STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255110	A. BUILDING _____ B. WING _____	C 01/30/2025

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MS CARE CENTER OF ALCORN COUNTY, INC-SNF	3701 JOANNE DRIVE CORINTH, MS 38834

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Re-Certification Survey along with one (1) Complaint Investigation (CI MS # 27465), at the facility from 1/28/25 through 1/30/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F600, F609, F656, F697 for CI MS #27465 related to Abuse and Neglect, failure to implement a care plan, failure to notify the SA of an allegation of abuse and failure to monitor pain. The SA also cited F565, F584, F644, F656, F699, and F812 on the annual recertification survey. The census at the time of the survey was 90 and the facility is licensed for 119 beds.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		2/24/25

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

Electronically Signed | 02/19/2025

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F 600	Continued From page 1 Based on record reviews, staff interviews and facility policy review, the facility failed to ensure a resident's right to be free from abuse and neglect as required for one (1) of 20 residents reviewed. Resident A. Cross Reference F609, F656, F697 Findings Include: Review of facility policy " Freedom from Abuse, Neglect and Exploitation" revised October 2022 revealed "Policy Statement: All residents of this facility have the right to be free from neglect...Residents must not be subject to abuse by anyone...Practices of omitting part of resident care or neglecting resident and misappropriation of property is to be considered as leading to abuse and should be investigated and treated as abuse." A record review of the "Grievance/Complaint Report" documented by Social Services on 10/22/24 revealed that Resident A reported that staff was rude to him and refused to give him his medications, stating it was "bad for him" and that he "did not need it." He further reported that staff threw his call light on the floor, refused to assist him onto the bedside commode, and that he was scared. A record review of the "Record of Complaint" documented by the Director of Nursing (DON) on 10/21/24 indicated that Resident A's responsible party stated that the night shift nurse was rude and hateful. The resident expressed a desire to discharge home, stating he felt unsafe and was not receiving proper care at night. The investigation found that the resident's pain was	F 600	1. Resident A was assessed for pain by the medication nurse, Licensed Practical Nurse with a pain score of "2" on 10/21/24 at 9:58 am. Licensed Practical Nurse #3 was terminated on 10/23/24 at 10:00 am by Director of Nursing for improper conduct after investigation. License Practical Nurse #3 was not allowed to work in facility during investigation. Abuse report for resident A was submitted untimely to the State Agency by the Administrator on 1/30/25 at 2:57 p.m. Was reported to the Mississippi Attorney General on 1/30/25 at 3:13 p.m. by the Administrator, and reported to the MS Board of Nursing on 1/30/25 by the Director of Nursing 2. All residents who receive pain medication and has a less than adequate nurse have the potential to be affected by this situation. 3. a. All nurse staff were in-service on 2/11/25 on Pain Assessment and Management Policy by Staff Development Nurse. b. Attorney General investigator in-service all staff on 2/16/25 on Abuse. c. Resident's Right Policy was reviewed by Administrator on 2/18/25 and no revisions were necessary. d. All staff was inserviced on What is Abuse (Hand-in-Hand) Module 2 on 2/6/25 by Staff Development Nurse e. Employee Questionaire Related to Recent Survey Corrections is being done for 9 employees per day beginning on 2/14/25 and then weekly X1 month to	

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F 600	Continued From page 2 left untreated, and staff interviews revealed examples of misconduct toward resident by the nurse. The immediate corrective actions at the time of the incident included the termination of the night shift nurse, relocating the resident to a different hall per his request, and in-servicing staff on professional conduct, abuse, and neglect. A record review of the "Witness Statement" documented by the Physical Therapy Assistant (PTA) on 10/21/24 revealed that Resident A stated he wanted to leave the facility. The resident became emotional and expressed fear, stating he had no defense and could not protect himself. He also reported that no one answered his call light, that staff threw it on the floor, and when he asked for it back, they refused, telling him he did not need it. During an interview with the PTA on 1/29/25 at 9:25 AM, she confirmed that her statement accurately reflected what Resident A had reported to her on 10/21/24. A record review of a "Witness Statement" documented by Licensed Practical Nurse (LPN) #2 on 10/22/24 revealed that she heard LPN #3 yelling, "Shut up!" down the hall on 10/19/24 while Resident A was calling for help. She also stated that LPN #3 said she was not going to give Resident A anything for pain because he could not have a bowel movement. During an interview and record review of the "Grievance/Complaint Report," "Record of Complaint," and "Witness Statements" on 1/29/25 at 9:28 AM, the Social Services/Grievance Official agreed that Resident A's complaint constituted an allegation of abuse and neglect.	F 600	ensure nursing staff knows what to do if a resident complains of pain by Director of Nursing and reported to Quality Assurance. Exhibit #3 4.a. All residents with pain will have Comprehensive Care Plan for Pain Audit performed to ensure they are currently receiving their pain med timely when requested. Comprehensive Care Plan for Pain Audit will be done on 15 residents by chart audit and verbal resident interviews beginning on 2/14/25 then weekly X 2 weeks, then monthly X 2 months, then quarterly by Director of Nursing and submitted to Quality Assurance committee. Exhibit #7 b. The Quality Assessment and Assurance Committee will meet on 2/21/25 then monthly X 3 months to review findings and make recommendations and changes as needed to ensure continued compliance.	

