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	255096	A. BUILDING _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISVILLE HEALTHCARE LLC	543 EAST MAIN STREET LOUISVILLE, MS 39339

(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 Re-certification survey with one (1) Complaint Investigation (CI MS#28410) at the facility from 4/14/25 through 4/16/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F558, F584, F656, F677, and F697. The SA investigated CI MS#28410 related to abuse and determined the facility was in compliance and no deficiencies were cited related to the complaint investigation. The census at the time of the survey was 54 and the facility is licensed for 60 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure that resident call lights were within reach, which limited residents' ability to request assistance as needed for two (2) of 54 residents observed. Resident #1 and Resident #47 Findings include: Review of the facility policy titled "Call Lights: Accessibility and Timely Response" dated	F 558	F558 Louisville Healthcare acknowledges receipt of the statement of deficiencies and propose this plan of correction as required by federal and state regulations and statues applicable to long term care providers. This plan does to constitute an admission of liability on the part of the facility, and such liability hereby specifically denies. The submission of this plan does not constitute an agreement by the facility that the	5/8/25

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

Electronically Signed | 04/29/2025

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F 558	Continued From page 1 8/12/2019 revealed, "The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance." ... 5. "Staff will ensure the call light is within reach of resident and secured, as needed." ...6. "The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room." Resident #1 An interview and observation in Resident #1's room on 4/14/25 at 10:35 AM revealed the door was closed. The resident was lying in bed and stated, "I want to get up," and revealed that she had told the staff. The call light was observed unreachable, and the button was clipped to the upper portion of the cord coming from the wall unit with a silver clip. An interview with Registered Nurse (RN) #1 on 4/14/25 at 10:42 AM confirmed Resident #1's call light was inaccessible. She revealed the call lights should always be in reach of the residents in case they needed somebody or were distressed. She revealed that without the call light, the resident could not call to get help. An interview with the Director of Nursing (DON) on 4/14/25 at 12:15 PM confirmed the call lights should be accessible to the residents. She revealed the charge nurse was responsible for making daily rounds and ensuring the call lights were in reach. She revealed she also made rounds once or twice weekly and had checked for this. The DON revealed that without the call light, the resident could not alert the staff of the need for assistance.	F 558	surveyors findings or conclusions are accurate, that the findings constitute a deficiency or the scope of severity regarding any of the deficiencies cited are correctly applied. Resident #1 and resident #47 call lights were placed within reach on 04/14/2025. Audit of all resident call lights was conducted on 04/14/2025 with all other resident call lights found within reach. Residents who are dependent upon staff for activiites of daily living have the potential to be affected by this practice. An audit of all call lights using the Call-Light Audit Tool was conducted on 4/14/2025 by RN charge nurse to ensure all call lights were within reach. If the resident prefers elsewhere a care plan will be initiated. The Staff Development nurse in-serviced all nursing staff on the call light policy on 04/14/2025. Nursing staff will conduct audits every two (2) hours beginning 04/14/2025 to ensure all call lights are within reach using the Nurse call light audit x three (3) months. Findings of these observations will be presented to Quality Assurance on 05/07/2025 and monthly thereafter, for 3 months.	

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F 558	Continued From page 2	F 558		

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 11, which indicated Resident #1 was moderately cognitively impaired.

Record review of the "Admission Record" revealed the facility admitted Resident #1 on 2/20/09 with a medical diagnosis that included Unspecified Dementia.

Resident #47

An observation and interview on 4/14/25 at 10:30 AM, revealed Resident #47 lying in bed with his call light secured and hanging behind a positioning bar, rendering the call light out of reach. Resident #47 stated, "I can't reach my call light. It doesn't do any good when you can't push it if you need anything."

During an interview on 4/14/25 at 11:37 AM, RN #1 confirmed that she had noticed earlier that several call lights were not within reach of the residents. She revealed she went around to ensure all of them were put where the residents could reach them. RN #1 emphasized that the call light is in place to allow residents to request assistance for their needs.

