STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09FD	A. BUILDING: _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRACE EXTENDED CARE & REHABILITATION	1004 EAST MADISON STREET HOUSTON, MS 38851

(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) COMPLETE DATE
M 000	Initial Comments On 05/15/23 through 05/16/23 the State Agency (SA) conducted an onsite complaint investigation CI MS #21005 for an alleged incident of neglect. The SA determined that the facility was not in compliance with the Minimum Standard for Institutions for the Aged or Infirm, and cited deficiencies at M500. The facility was licensed for 66 beds and had a resident census of 59.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to	M 500		6/29/23

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M 500	Continued From page 1 participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this	M 500		

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M 500	Continued From page 2	M 500		

responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as

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M 500	Continued From page 3 documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III Based on facility policy reviews, interviews, and record reviews the facility neglected to properly assess Resident #1 and manage pain after a fall with injury and delay of treatment for one (1) of four (4) residents reviewed for falls. Resident #1	M 500	1. Resident #1 was sent to emergency room on 3/11/23 she returned to facility on 3/14/23 and there were no further issues with pain. 2. All residents have the potential to be affected by this practice.	

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M 500	Continued From page 4 Finding include: Review of the facility policy and procedure titled Abuse Neglect and Exploitation dated 9/19/2022 revealed ..."Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress ..." The facility provided on letterhead dated 5/16/23 a statement that read: "We do not have a policy on lifting after a fall." signed by the facility Administrator (ADM). Record review of the facility policy "Fall Prevention Program" dated 11/10/2022 revealed," Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls... 9. When any resident experiences a fall, the facility will: : a. Assess the resident. b. Complete a post -fall assessment. c. Complete an incident report. D. Notify physician and family .... f. Document all assessments and actions ...." During a telephone interview on 05/15/23 at 10:00 AM, with the Ombudsman revealed that she had received a call from the family of Resident #1 on 03/11/2023. The family reported concerns of neglect and reported that the facility did not timely call for an ambulance to transport their mother to be evaluated and treated. The family did not think that the Resident should have been put in a wheelchair and taken to the dining room to eat breakfast while in pain and possibly with a fracture. The family stated that they had to insist that the facility call 911 after resident had been	M 500	3.Pain evaluations are being done with the Minimum Data Set (MDS), quarterly, on significant changes and annually by MDS Coordinators and with every incident/accident by nurses beginning 5/15/23. A pain management policy was put into place on 5/19/23 Fall Risk Evaluations on all residents were completed and or updated on 5/19/2023 by Admissions Nurse. A Lift transfer policy was put into place on 5/18/23. All nursing staff were educated on pain management, pain evaluation tool, falls, lifts and transfers by the Director of Nursing on 5/15/23, 5/23/23, and 6/5/23 . The nursing staff will complete a pain evaluation and provide treatment to alleviate pain with documentation in medical record of intervention used and follow up with resident to assure effectiveness of each incident/accident beginning on 5/15/23. 4. The accident/incident report, pain evaluation and interventions will be reviewed by the Director of Nursing or RN Supervisor daily beginning 5/17/23, for five weeks. Administrator will speak with cognitive residents to assure residents pain management is adequate beginning 5/17/23. Findings of Pain evaluation reviews will be brought to Quality Assurance/Risk Management Committee for three months for determination of proper pain management based on assessment/resident needs. Committee will determine if further interventions needed to assure that consistent	

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M 500	Continued From page 5 left sitting in a wheelchair in the dining room for hours after a fall in which the resident stated she thought her right hip was broken and that she was in pain. The family stated that an ambulance should have been called immediately after the fall and that Resident #1 should have been placed in the bed and given pain medications. In an interview on 03/15/23 at 1:30 P.M. with the Administrator (ADM) revealed that Resident #1 was severely cognitively impaired and had a Brief Interview for Mental Status (BIMS) score of 2 or 3. ADM stated that the resident was verbal and ambulatory without assistance and was able to verbalize to the staff that she had lost her balance and her leg gave way as she was standing at her dresser, and she fell to the floor. ADM stated that Resident #1 did complain of pain immediately after the fall and the staff called the family to report the fall and the family came to the facility and waited with the resident until the ambulance came to transport her to the emergency room (ER) for evaluation. The ADM stated that there was no local hospital near the facility and that there was no local ambulance service in the town where the facility was located. The ADM revealed that the town had a contract with neighboring towns ambulance services and the closest ambulance service was approximately 30 miles away and the closest ER for treatment of injuries was approximately 30 miles away. The ADM confirmed that the ambulance had to come from approximately 30 miles away to transport the resident to an ER which was another 30 or more miles away from the facility. The ADM revealed that the incident of the fall of Resident #1 occurred on 03/11/23 at approximately 7:00 AM during the change of shifts on a Saturday morning. Resident #1 did have an un-witnessed fall which resulted in a broken hip. Res #1 had hip	M 500	substantial compliance has been achieved. Immediate QA meeting was on 5/15/23 with Medical Director. First monthly Quality Assurance Performance Improvement (QAPI) meeting is on 6/28/2023.	