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F 600	Continued From page 3	F 600		

In an interview with the DON on 1/29/25 at 10:05 AM, she stated that when she arrived at work on 10/21/24, she was reviewing nursing notes and found documentation by LPN #3 that Resident A had yelled that he had requested pain medication over an hour ago. The DON further stated that, while in the Assistant Director of Nursing's (ADON) office, the resident's son reported that the previous evening, the resident had requested pain medication, but the nurse told him he did not need it due to stomach issues. The DON later spoke with the resident in the therapy department, where he confirmed he had not received his pain medication the previous night and expressed fear of LPN #3 due to her loud and rude behavior. The DON stated that during her investigation, she received reports from LPN #2 that LPN #3 had been loud and cursing in the hallway. When she interviewed LPN #3, the nurse admitted to withholding the pain medication because the resident was constipated. The DON informed her that this was not a valid reason to deny medication. The nurse was subsequently terminated. However, the DON stated she could not substantiate the allegations that staff had taken or ignored the resident's call light and that after review of the camera footage at that time you could see a CNA going in and answering his call light that night. The DON agreed that this incident was an allegation of abuse and neglect.

In an interview at 10:12 AM on 1/29/25 with the Administrator he confirmed that the "Grievance Investigation" was an allegation of abuse.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/24 revealed that Resident A had a Brief

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F 600	Continued From page 4 Interview for Mental Status (BIMS) score of 15, indicating that he was cognitively intact. A record review of the Admission Record revealed that Resident A was admitted to the facility on 10/1/24 with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24.	F 600		
F 609 SS=G	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		2/24/25

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F 609	Continued From page 5 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to identify and report an allegation of abuse and neglect to the proper authorities within prescribed timeframes as required for one (1) of 20 residents reviewed. Resident A. Cross reference F600, F656, F697 Findings Included: Review of facility policy " Freedom from Abuse, Neglect and Exploitation" revised October 2022 revealed "Policy Statement:..Practices of omitting part of resident care or neglecting resident and misappropriation of property is to be considered as leading to abuse and should be investigated and treated as abuse...5. The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse ...are reported immediately to the supervisor, and the administrator of the facility, or other officials, such as the State Board of Health and the Office of the Attorney General ... A review of the "Record of Complaint" documented by the Director of Nursing (DON) on 10/21/24 indicated that Resident A's responsible party (RP) stated that the night shift nurse was rude and hateful. The resident expressed a desire to discharge home, stating he felt unsafe and was not receiving proper care at night. The investigation found that the resident's pain was left untreated, and staff interviews revealed	F 609	1. The Administrator was in-serviced on 2/17/25 by Corporate Field Manager on the Proper Reporting Identifying Reporting Allegations of Abuse and Neglect to proper authorities within required time frames. 2. All residents who receive pain medication have the potential to be affected. 3. a. An in-service on Reporting of Alleged Violations Policy, Guidance to Surveyors and Critical Pathways for F600, F609 was conducted on 2/17/25 by the Field Manager with the Administrator. Administrator stated understanding. 4. a. The Administrator will report five incidents a week beginning on 2/18/25 for six weeks for review by the Field Manager using the Reporting Alleged Violations Form. Exhibit #8 b.Field Manager will inform Quality Assurance Committee with any concerns. The Quality Assessment and Assurance Committee will meet on 2/21/25 then monthly for 3 months to review findings and make recommendations and changes as needed to ensure continued compliance.	

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F 609	Continued From page 6	F 609		

examples of misconduct toward resident. The immediate actions included the termination of the night shift nurse, relocating the resident to a different hall per his request, and in-servicing staff on professional conduct, abuse, and neglect.