In an interview on 4/14/25 at 11:55 AM, the DON revealed that it is the facility's expectation that all residents always have access to their call lights. She revealed the charge nurse was responsible for making rounds each shift to ensure call lights are accessible, and all staff must make sure the call light is within reach before exiting a resident's

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F 558	Continued From page 3 room. A review of Resident #47's Admission Record revealed he was admitted to the facility on 01/02/2024 with diagnoses that include a history of falling, Chronic Respiratory Failure, and Anxiety Disorder. Record review of the MDS with an ARD of 01/14/25 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident is cognitively intact.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		5/8/25

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F 584	Continued From page 4 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to provide a clean homelike environment for residents in four (4) of forty-eight rooms observed during the survey. Rooms 209, 210, 212, and 216. Findings include: Record review of the facility policy "Safe and Homelike Environment" revealed, "In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment..." Room #210 An observation on 4/14/25 at 10:45 AM and on 4/15/25 at 8:45 AM in the bathroom of Room #210 revealed a strong foul odor. An interview on 4/15/25 at 9:10 AM with the	F 584	F 584 Louisville Healthcare acknowledges receipt of the statement of deficiencies and propose this plan of correction as required by federal and state regulations and statues applicable to long term care providers. This plan does to constitute an admission of liability on the part of the facility, and such liability hereby specifically denies. The submission of this plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or the scope of severity regarding any of the deficiencies cited are correctly applied. Environmental Services deep cleaned bathroom floor and residents bedroom floor in Room 210 on 4/15/2025.	

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F 584	Continued From page 5 Housekeeping Supervisor revealed that they had a hard time keeping the urine smell out of the bathroom in Room #210. She revealed that they cleaned and mopped it once daily and within an hour of cleaning it, the smell was back. She explained that the residents were bad to urinate on the floor, and urine "ran out into the rooms." The Housekeeping Supervisor revealed that there were four men sharing that one bathroom and she thought that the urine was down underneath the tile. She confirmed the strong, foul smell and stated, "It's always like this." She agreed that the strong odor in the bathroom was not ideal and that she would not want to smell it in her home. An observation and interview on 4/15/25 at 9:18 AM with Licensed Practical Nurse (LPN) #1, revealed that the bathroom in Room #210 had a foul odor and stated, "It smells like urine in here." LPN #1 confirmed that with the strong, urine smell present, this was not a clean, homelike environment for the residents. An interview on 4/15/25 at 9:20 AM with the Administrator (ADM), revealed that the facility has had some issues in the past with a resident urinating in the air conditioner unit and with the urine odors in the bathroom in Room #210. She confirmed the foul odor in the bathroom in Room #210 and revealed that they might have to take the floor up and replace it to fix the issue. She agreed that the strong foul odor in the bathroom needed to be fixed to provide the residents with a clean homelike environment. Rooms #209, #212, #216 - Walls An observation on 4/14/25 at 11:05 AM in Room #209 revealed that the upper right corner of the	F 584	Environmental rounds were conducted by maintenance director on 04/15/2025 to check around all air conditioners and to check all rooms for holes in walls. Maintenance Director made repairs to hole around a/c on 4/15/2025. Holes in walls in rooms #209, 212, and 216 were repaired by maintenance director on 4/17/2025. All residents have the potential to be affected by this deficient practice. Environmental Services was in-serviced by administrator on 4/15/2025 on conducting every four hour audits of room 210 bathroom. Nursing staff in-serviced on 4/15/2025 by Director of Nursing on conducting every two hour toileting. All staff in-serviced on Homelike environment on 4/15/2025 by Administrator. Maintenance Director in-serviced on 4/15/2025 by Administrator to check around all a/c units after being installed. Nursing staff will conduct every two hour audits for toileting for resident in room #210 for three months. Environmental services will conduct audits on room 210 every 4 hours during hours of 7am to 7pm daily to ensure their is no foul odor smell x 3 months beginning 4/16/2025.. Administrator or Maintenance Director will audit 10 rooms daily, five days a week for home-like environment times three months beginning 4/16/2025. Results will be reported to Quality Assurance on 05/07/2025, and continue monthly times three months.	

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F 584	Continued From page 6	F 584		

air conditioner unit was pulled out from the wall and the ground outside the facility was visible. There was an opening measuring approximately one inch by one inch at the right upper corner of the air conditioner unit with daylight visible, and warm air felt entering the room from the outside. An observation also revealed a hole in the wall measuring approximately six inches by six inches above and to the left of the sink faucet in Room #209.

An observation on 4/14/25 at 2:55 PM in Room #212 revealed a hole in the wall to the left of the sink faucet which measured approximately seven inches by seven inches.

An observation on 4/14/25 at 3:00 PM in Room #216 revealed a hole in the wall above the sink faucet which measured approximately seven inches by seven inches.

