STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A162	A. BUILDING _____ B. WING _____	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOME	512 ROCKWELL DRIVE OKOLONA, MS 38860

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey with a Complaint Investigation (CI MS#26480), at the facility from 9/30/24 through 10/3/24. During the survey the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA determined the facility was not in compliance with CI MS#26480 for resident's rights and cited F 550 and F 585. The SA also cited on the annual survey F640 for resident assessments and F656 for development of care plans. During the survey, the census at the facility was 68 with a license for 73 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		11/8/24

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

Electronically Signed | 10/22/2024

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident representative (RR) interview and facility policy review revealed the facility failed to ensure residents were treated with dignity and respect as evidence by staff members calling the residents by their last name only and failing to use a salutation for two (2) of 18 residents sampled during this survey. Resident #2 and Resident #39. Findings Include Record review of the facility policy review titled, "Promoting/Maintaining Resident Dignity" with a revision date of 10/2/23 revealed "Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each	F 550	On 10/2/2024 the administrator spoke with the caregivers of Resident #39 and Resident #2 which included two (2) nurses and eight (8) nursing assistants, about the need to address these residents with respect, as evidenced using a salutation of (Mr./Ms.) with his or her first or last name prior to engaging with either resident. On 10/10/24 social services contacted the spouse of Resident #39 and staff's use of a preferred name that is not indicated in this residents' medical record, with her stating that he is known by the community, friends and family by two other names and gave permission for use of these names. Resident #39's medical record and care-plan was updated on	

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F 550	Continued From page 2 resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality". Resident #2 A phone interview on 9/30/24 at 11:20 AM, with Resident #2's Resident Representative (RR) revealed he has complained numerous times to the Director of Nurses (DON) and Administrator regarding issues with his mother. He revealed he complained most recently about the way the aides call her by her last name only and do not use a salutation and they take personal phone calls while in her room, during times when they are changing and cleaning her. He stated that a week ago when he tried to file that complaint, the DON told him he was just hard to get along with and confirmed that he has never heard back from the facility regarding a resolution to any of his complaints. An interview on 10/02/24 at 8:56 AM, with Certified Nurse's Assistant (CNA) #1 confirmed that she does call some of the residents by their last name only and can see now how that might be disrespectful to the resident by not using a salutation. An interview on 10/2/24 at 3:00 PM, with the DON and the Administrator who confirmed they knew that some residents were called by their last names only and can see how that could appear as a dignity issue. The Administrator revealed the staff have been trained to address the residents as Mr. or Mrs. and she wasn't sure why they were doing this. Record review of Resident #2's "Admission	F 550	10/10/24 to include the agreed upon names per Interdisciplinary Team. Resident #2's representative had been informed that the staff member he referenced had been counseled with and that other staff members had been instructed to utilize salutations when engaging with his mom. Between 10/7/24 and 10/11/24, the social and activity directors conducted interviews with all sixty-eight (68) residents and/or resident representative if needed to identify accuracy of the resident(s) preferred name. It was identified that twenty-seven (27) of 68 residents wanted their preferred name reflective within their medical record. On 10/7/24 the Interdisciplinary Team (IDT) met to initiate a Performance Improvement Plan (PIP), which indicated the need for further education of all staff on the facility's Resident Rights policy regarding the need to provide dignity and respect when addressing a resident, along with where to locate the residents' name preference within the electronic health record. That A satisfaction survey should be developed and distributed to all residents or resident representative addressing their opinion with staff's performance in providing dignity and respect. Social services should be responsible for training of all new hires within 5 days of hire on the facility's policy on resident rights. The administrator initiated a mail-out of the satisfaction survey on 10/10/24 to 63 resident	

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F 550	Continued From page 3	F 550		

Record" revealed the resident was admitted to the facility on 2/10/23.

Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/19/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident was severely cognitively impaired.

Resident #39

During an observation on 9/30/24 at 2:30 PM, it was noted that Resident #39 was in his wheelchair sitting by a window in the dayroom and the resident had called out to CNA #1 for assistance. As CNA #1 was walking towards him, she stated, "You can't get no sugar, (resident's last name)". Then she turned and walked away shaking her head and said, "(resident's last name, resident's last name)."

An interview with CNA #1 on 10/2/24 at 9:00 AM, confirmed she called Resident #39 by his last name and acknowledged this could be seen as disrespectful since he had not told her that he preferred to be called by only his last name.

During an observation and interview on 10/2/24 at 9:30 AM, CNA #2 was observed to be in the dayroom with Resident #39 and said, "Hey (resident's last name)." During the interview, CNA #2 acknowledged she called him by only his last name and thought he preferred that name since that was what everyone called him and she was not sure if he liked being called that or not.