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surgery and spent three (3) nights in the hospital prior to her return to the facility on 03/14/23.

In an interview on 05/15/23 at 3:00 PM, with Registered Nurse (RN #2) who works the first shift on weekends 7:00 AM-7:00 PM, stated that she did not give any pain medications to Resident #1 on 03/11/23. RN #2 stated that she did not witness any pain medications given to Res #1 on 03/11/23 and RN #2 did not call the physician or the nurse practitioner (NP) to obtain orders for pain medications. RN #2 stated that the family came to the facility early on that Saturday morning of 03/11/23 shortly after they were contacted that the resident had fallen which was approximately 6:45 AM. The family (3-4 people) were at the facility with the resident, and they were upset that an ambulance had not been called to transport Resident #1. The on-call x-ray technician had been called to come do a bed-side portable x-ray, but she had not answered her phone and a voicemail message was left on her phone. At approximately 9:30 AM the x-ray technician called back to the facility, but the ambulance had been called to transport Res #1 to the ER for x-ray and evaluation. Res #1 did complain of pain, but the pain was mild at 7:00 AM and no orders were obtained for pain medications. The pain scale of 1-10 was used and Res #1 stated at 7:00 AM that her pain was a "4" on the pain scale. RN #2 stated that she did not reassess her pain after the initial complaint of pain at 7:00 AM. The ambulance was not called until approximately 9:00 AM on 03/11/23 after the family had requested that 911 be called. It took the ambulance approximately 20 minutes to arrive at the facility. The ambulance left the facility with Res #1 at approximately 9:32 AM.

During an interview on 05/15/23 at 3:15 PM, with

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M 500	Continued From page 7 Licensed Practical Nurse (LPN) #2 she revealed she was the medication nurse on the 7 AM - 7 PM shift on 03/11/23. LPN#2 stated that the resident was sitting in her wheelchair in the dining room with two (2) daughters and one (1) son when they asked LPN #2 for some pain medication for Res #1. LPN#2 stated that she told the family that the only thing that was ordered for Res #1 was Tylenol and that was all that she could give Res #1. LPN #2 stated that Res #1 was complaining of pain and that she gave the Tylenol to Res #1 in the dining room while she sat in her wheelchair. LPN #2 stated that she documented the giving of the Tylenol in the "EMAR" (electronic Medication Administration Record). LPN #2 stated that she gave Res #1 two (2) 325 mg Tylenol because that was all that she had orders to give. LPN #2 stated that the family was insisting that the staff call an ambulance to transport Res #1 to the ER for an x-ray. LPN #2 stated that she had been told that the x-ray technician that was on call had not answered and the facility had left a message on the voicemail for a bedside x-ray. The family expressed that they were tired of waiting on the "on-call x-ray technician" to respond. The family wanted the staff to call 911 and have an ambulance to take Res #1 to the ER for evaluation and x-ray. An interview on 05/15/23 at 3:30 PM, with Certified Nursing Assistant (CNA) #1 revealed that he was walking down the hall at shift change on Saturday morning at approximately a little before 7:00 AM when he passed Res #1's room and saw her on the floor in front of her dresser. He turned around and went back to check on Res #1 and she stated that she had fallen, and her leg had given out and it was hurting. CNA #1 stated that he was not assigned to Res #1 that morning,	M 500		

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but he immediately went and got the nurse and the CNA assigned to Res #1. CNA #1 and CNA #2, RN #1 and LPN #1 all went into Resident #1's room, and she told them all that her leg was hurting and that it had given way and she fell to the floor. CNA #1 stated that the right leg did look shorter than the left leg and when the nurse touched her, she stated that it hurt. CNA #1 stated that the resident did verbalize pain to him and to the nurses. He said the Charge Nurse (RN#1) told us to pick up Res #1 off the floor and place her in her wheelchair and push her to the dining room for breakfast. I did not see any medications given to Res #1 after the fall on 03/11/23 at 6:50 AM. I left the facility at 7:00 AM on 3/11/23. We physically picked the resident up off of the floor and placed her in a wheelchair at the request of the charge nurse RN #1 and took her to the dining room. CNA #1 confirmed that Resident #1 did complain of pain while we were putting her in the wheelchair. We did not use a lift to pick the resident up off the floor.