An observation and interview on 4/15/25 at 9:25 AM with the ADM revealed the facility had contractors come in and replace the sink faucets, closets, and overbed tables in the resident rooms about a year ago. She revealed that the contractors removed the built-in soap dishes, and it left the holes in the walls. The ADM revealed that the contractors had started at one end of the building repairing the walls and never made it to that end of the building on 200 wing. She revealed that the contractors had not been back to the facility in a while. She acknowledged that there were holes in the walls in rooms #209, #212, and #216 and confirmed that they needed to follow up to get them fixed.

An observation and interview on 04/15/25 at 9:45 AM with the Maintenance Director confirmed the

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F 584	Continued From page 7 air conditioner unit in Room #209 was pulled away from the wall on the right upper corner with exposure to the outside. He revealed that leaving the air conditioner loose like that could allow bugs, dust, hot or cold air, and other unwanted pest or rodents to get into the facility from the outside.	F 584		
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 §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)-	F 656		5/8/25

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F 656	Continued From page 8 (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- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to implement a person-centered comprehensive care plan for a resident with chronic pain (Resident #39) and a resident dependent on staff for nail care (Resident # 22) for two (2) of 16 care plans reviewed. Resident #22 and #39 Findings Include: Review of the facility policy titled "Care Plans-Comprehensive" revealed under, "Policy Statement: An individual (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." Resident #22	F 656	F656 Louisville Healthcare acknowledges receipt of the statement of deficiencies and propose this plan of correction as required by federal and state regulations and statues applicable to long term care providers. This plan does to constitute an admission of liability on the part of the facility, and such liability hereby specifically denies. The submission of this plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or the scope of severity regarding any of the deficiencies cited are correctly applied. Care plans were reviewed on Resident #22 and Resident #39 by MDS nurse on 04/16/2025.	

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F 656	Continued From page 9 Record review of Resident #22's "Care Plan Report" revealed that he required assistance with his ADL's (Activities of Daily Living) related to confusion and cognitive impairment and had interventions initiated on 10/24/22 that included, "Nail care as needed or scheduled." An observation on 4/14/25 at 2:43 PM revealed Resident #22 sitting up in his wheelchair in the room and his fingernails on both hands were long. They were approximately one-half to three-fourths inch long and there was a brown substance underneath them. An observation and interview on 4/15/25 at 9:20 AM with Licensed Practical Nurse (LPN) #1, confirmed that Resident #22 had long, dirty fingernails and she revealed that they should have been taken care of. An interview on 4/15/25 at 2:50 PM with the Minimum Data Set (MDS) Coordinator revealed that they developed a patient specific personalized care plan, so the staff knew how to care for the individualized needs of the residents. She confirmed that Resident #22's ADL care plan which includes his nail care was not followed. Record review of Resident #22's "Admission Record" revealed an admission date of 10/17/22 and that he had diagnoses that included Unspecified Dementia, Age-Related Physical Debility, and Unspecified Depression..	F 656	Residents receiving oral medications have the potential to be affected. residents who are dependent on staff for nailcare have the potential to be affected. Inservice conducted to nursing staff on 04/15/2025 by Assistant Director of Nursing on ordering narcotics before they are out of the medication and if the doctor refuses to refill, they must notify the Administrator to ensure medications are being administered according to plan of care and nursing standards. Nursing Staff was in-serviced on 04/15/2025 by Assistant Director of Nursing on following policy for nailcare. Nailcare audit of all residents was conducted on 4/15/2025 by Infection Preventionist and Medical Records Nurse. Nursing staff in-serviced on 04/16/2025 by Assistant Director of Nursing on following care plans. Medical Records Nurse or Director of Nursing will review the narcotic book twice weekly on Mondays and Thursdays to check for sufficient quantity of medication times three months. Results of these audits will be reviewed in Quality Assurance monthly times three months. Nursing Staff will conduct twelve nailcare audits per day, five days a week to cover all residents times three months. Results of those audits will be reviewed at Quality Assurance on 05/07/2025, then monthly times three months.	