During an observation and attempted interview with Resident #39 on 10/2/24 at 1:55 PM, when

representatives, and five (5) self-representatives. A follow-up survey will be distributed by 04/30/2025 and repeated annually to help identify with any noncompliance in providing dignity and respect to all residents. The administrator and social services began in-servicing staff on resident's rights beginning 10/16/24 with 88% of staff attendance as of 10/21/24. All other staff will be in-serviced on resident rights by 11/8/24 or they cannot return to work till they have met this requirement. 10/18/24, the administrator ran a report reflective of thirty-six (36) residents scoring an eight (8) or above on their Brief Interview Mental Status received a satisfaction survey for completion. Beginning the week of 10/20/24, the social service director will be responsible to educate all new hires within 5 days of hire on resident rights with emphasis on honoring all name preferences with emphasis on including a salutation when greeting or engaging in care and will conduct annually an in-service to all staff on Resident Rights. Upon review by the Compliance Officer on 10/21/24, there were no negative findings found regarding the 27 residents that were identified with name preferences.

The Quality Assurance Nurse (QA) will be responsible for monitoring effectiveness of the Performance Improvement Plan (PIP) beginning 10/14/24 through the QAPI Program as outlined per review of all new admissions at least one day a week for eight (8) weeks to ensure any noted name preference has been added

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F 550	Continued From page 4 asked his name and what he preferred to be called, it sounded like he said his first and last name together to both questions. Resident was difficult to interview since he had a BIMS of 4 which indicated he had severe cognitive impairment. During an interview on 10/2/24 at 3:00 PM, the DON and the Administrator confirmed they were aware that some residents were called by their last names only and could see how that could appear as a being disrespectful. The Administrator revealed that the staff know they should call them Mr. or Mrs. The record review of Resident #39's "Admission Record" revealed the facility admitted the resident on 10/30/23. Record review of Resident #39's MDS with ARD of 9/20/24, revealed a Brief Interview for BIMS of 4 which indicated the resident had a severe cognitive impairment.	F 550	to the individuals care plan and interview staff regarding knowledge of preference. Social services will interview at least 15% of current residents weekly for 8 weeks beginning the week of 10/21/24 to ensure staff is utilizing name preferences as indicated per resident. The QA Nurse and the Administrator will review all returned surveys for any negative reviews regarding staff's performance with dignity and respect and apply any actions necessary for compliance. The Administrator will report any negative findings to the governing board (meets the 3rd. Monday of each calendar month), and the Quality Assurance Committee including the Medical Director as scheduled for the 3rd Wednesday of each month, after being held on Friday, October 18, 2024.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		11/8/24

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F 585	Continued From page 5 §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all	F 585		

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F 585	Continued From page 6	F 585		

information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance

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F 585	Continued From page 7 decision. This REQUIREMENT is not met as evidenced by: Based on resident representative (RR) and staff interview, record review and facility policy review the facility failed to ensure a resident representative's grievance was resolved for one (1) of 18 residents reviewed, Resident #2. Findings Include Record review of the facility policy titled, "Resident and Family Grievances" with a revision date of 10/1/23 revealed under, "Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Policy Explanation and Compliance Guidelines ...#12. The facility will make prompt efforts to resolve grievances". On 9/30/24 at 11:20 AM, during a phone interview with Resident #2's RR revealed he has complained numerous times to the Director of Nurses (DON) and Administrator regarding his mother. He revealed he complained most recently about the way the aides call her by her last name only and that they take personal phone calls in her room, while they are changing and cleaning her. He stated that a week ago when he tried to file that complaint, the DON told him he was just hard to get along with and confirmed that he has never heard back from the facility regarding a resolution to any of his complaints. An interview on 10/01/24 at 3:18 PM, with the DON and the Administrator confirmed that Resident #2's RR had made numerous complaints. The Administrator confirmed that	F 585	10/4/24 the administrator completed a written grievance form regarding the stated concern regarding the stated deficiency. Resident #2's responsible party was called on 10/9/24 and noted by the Social Service Director the actions taken by the facility for resolution of his noted concern, with responsible representative stating he was okay with the actions taken. Sixty-eight (68) of 68 residents could have been affected by the stated deficient practice. On 10/3/24 the administrator in-serviced the facility's grievance policy with eight (8) of twelve (12) department managers, with emphasis placed on utilizing a written form for record keeping, monitoring and tracking of grievances by the social service department and the administrator till resolution can be met. On 10/7/24, the Interdisciplinary Team (IDT), met to initiate a Performance Improvement Plan (PIP) outlining the need for further education of all staff regarding the facility's Resident and Family Grievance policy including reporting, investigating, notification of outcome and logging of grievance. As of 10/21/2024, there has been 88% of staff in-serviced on the grievance policy. All other staff will be in-serviced by 11/8/24 or will not be allowed to return to work until receipt of in-service. Upon receipt of a grievance, social services will be	