A record review of the "Grievance/Complaint Report" documented by Social Services on 10/22/24 revealed that Resident A reported staff was rude to him and refused to give him his medications, stating it was "bad for him" and that he "did not need it." He further reported that staff threw his call light on the floor, refused to assist him onto the bedside commode, and that he was scared.

Record review of the "Witness Statement" documented by the Physical Therapy Assistant (PTA) on 10/21/24 revealed that Resident A stated he wanted to leave the facility. The resident became emotional and expressed fear, stating he had no defense and could not protect himself. He also reported that no one answered his call light, that staff threw it on the floor, and when he asked for it back, they refused, telling him he did not need it.

Record review of a "Witness Statement" documented by Licensed Practical Nurse (LPN) #2 on 10/22/24 revealed that she heard LPN #3 yelling, "Shut up!" down the hall on 10/19/24 while Resident A was calling for help. She also stated that LPN #3 said she was not going to give Resident A anything for pain because he could not have a bowel movement.

On 1/29/25 at 9:28 AM, during an interview with the Social Services/Grievance Official, she agreed that Resident A's complaint constituted an

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F 609	Continued From page 7 allegation of abuse and neglect and confirmed that it had not been reported to the State Agency. At 10:10 AM on 1/29/25, the DON confirmed that this incident was an allegation of abuse and acknowledged that it had not been reported to the State Agency because she had not identified it as such at the time. At 10:12 AM on 1/29/25, the Administrator confirmed that it constituted an allegation of abuse and neglect and should have been reported to the State Agency and stated that he typically reports all such allegations but did not recall being aware of this specific incident. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/24 revealed that Resident A had a Brief Interview for Mental Status (BIMS) score of 15, indicating that he was cognitively intact. A record review of the Admission Record revealed that Resident A was admitted to the facility on 10/1/24 with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24.	F 609		
F 656 SS=G	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	F 656		2/24/25

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F 656	Continued From page 8	F 656		

§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 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-

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F 656	Continued From page 9 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to implement pain management care plan interventions and failed to develop a care plan with individualized interventions to include triggers for Post Traumatic Stress Disorder (PTSD) for two (2) of 20 sampled resident care plans reviewed. Resident A and Resident #64. Findings include: Record review of the facility policy "Pain Management" revealed, "Policy: The facility will 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." A record review of Resident A's Care Plan revealed, "Focus: Risk for altered comfort related to benign hypertrophy of the prostate (BHP) and pain related to fractures, with interventions including: " ...Administer pain medication as needed ..." A record review of the "Grievance/Complaint Report" documented by Social Services/Grievance Official on 10/22/24 revealed that Resident A reported staff refused to administer his pain medication. The investigation findings noted: "Resident pain left unattended." A record review of "Progress Notes" for Resident A, dated 10/21/24 at 1:39 AM, revealed that the resident yelled out, stating, "I asked for my	F 656	1. Resident A was discharged home after completing therapy on 10/26/24 and Resident #64 care plan was reviewed on 1/30/25 by the MDS Nurse. with revisions made to include residents triggers. 2. All residents with care plans for mental illness and with orders for pain meds have the potential to be affected. 3. a. All interdisciplinary care plan team members responsible for writing care plans were in-service on 2/13/25 by the Director of Nursing on the facility's Policy and Procedure for Developing Appropriate Care Plans for Pain and Post Traumatic Stress Disorder (PTSD). 4. a. Care plans will be reviewed for pain by the Director of Nursing using the Comprehensive Care Plan for Pain Audit form by chart review and resident interviews beginning on 2/14/25 then weekly x4, then monthly x4, then quarterly x3. Post Traumatic Stress Disorder (PTSD) triggers will be audited using the Post Traumatic Stress Disorder(PTSD) Audit form by Social Services beginning 2/14/25, then weekly x4, then monthly x4, then quartlery x3 and given to Quality Assurance Committe monthly. Exhibit #7 and #11. b. The Quality Assessment and Assurance Committee will meet on 02/21/25 and them monthly X3 to review	