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F 656	Continued From page 10 Resident #39 Record review of the "Care Plan Report" for Resident #39 revealed under, "Focus: Resident has intermittent episodes of chronic pain ..." and listed under, "Goals: Resident will verbalize full relief from pain with interventions provided by staff ..." Also revealed under, "Interventions: Monitor for worsening pain symptoms and report to physician if indicated. Date initiated 4/3/25." An observation and interview on 4/14/25 at 2:48 PM with Resident #39 revealed she was sitting in a chair in her room and she stated that she was newly admitted to the facility and explained that she had been out of her "pain medication" (Lyrica) for almost a week. The resident revealed she came into the facility taking it for neuropathy pain for her lower legs and feet. She stated, "I cannot even walk due to the leg pain." The resident explained that she had Tylenol that she could take, but it was not effective for her nerve pain in her legs and feet. Record review of the "Pain Assessment" dated 4/08/25 revealed Resident #39 frequently experienced pain in the last 5 days with a pain intensity scale rated 7 on a scale of 1-10. An interview with Licensed Practical Nurse (LPN) #1 on 4/15/25 at 2:10 PM, while in the room with Resident #39, confirmed that the resident was currently reporting pain in her feet and legs and rated the pain 8 on a scale from 1 to 10 with 10 being the worst pain. The resident stated, "It hurts to even touch my feet and to stand." She revealed that Lyrica helped with her nerve pain and explained that without the medication, the pain was constant and intense with the faintest	F 656	Daily audits of Resident's every shift pain scales by Director of Nursing and Medical Records nurse times three months. Results of those audits will be reviewed at Quality Assurance on 05/07/2025, then monthly times three months.	

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F 656	Continued From page 11 touch. An interview with the MDS Nurse on 4/16/25 at 10:29 AM revealed the purpose of the care plan was to develop a plan of care for the direct care staff to follow so they can provide the best care needed. She then confirmed that the pain care plan was not followed because the staff had failed to administer medications to relieve the resident's pain. An interview with the Physical Therapy Assistant (PTA) on 4/16/25 at 8:55 AM revealed occupational therapy (OT), and she had been working with Resident #39 to build strength and endurance, but that they had to modify her therapy because she was in pain during therapy sessions. Record review of the "Order Listing" for Resident #39 revealed an order dated 4/02/25, "Lyrica (nerve pain) Oral Capsule 200 MG (milligrams) (Pregabalin) Give 1 (one) capsule by mouth three times a day related to other chronic pain," with a discontinued date of 4/10/25. Record review of the "Admission Record" revealed the facility admitted Resident #39 on 4/02/25 with medical diagnoses that include Chronic Pain, Anxiety Disorder, Peripheral Vascular Disease and Type 2 Diabetes Mellitus. Record review of the MDS with an Assessment Reference Date (ARD) of 4/08/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #39 was cognitively intact.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		5/8/25

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F 677	Continued From page 12 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to provide nail care for one (1) of sixteen sampled residents reviewed. Resident #22. Findings Include: Record review of the facility policy, "ADL (Activities of Daily Living) Care Policy" revealed "It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents to ensure all ADL needs are met on a daily basis..." On 4/14/25 at 2:43 PM an observation revealed Resident #22 sitting up in his wheelchair in the room and his fingernails on both hands were long and approximately one-half to three-fourths inch past his fingertips. There was a brown substance underneath each of them. An observation and interview on 4/15/25 at 9:14 AM with Certified Nursing Assistant (CNA) #1, revealed that Resident #22 had long fingernails with brown substance underneath. She confirmed that Resident #22 had long, dirty fingernails and revealed that this could cause a lot of health problems, the spread of germs, and could cause infections. She revealed that they were supposed to clean fingernails every day as needed.	F 677	F677 Louisville Healthcare acknowledges receipt of the statement of deficiencies and propose this plan of correction as required by federal and state regulations and statues applicable to long term care providers. This plan does to constitute an admission of liability on the part of the facility, and such liability hereby specifically denies. The submission of this plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or the scope of severity regarding any of the deficiencies cited are correctly applied. Resident #22 received nail care on 04/15/2025 by RN Charge Nurse. All residents that need assistance with nailcare have the potential to be affected by the alleged deficient practice. Nursing Staff was in-serviced 4/15/2025 by Assistant Director of Nursing on policy for nailcare. Nailcare audit was conducted on all residents by Infection Preventionist on 04/15/2025.	