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F 585	Continued From page 8 they have never written any of his complaints up formally and included them on the grievance log. She stated that she usually just follows up and jots notes down and then calls him back. The DON stated we have not heard back from him, so we thought everything was ok. They both admitted that he came to the last care plan meeting a couple of weeks ago and complained about an aid cussing and talking loudly outside his mother's room. The Administrator confirmed she should have written these up so that they would have documentation of the grievances and what was done to resolve it and provided follow up back to the RR, but they had failed to do so. An interview on 10/02/24 at 2:53 PM, with Social Services confirmed she was aware that Resident #2's son had complained about stuff in the past. She stated that he always goes to either the DON or Administrator, but she had never been told to write it up as a formal grievance. Record review of the Grievance Summary Log for the past six (6) months revealed there was one grievance documented for Resident #2 and that was related to broken glasses and revealed no other grievances. Record review of Resident #2's "Admission Record" revealed the resident was admitted to the facility on 2/10/23. Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/19/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident was severely cognitively impaired.	F 585	responsible to share the information to the attention of other needed disciplines during the facility's morning stand up meeting scheduled Monday-Friday for assignment and follow up. The administrator will be responsible to follow up with the social service director and ensuring a written grievance form is on file. A satisfaction survey regarding the handling of grievances was mailed on 10/10/24 to assist in identifying any unknown issues. The social service director will be responsible to inform the resident council of the survey outcome at the next scheduled meeting 10/29/2024. The QAPI committee met on 10/16/24 and discussed the PIP regarding grievances and expectations of monitoring for written grievances and follow-up beginning the week of 10/21/24 and reviewed during the next scheduled QAPI meeting on 10/23/24 and weekly till 01/31/2025. The Quality Assurance Nurse will review grievance log at least 1 day a week for 3 months, beginning 10/17/24 till 01/31/2025 to ensure ongoing compliance with record keeping, logging of event and resolution. Any negative findings found will be reported to the administrator immediately for further action(s). This will be reviewed by the QAPI Committee on the third Wednesday of the month beginning 10/23/2024 thru 01/31/2025. The administrator will be responsible to inform the governing body of any negative findings during the monthly meeting	

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F 585	Continued From page 9	F 585	scheduled for the 3rd Monday of the month. The QA Nurse will be responsible to report any negative findings at the Quality Assurance Committee meeting scheduled the 3rd Wednesday of the month.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F 640		11/8/24

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F 640	Continued From page 10 (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to complete and transmit a discharge Minimum Data Set (MDS) Assessment for one (1) of 21 residents reviewed for MDS assessments. Resident #33 Findings include: A review of the facility policy titled Resident Assessment-RAI (Resident Assessment Instrument) with a revision date of 3/10/24 revealed, "This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by CMS." A record review of Resident #33's Admission Record revealed an admission date of 4/19/22	F 640	On 10/4/24 the MDS coordinator completed an assessment for Resident #33 with a corrected discharge date, resubmitted and it has been accepted per CMS guidelines. With all MDS data being shared with CMS, sixty-eight (68) of sixty-eight (68) residents could have been identified as being affected by the stated deficient practice. On 10/7/24 the administrator and director of nurses met with the MDS Coordinator to discuss the stated deficiency and corrective measures to be taken to ensure ongoing compliance with proper discharge date inputted onto the residents discharge assessment. Beginning 10/21/2024	

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F 640	Continued From page 11 and a discharge date of 5/2/24. A record review of the "Discharge Summary" revealed Resident #33 was discharged home on 5/2/24. During an interview on 10/02/24 at 2:45 PM, the MDS Coordinator confirmed that Resident #33 was admitted to the facility on 4/19/22 and discharged home on 5/2/24. She revealed that she had, in error, omitted entering and transmitting the discharge MDS assessment for the Assessment Reference Date (ARD) of 5/2/24, which resulted in the assessment being not completed and transmitted over 120 days late.	F 640	Minimum Data Set (MDS) Coordinator or Registered Nurse (RN) Supervisor will be responsible to provide an assessment history report to the director of nursing (DON) and administrator for review at least 5 days a week which will list assessments completed, submitted, accepted and transmitted. The DON and the administrator will ensure that any discharge assessment(s) completed have the correct discharge date entered prior to submission. The compliance officer completed an audit on 10/22/24 of coding of any resident discharge assessments for the period of 07/01/24-10/18/24 had been completed with the appropriate date of discharge with no negative findings identified. The Quality Assurance (QA) Nurse will review the same Assessment History Report at least 1 time a week for 12 weeks beginning 10/17/24 till January 31, 2025, to ensure that compliance has been met with discharge assessment(s) to be coded appropriately and submitted. The QA Committee will be informed of any negative findings during the monthly QA meetings typically scheduled for the 3rd Wednesday of each month. A QA meeting was held 10/18/24 with the medical director to discuss survey deficiencies and plan of correction. The Administrator will be responsible for notifying the facility's governing board of any negative findings during the scheduled board meeting for the 3rd Monday of each month.	