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F 656	Continued From page 10 medicine an hour ago. Do you just not have any help?" A record review of the Medication Administration Record (MAR) revealed that Resident A had an active order for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligrams), with instructions to administer one (1) tablet orally every six (6) hours as needed for pain. Further review of the MAR revealed that on 10/20/24, Resident A received a dose of pain medication at 1:34 PM. However, there was no documentation that the resident received any additional pain medication until 9:58 AM on 10/21/24. In an interview with the Director of Nursing (DON) on 1/29/25 at 10:05 AM, she stated that when she arrived at work on 10/21/24, Resident A's son voiced concerns that the nurse did not give his father any pain medication last night. The DON stated that she interviewed Licensed Practical Nurse (LPN) #3 regarding not administering pain medications to the resident and the nurse stated that she withheld the pain medication because the resident was constipated. On 1/30/25 at 9:41 AM, during an interview with the Minimum Data Set (MDS) Coordinator and the MDS LPN, they stated that the purpose of the care plan is to guide staff in providing appropriate care for the resident. The MDS Nurses confirmed that the nurse failed to follow the care plan when she did not administer pain medication as needed and that were requested by the resident. They further explained that the potential negative outcomes of untreated pain include unrelieved pain, increased anxiety, and difficulty participating in therapy and Activities of Daily Living (ADLs).	F 656	findings and make recommendations and changes as needed to ensure continued compliance.	

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F 656	Continued From page 11	F 656		

A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/24 revealed that Resident A had a Brief Interview for Mental Status (BIMS) score of 15, indicating that he was cognitively intact. The Pain Assessment Interview in section J documented that Resident A had experienced occasional pain over the past five (5) days, which limited his daily activities. He rated his pain as a five (5) on a numeric scale from zero (0) to ten (10), with zero (0) representing no pain and ten (10) representing the worst pain imaginable.

A record review of the Admission Record revealed that Resident A was admitted to the facility on 10/1/24 with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24.

Resident #64

Record review of facility policy titled, "Trauma-Informed Care" undated, revealed, "The general idea of trauma-informed care is to provide increased sensitivity to residents who have experienced trauma. Educating staff on how to interact with residents in an effort to limit triggering events and provide sensitive psychosocial interventions. A Care Plan for a resident who has experienced requires the same structure as all resident care plans - there is an identified problem, a goal and interventions. The problems must be measurable and time-based. Broad generalizations are insufficient. ... Goal: ... Resident will describe any triggers or stresses

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related to traumatic events and how they cope with it." The policy also revealed, "Person centered care plan is the key to Trauma Informed Care, Resident Centered Care mandates include: address training needs of staff to improve knowledge and sensitivity; identify an individual's hope, capacities, interests, preferences, needs, and abilities; the individual is the expert of his/her life; practice is a collaborative process; individual choice is evident; resident's voice is used in treatment plans - goals are in his/her own words; strength based, recovery-oriented principles; assess for traumatic histories and symptoms; recognition of culture and practices that are re-traumatizing".

Record review of Resident #64's Care Plan, date initiated 10/10/24, revealed, "Focus: Psychiatric diagnosis related to post traumatic stress disorder", but the care plan did not include specific triggers that the resident experienced due to his diagnosis.

During an interview on 1/28/25 at 11:55 AM, Resident #64 revealed he was in the Vietnam War, and he suffered from Post Traumatic Stress Disorder (PTSD) from his military service. He stated he was left for dead and the two soldiers with him were killed and it was a miracle he survived. He said that during that event, he was praying for God to keep him still so they would think he was dead and then he talked about how his mother prayed constantly for him to safely return home. He believed that God gave him the strength not to move even though he was getting kicked and beaten. He acknowledged he had triggers such as loud thunder or a loud noise from something being dropped, and when he heard these things, "I almost hit the floor". While he

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was talking about his experience, he became teary eyed and cried softly.

During an interview on 1/29/25 at 4:15 PM, the Director of Nursing (DON) revealed the resident had a diagnosis of PTSD and a care plan was developed for this. She stated a care plan should guide staff in the individualized care of each resident. She confirmed a PTSD assessment was not done, and triggers were not identified, therefore, the care plan did not give staff information needed for the triggers that affected this resident's mental health status.

An interview with Registered Nurse (RN) MDS Coordinator on 1/30/25 at 9:30 AM, revealed she was responsible for developing and updating care plans to provide the staff with a guide for the resident's care. She stated that since the resident was not assessed for his PTSD needs and triggers, the care plan did not contain these items. She stated for a resident with PTSD, the staff should be aware of triggers that could cause the resident to have increased anxiety and they needed to be included in the care plan. She confirmed the facility failed to individualize a care plan by including triggers for a resident with PTSD.

Record review of Resident #64's "Admission Record" revealed the facility admitted the resident on 7/15/22. Diagnoses included PTSD.