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F 677	Continued From page 13 An interview on 4/15/25 at 9:20 AM with Licensed Practical Nurse (LPN) #1, revealed that Resident #22 was prone to have dirty fingernails, and they were supposed to check his fingernails and clean them every day if needed. She revealed that the aides were to check fingernails during resident bath/shower times, and they trimmed and cleaned them as needed. LPN #1 confirmed that Resident #22 had long, dirty fingernails and she revealed that they should have been taken care of. Record review of Resident #22's "Admission Record" revealed an admission date of 10/17/22 and that he had diagnoses that included Unspecified Dementia, Age-Related Physical Debility, and Unspecified Depression. Record review of Resident #22's Minimum Data Set (MDS) with Assessment Reference Date of 1/08/25 under Section C revealed, a Brief Interview for Mental Status (BIMS) Score of 99 which indicated that he had severe cognitive deficits.	F 677	Nursing Staff will conduct twelve (12) nailcare audits per day, five (5) days a week to cover all residents times three (3) months. Results of those audits will be reviewed at Quality Assurance on 05/07/2025, then monthly x three (3) months.	
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 observation, interview, facility policy review, and record review, the facility failed to ensure effective pain management for one (1) of	F 697	F697 Louisville Healthcare acknowledges receipt of the statement of deficiencies	5/8/25

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F 697	Continued From page 14 sixteen (16) sampled residents (Resident #39), when staff failed to provide continued access to prescribed pain medication (Lyrica) and failed to implement appropriate interventions. This resulted in the resident experiencing uncontrolled neuropathic pain, impaired mobility, disruption in therapy services, and a decline in quality of life. Findings Include: Review of the facility policy titled "Pain Assessment/Management" with a revision date of 9/10 revealed, "It is the policy of this facility to provide guidelines in the identification and treatment of residents at risk for acute and chronic pain. Each residents pain will be assessed in an approach designed to increase comfort and promote dignity through administering alternative interventions or medications." On 4/14/25 at 2:48 PM an observation and interview with Resident #39 revealed that she was newly admitted to the facility and explained that she had been out of her pain medication (Lyrica) for almost a week. The resident revealed she came into the facility taking it for neuropathy pain in her lower legs and feet. She explained that staff told her that they contacted the facility doctor, but he would not refill it for her. She stated that she has an upcoming appointment with her pain specialist this Thursday, but she would rather not wait that long and stated, "I cannot walk anymore due to the leg pain." The resident explained that she had Tylenol that she could take, but it was not effective for her nerve pain in her legs and feet. An interview with the Director of Nursing (DON)	F 697	and propose this plan of correction as required by federal and state regulations and statues applicable to long term care providers. This plan does to constitute an admission of liability on the part of the facility, and such liability hereby specifically denies. The submission of this plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency or the scope of severity regarding any of the deficiencies cited are correctly applied. Resident #39 Resident received a prescription for Lyrica on 4/16/2025 from the medical director to cover her pain needs until her pain clinic appointment on 04/17/2025. Resident was assessed for pain daily, every shift by LPN charge nurse, continuously. Audit was done by Director of Nursing and Medical Records nurse on 04/15/2025 of all residents on pain medication to ensure pain is being relieved. Residents who receive narcotics have the potential to be affected by this practice. Nursing staff in-serviced on 04/15/2025 by Assistant Director of Nursing on ordering narcotics before they are out of the medication and if the doctor refuses to refill, they must notify the Administrator.to ensure medications are being administered according to plan of care and nursing standards.	

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F 697	Continued From page 15 on 4/14/25 at 3:10 PM revealed Resident #39 was a new admission to the facility on 04/02/25 and had a contract with the pain clinic and could not get pain medication prescribed by anyone besides with them. She explained that the resident has an appointment to have a drug screen on 4/17/25 and will have a telehealth visit through the pain clinic after the drug test to get her refills. She confirmed that the resident was admitted to the facility on Lyrica for pain management and revealed that the order was discontinued after the facility medical director was contacted about refilling it. The DON explained that he refused to refill the medication and told them that the resident must get her pain medications refilled by her pain management physician. She stated, "If he was not willing to refill the Lyrica, that was the physician's order from him to discontinue the medicine." Record review of the "Order Listing" for Resident #39 revealed an order dated 4/02/25, "Lyrica (nerve pain) Oral Capsule 200 MG (milligrams) (Pregabalin) Give 1 (one) capsule by mouth three times a day related to other chronic pain," with a discontinued date of 4/10/25. Record review of the April 2025 Medication Administration Record (MAR) revealed Resident #39 last received a dose of Lyrica 200 mg on 4/10/25 at 1400 (2:00 PM), and the order was discontinued. Record review of the "Pain Assessment" dated 4/08/25 revealed Resident #39 frequently experienced pain in the last 5 days with a pain intensity scale rated 7 on a scale of 1-10. An interview with Licensed Practical Nurse (LPN)	F 697	Medical Records Nurse or Director of Nursing will review the narcotic book twice weekly on Mondays and Thursdays beginning 04/16/2025 to check for sufficient quantity of medication times three months. Daily audits of Residents' pain scales by Director of Nursing and Medical Records nurse for three months. Results of those audits will be reviewed at Quality Assurance on 05/07/2025, then monthly times three months	