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F 656	Continued From page 12	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		11/8/24

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F 656	Continued From page 13 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews and facility policy review, the facility failed to develop a care plan for Resident #10 related to chronic pain for one (1) of 18 residents reviewed. Findings include: Record review of facility policy titled, "Comprehensive Care Plans" with revision date of 3/10/23, revealed, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." The policy also revealed, "3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being," During an interview on 9/30/24 at 10:50 AM, Resident #10 stated that she has swelling in her left leg and at times it caused her to have pain in this leg.	F 656	Resident #10's care plan was updated on 10/2/24 by the MDS Coordinator to include a pain management intervention. Upon review of 68 residents electronic health record by the MDS coordinator on 10/07/2024 it was identified that there were fifty-nine (59) residents that could have been affected by the stated deficient practice. On 10/7/24 the interdisciplinary team (IDT) met to initiate a performance improvement plan (PIP) regarding pain management and the need to update care plans accordingly. Upon review of 68 medical records, it was determined that fifty-nine (59) residents needed having their person-centered care plan updated to include pain management for the use of prn medications. The fifty-nine (59) care plans were reviewed and updated as needed between 10/07/2024-10/15/2024. Beginning 10/14/2024 the DON and Nurse Supervisor will review physician orders at least 5 times a week for 12 weeks ending December 31, 2024, for any new or changed pain medication to ensure that	

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F 656	Continued From page 14 Record review of Resident #10's "Care Plan" revealed no care plan for pain was developed for this resident who had a diagnosis of Chronic Pain Syndrome. An interview with Registered Nurse (RN) #1 on 9/30/24 at 10:55 AM, revealed the resident had swelling in her leg which caused pain. She stated Resident #10 received scheduled Tylenol and a fluid pill as needed (PRN) for the swelling. During an interview on 10/1/24 at 2:00 PM, the RN Supervisor revealed the resident has pain in her foot and leg occasionally which improved when elevated. She stated she received Tylenol two times a day which generally controlled her pain and also has an order for a cream to use as needed. An interview with the Minimum Data Set (MDS) Coordinator on 10/2/24 at 9:40 AM, revealed she was the person responsible for the development of care plans which provided the staff the information of the needed care and preferences of each resident. She confirmed the resident had a diagnosis of chronic pain syndrome and was receiving a scheduled analgesic medication for her pain and confirmed she failed to develop a care plan for this resident's pain. During an interview on 10/2/24 at 2:00 PM, the Director of Nursing (DON) acknowledged Resident #10 had a diagnosis of chronic pain syndrome and received a scheduled analgesic medication two times each day. She confirmed a care plan for pain was needed to inform the staff of care that was desired and needed and since this resident had pain, a pain care plan should	F 656	the individual resident has a pain management care plan. A review of care plans for sixty-eight residents was completed by the compliance officer on 10/16/24 to ensure compliance for a care plan offering intervention of pain for sixty-six (66) of sixty-eight residents. It was found that two residents were not in need of any type of pain medication. The administrator did an in-service/teachable moment on 10/07/2024 with the MDS nurse, DON and Nurse Supervisor on the necessity of identifying the need for and completing a care plan accurately and timely in regard to pain. The Quality Assurance (QA) Nurse will review same physician order listings at least 1 time a week for 12 weeks beginning 10/21/2024 until 01/31/2025 regarding pain management to ensure that this action is being addressed in the individual care plan. The QA Committee will begin monitoring 10/16/2024 and will monitor weekly for 12 weeks until 01/31/2025. The QA Nurse is responsible to report any negative findings to the administrator immediately for further actions to be taken. The administrator will report any negative findings to the governing board during the monthly meeting scheduled the 3rd Monday of each month. The QA Nurse will report to the QA committee and the medical director any negative findings during the normal scheduled meetings for the 3rd Wednesday of each month.	

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F 656	Continued From page 15	F 656		

have been developed and confirmed that the facility had failed to do this.

Record review of Resident #10's "Order Summary Report" revealed an order for Biofreeze External Gel 4% to apply to hands topically every four hours as needed for arthritis pain, Diclofenac Sodium External Gel 1% to apply to affected areas topically every 12 hours as needed for pain related to arthropathy, Tylenol Extra Strength 500 mg - give one tablet two times a day related to chronic pain syndrome and Tylenol 325 mg give 2 tablets every four (4) hours as needed for pain/discomfort.

Record review of Resident #10's "Admission Record" revealed the facility admitted her on 5/10/24 with diagnoses that included Erosive Osteoarthritis, Arthropathy, and Chronic Pain Syndrome.

Record review of Resident #10's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.