In an interview on 05/15/23 at 4:10 PM, with RN #1 stated that she was the charge nurse on 03/11/23 on the 7:00 PM-7:00 AM shift. She confirmed that they picked up Res #1 off the floor and did not use a lift. They put Resident #1 in a wheelchair and took her to the dining room so there would be "eyes on her. I did not want to leave her (Res #1) alone in her room after the fall because I thought that there was too much going on during shift change and she may try to get up again if she was left alone. Things were very busy at the change of shift." RN#1 confirmed that the resident sat in a wheelchair in the dining room at the breakfast table. Her family was contacted, and 3-4 family members came to the facility to be with her at approximately 7:45 AM. RN#1 stated that Resident #1 did complain of pain and stated,

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"I did not give her any pain medications and I did not obtain an order from the NP for any pain medications." RN#1 stated, "To my knowledge there were no pain assessments documented for the resident on 3/11/23.

In an interview on 05/15/23 at 4:25 PM, with the two (2) daughters of Resident #1 revealed that they along with their brother had all come to the facility to be with their mother after they were notified that she had a fall. Upon arriving at the facility at approximately 7:40 AM on 03/11/23, they found her sitting in the dining room in a wheelchair at the breakfast table and she was complaining of pain in her right hip and leg. The nurse told the children that they were going to get an x-ray but that the clinic did not open until 10:00 AM and they were waiting for the x-ray person to arrive at the clinic to get the x-ray at that time. Resident #1 told the family that she thought her right hip and leg may be broken and she was having pain. The daughter stated that she was yelling out in pain as she sat in her wheelchair, and we all thought that she should be in her bed lying down and not sitting up. She was asking us to please put her in the bed. We asked the nurse if we could have pain medication given to her and the nurse told us she would give her some Tylenol and she left and never came back with the medication. The daughter confirmed no pain medications were given to Res #1 on 03/11/23 at the facility while the family was there. We asked if we could put her in her bed and the nurse told us she needed to sit up and wait for the x-ray. We waited until after 9:00 AM and nothing was done for our mother so we asked if they could call 911 and have her sent to for x-ray and evaluation. We all were not happy with how little consideration the staff gave her and they did not put her to bed. They left her in a wheelchair

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crying out in pain and never gave her any pain medications. We do not want to get anyone in trouble, but we do not think that any resident should be treated with such disregard. We want proper procedures to be executed for all residents and no one deserved to be treated like they treated our mother. We finally took her to her room, and we put her to bed where she was requesting to be placed. It was hurting her sitting up on that hip in that wheelchair. When we got to the ER, we found that our mother had a broken right hip, and she went to surgery the next day. We also do not feel that the facility gave us an explanation of how the entire incident occurred. The facility did nothing to address her pain after the fall. She should never be placed in a wheelchair to sit on a broken hip.

During an interview on 05/16/23 at 10:30 AM, with the Director of Nurses (DON) revealed that Resident #1 should not have been physically picked up off the floor and placed in a wheelchair. She should have been placed in bed and assessed. The DON stated that Resident #1 should have been put in the bed and her pain should have been assessed and monitored until she left the facility for the ER. "We teach this in our employee training," but we have no written training records and no written policies and procedures for the monitoring of pain. "We do not have any pain assessments on this resident, and we should have done them." The DON confirmed that the "Standing Orders" for pain medication of Tylenol was not given after Resident #1 fell and confirmed that the Medication Administration Record (MAR) had not been documented on 03/11/23 for the administrating of pain medications to Resident #1.

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M 500	Continued From page 11 On 05/16/23 at 12:20 PM, in an interview with the NP she revealed that she does not recall the details of the incident with Resident #1 on 03/11/23 but she does remember that she was asked if they could get a bed side portable x-ray ordered. NP stated that this was early on a Saturday morning when she was called, and she does not have any notes from the call, so she does not recall the details. The details of Resident #1's pain were not relayed to the NP by the facility staff, and she confirmed that the "Standing Orders" should have been implemented and the nurses at the facility could have called for an ambulance or for additional orders as soon as the fall occurred. On 05/16/23 at 2:30 PM, an interview with CNA #2, revealed that she was assigned to Res #1 on the third shift on 03/11/23. She was on her way out of the facility when she was notified that one of her assigned residents had fallen. Upon entering the room there were two (2) nurses and another CNA (CNA #1) in the room with Res #1 on the floor. The nurse told them to pick up the resident and put her in the wheelchair and take her to the dining room to eat breakfast. CNA #2 did not witness the fall of Res #1 and she did not witness any pain assessments or pain medications given to Res #1. Record review of the facility "Resident Incident Report" dated 3/11/23 at 06:50 AM, revealed that the incident was "Non-Witnessed" Type of Injury: Pain. Narrative of incident and description of injuries: (CNA #1) Reported resident was found sitting on floor in her room. No injuries noted resident has c/o (complaint of) pain to rt. (right) leg. Immediate Actions Taken: Resident was assessed for injuries and assisted up to wheelchair ... Pain Scale: 4 ...Family notified, and	M 500		

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Nurse Practitioner notified 3/11/23. Exam by Physician: No. Taken to Hospital: No. Report prepared by RN#1.