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#1 on 4/15/25 at 2:10 PM, while in the room with Resident #39, confirmed the resident had been out of the Lyrica. She revealed that the resident was currently reporting pain in her feet and legs and rated the pain 8 on a scale from 1 to 10 with 10 being the worst pain. LPN #1 revealed stopping the medication abruptly could cause a recurrence of pain symptoms and withdrawal side effects. The resident stated, "It hurts to even touch my feet and to stand." She revealed that Lyrica helped with her nerve pain and explained that without the medication, the pain was constant and intense with the faintest touch. The resident explained that the facility's Medical Director saw her last week and told her he could not prescribe pain medications to her because it would void her contract with the pain clinic. She stated, "I don't know what to do."

An interview with the Director of Nursing (DON) on 4/15/25 at 2:19 PM revealed the staff had contacted Resident #39's pain clinic for the Lyrica refill, but they were told the resident must come in. She explained there was nothing they could do since the medical director would not refill it.

A telephone interview with the facility Medical Director (MD) on 4/15/25 at 2:35 PM revealed Resident #39 has chronic pain and currently has rib fractures due to a fall at home. He confirmed he saw the resident last week in the facility, and revealed the staff did not tell him the resident was out of Lyrica. He explained that the staff did ask him about refilling her medications, and he told them that she would need to get it refilled by her pain specialist. The MD stated, "There was a misunderstanding because I was never told that she was out of the medicine." He further elaborated, "It was not my intention for her to go

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without." He acknowledged that he had no problem with giving the resident enough medication until she got back in with the pain clinic, but would not want to do it on a long-term basis. The MD confirmed this medication should not be abruptly stopped and would cause a recurrence of pain for the resident.

An interview with the Administrator on 4/15/25 at 2:55 PM revealed Resident #39 should not be in pain and confirmed the facility was responsible for ensuring the resident had the medications available to manage her pain. She revealed her expectations were for the Medical Director to provide the medication until the resident was able to see her pain specialist.

An interview with the Physical Therapy Assistant (PTA) on 4/16/25 at 8:55 AM revealed occupational therapy (OT), and she had been working with Resident #39 to build strength and endurance. She revealed they had previously been walking and doing exercises, but explained that the resident complained of pain in her feet yesterday and could not stand and we had to modify her therapy treatment plan to adapt due to the pain.

Record review of the "PT (Physical Therapist) Flowsheet" revealed the following entries: Dated 4/14/25... "Pt (patient) reported not feeling well and needing to sit with c/o (complaints of) rib pain and foot nerve pain. PTA transitioned activity to dynamic sitting activity ..." Dated 4/15/25 "... dynamic sitting balance activity requiring pt to reach across midline to challenge trunk stability needed for daily tasks. Pt reported not feeling well with LE (lower extremity) pain. No standing on this day date related to pain."

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Record review of Resident #39's April 2025 Medication Administration Record revealed under, "Pain scale-evaluate pain per pain scale (0-10) Q (every) shift and PRN (as needed). If pain is present document interventions and follow up on effects. Notify MD of persistent pain unrelieved by intervention" with zeros (0) documented on all shifts from 4/10/25 until 4/16/25 indicating the resident had no pain.

An interview with LPN #1 on 4/16/25 at 9:45 AM confirmed that she did not document Resident #39's pain level correctly on her shift. She revealed the resident complained of pain in both feet rated 8/10 and explained that she gave the resident two (2) Tylenol 325 milligrams (MG) at 245 PM yesterday, and upon follow-up the resident stated, "It helped a little bit but not much." She confirmed that she failed to document the pain or that Tylenol was given because she forgot. LPN #1 confirmed that the resident had told her that her pain was an 8 on a scale of 1-10.

Record review of the "Admission Record" revealed the facility admitted Resident #39 on 4/02/25 with medical diagnoses that include Chronic Pain, Anxiety Disorder, Peripheral Vascular Disease and Type 2 Diabetes Mellitus.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/08/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #39 was cognitively intact.