) [right] hip pain and pelvic pain after fall. . . . Pain has continued to worsen and unable to reposition due to pain. . . . updated [Physician's Assistant] when she was here on rounds on 1/20/24 [This date was entered in error.] and she gave orders to transfer to emergency room via ambulance. . . ."<br>* 01/22/24 at 10:59 a.m., ". . . Reason for Transfer . . . increased pain, edema and bruising right hip after fall . . ."<br>* 01/22/24 at 2:17 p.m., ". . . Resident presenting with uncontrollable pain with movement of LE [lower extremity]. Noted edema RLE from the hip to the knee. Resident unable to bear weight due | F 697 | | |

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| F 697 | Continued From page 4 | F 697 | | |

to increased pain. . . 9/10 pain limited ROM on RLE, increased pain with movement of LLE [left lower extremity]. . . ."
* 01/22/24 at 2:40 p.m., ". . . Right hip fx [fracture], admitted to [Hospital] for pain control until resident can be transferred to [another Hospital] for surgical repair. . . ."

Review of the eMAR [electronic medication administration record] showed Resident #1 received two doses of as-needed acetaminophen (a medication given for mild pain); the first dose on 01/20/24 at 3:21 p.m. and the second dose on 01/22/24 at 10:23 a.m. Follow-up documentation, dated 01/22/24 at 12:43 p.m., identified the as-needed acetaminophen "was ineffective . . . Pain Scale was: 9 [on 10 point scale]."

During an interview on 02/13/24 at 5:20 p.m., an administrative nurse (#1) acknowledged staff failed to identify/respond to Resident #1's verbal and nonverbal signs/symptoms of pain that were indicative of a possible hip fracture. The administrative nurse (#1) indicated staff felt these signs were related to his flu-like symptoms, weakened condition, and bruised tailbone.

Resident #1 experienced uncontrollable pain when facility staff failed to:
* Identify circumstances when pain could be anticipated: when Resident #1 was rolled side-to-side, repositioned, and/or bearing weight,
* Recognize when Resident #1 experienced pain: when Resident #1 denied being in pain while lying still, but was "frustrated, irritated, angry, agitated, aggressive and/or yelling out in pain" while being moved,
* Identify Resident #1's inability to perform ADLs:

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| F 697 | Continued From page 5<br>when Resident #1 showed limited ROM and his status changed from ambulating independently to requiring a stand-lift and/or being changed by staff, and<br>* Follow-up with the on-call provider regarding Resident #1's verbal/nonverbal signs/symptoms of pain that were indicative of a possible hip fracture versus waiting for the nurse practitioner to make her scheduled rounds. | F 697 | | |