Record review of the MDS Section C dated 1/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #64 was cognitively intact.

Record review of Resident #64's admission MDS

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F 656	Continued From page 14 Section I dated 7/21/22 and the most recent quarterly assessment dated 1/7/25 revealed a diagnosis of PTSD.	F 656		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. 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. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and facility policy reviews, the facility failed to ensure that a resident received pain medication as ordered by the physician for one (1) of one (1) resident reviewed for pain management. Resident A. Cross reference F600, F656, F609 Findings include: Record review of the facility policy "Pain Management" dated September 2022 revealed, "Policy: The facility will 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." A record review of the Admission Record revealed that Resident A was admitted to the facility on 10/1/24 with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture	F 697	1. Resident A was assessed for pain on 10/21/24 by the day shift medication nurse, and resident was medicated for a pain score of "2" at 9:58 a.m. and pain was relieved. 2. All residents who receive pain medication and has a less than adequate nurse have the potential to be affected by this situation. 3. a. All licensed nursing staff has been in-serviced on 2/11/25 by Staff Development Nurse on the facility□s Pain Management. b. Employee Questionaire Related to Recent Survey Corrections is being done for 9 employees per day X1 week, then weekly X1 month to ensure nursing staff knows what to do if a resident complains of pain and the Director of Nursing will report results to Quality Assurance. Exhibit #3	2/24/25

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F 697	Continued From page 15 of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24. A record review of the "Grievance/Complaint Report" documented by Social Services/Grievance Official on 10/22/24 revealed that Resident A reported staff refused to administer his pain medication. The investigation findings noted, "resident pain left unattended." A record review of "Progress Notes" for Resident A, dated 10/21/24 at 1:39 AM, revealed that the resident yelled out, stating, "I asked for my medicine an hour ago. Do you just not have any help?" A record review of the Medication Administration Record (MAR) revealed that Resident A had an active order for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligrams), with instructions to administer one (1) tablet orally every six (6) hours as needed for pain. Further review of the MAR revealed that on 10/20/24, Resident A received a dose of pain medication at 1:34 PM. However, there was no documentation that the resident received any additional pain medication until 9:58 AM on 10/21/24. Record review of the Pain Assessment Interview dated 10/01/24 in "Section J" documented that Resident A had experienced occasional pain over the past five (5) days, which limited his daily activities. He rated his pain as a five (5) on a numeric scale from zero (0) to 10, with zero (0) representing no pain and 10 representing the worst pain imaginable.	F 697	4. a. The Director of Nursing will complete Comprehensive Care Plan Pain Audit on 15 residents with chart audits and resident interviews to ensure appropriate administration of pain med. Audit will be done weekly X 2 weeks, monthly for 2 months then quarterly. Director of Nursing will report to Quality Assurance Committee. Exhibit #7 The Quality Assurance Committee will meet 2/21/25 then monthly x3 to review findings and make recommendations and changes as needed to ensure continued compliance.	

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A record review of a "Witness Statement" dated 10/22/24 revealed that Licensed Practical Nurse (LPN) #2 reported hearing LPN #3 state that she was not giving Resident A pain medication because he could not have a bowel movement.

On 1/29/25 at 10:05 AM, an interview with the Director of Nursing (DON) she stated that when she arrived at work on 10/21/24, she was reviewing nursing notes and saw the documentation by LPN #3 regarding Resident A's request for medication. While reviewing this information, Resident A's son approached her and reported that his father had requested pain medication the previous evening, but the nurse told him he did not need it due to stomach issues. Later, in the therapy department, Resident A confirmed to the DON that he had not received his pain medication the previous night. Upon interviewing LPN #3 regarding not administering requested pain medication, the nurse stated that she withheld the pain medication because the resident was constipated. The DON stated that she informed the nurse that this was not a valid reason to withhold pain medication, and that the medication should have been administered as ordered by the physician. The DON agreed that the resident's pain was left untreated throughout that night.

During an interview with the Minimum Data Set (MDS) Coordinator on 1/30/25 at 9:41 AM, she stated that failure to administer pain medication as prescribed could lead to unrelieved pain, anxiety, and difficulty participating in therapy and Activities of Daily Living (ADLs).

A record review of the MDS with an Assessment Reference Date (ARD) of 10/22/24 revealed that

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F 697	Continued From page 17 Resident A had a Brief Interview for Mental Status (BIMS) score of 15, indicating that he was cognitively intact.	F 697		