Record review of the facility Departmental Notes dated 03/11/23 at 7:14 AM revealed, "0650-(CNA #1) reported to nurse that resident was found sitting on the floor in her room. Resident reported that she did fall, she stated "My Leg gave out", resident was assessed for injuries. Has c/o (complaint of) pain to Rt (right) leg when touch or moved/lifted. Resident stated, "that's the leg I hit when I fell." 0655-Fall with c/o rt. leg pain was reported to FNP- (Family Nurse Practitioner) Order was obtained for x-ray of RT/hip/leg. 0709-Fall with c/o rt. leg pain was reported to son -he was informed that x-ray was ordered. Nurses note signed by the third shift Charge Nurse (RN #1). The nursing note 3/11/23 9:32 AM Leaving via ambulance to ER for eval and treatment. Signed by the first shift Charge Nurse (RN #2). 3/11/2023 9:50 AM Called report to ER. Signed by (RN#2). The nursing note dated 3/11/2023 at 10:46 AM read: Late charting for 9:07 AM: Resident had started yelling out in pain, radiology not available at this time. Family agreed that this nurse should call 911. Called FNP and received order to call (EMS) Emergency Management Services. Signed by (RN #2). Nursing note dated 3/11/2023 at 1:43 PM "Late charting for 8:20 AM: Resident sitting up in wheelchair in the dining room and has eaten breakfast with her family. Family then transported resident back to her room in her wheelchair. Asked by her son and CNA if she should go to bed. This nurse advised against putting her back to bed due to resident needed an x-ray of her right hip, right femur and right knee. Came back to check on resident later and family member had put her in bed. Resident had started yelling due to pain because she was

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lying on the affected side. This nurse then called FNP to get order to send resident to the ER." Signed by RN#2.

Record review of the Electronic Medication Administration Record (eMAR) for March 2023 revealed no documentation that Resident #1 had not been given pain medications on 03/11/23 including Tylenol from the "Standing Orders".

Record review of the undated facility "Standing Orders" revealed "Pain: Tylenol 500 mg (milligrams) PO (by mouth) Q (every) 4HRS (hours) PRN (as needed). Notify Provider within 24 hours if pain persists or worsens." The facility did not implement the facility's standing orders for the PRN pain medications of Tylenol 500 mg PO Q 4 HRS PRN.

Record review of the Emergency Department report dated 03/11/23 at 1009 revealed: "RN/Triage Created: 3/11/23 1009 Last Entry: 1011 EMS (Emergency Medical Services) enroute with a 89 yo (year old) F (female) with fall. Additional Information: Fall, unwitnessed. C/O Right Hip pain. Denies LOC (loss of consciousness), no blood thinners. Alert but confused. 20ga(gauge) IV(intravenous) RAC (right antecubital). 100mcg (micrograms) fentanyl given. FSBG(Fingerstick blood glucose) 203. Emergency Alert: Alert Called: Pre-Hospital Care: Patient was not medicated for pain... HPI: Fall: Occurred at 2 hours ago. Fall from standing height onto floor approx. (approximately) 0 feet injuring RLE (right lower extremity)... Chief Complaint: Fall, leg pain HPI: Patient complaining of prior to arrival of the following symptoms: Patient presents the emergency room from nursing home and apparently an unwitnessed fall confused at

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M 500	Continued From page 14 baseline with dementia but complaining of right hip leg pain no other evidence of trauma. 3/11/23 at 1151 doctor wrote: Provider Note: I reviewed x-ray finding fracture with family. Patient was given pain medications she has a right femoral neck fracture I consulted orthopedics. Patient will be admitted to the hospital service..." Record review of the Face Sheet of Resident #1 revealed that she was admitted to the facility on 06/18/2013 and was discharged on 03/30/2023. Resident #1 had diagnoses of Type I Diabetes, Alzheimer's Disease, Dementia unspecified severity and Poly osteoarthritis unspecified. Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 03/21/23 revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating that the resident was unable to complete the interview.	M 500		

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Based on facility policy reviews, interviews, and record reviews the facility neglected to properly assess Resident #1 and manage pain after a fall with injury and delay of treatment for one (1) of four (4) residents reviewed for falls. Resident #1

Finding include:

Review of the facility policy and procedure titled Abuse Neglect and Exploitation dated 9/19/2022 revealed ..."Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress ..."

The facility provided on letterhead dated 5/16/23 a statement that read: "We do not have a policy on lifting after a fall." signed by the facility Administrator (ADM).

Record review of the facility policy "Fall Prevention Program" dated 11/10/2022 revealed," Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls... 9. When any resident experiences a fall, the facility will: : a. Assess the resident. b. Complete a post -fall assessment. c. Complete an incident report. D. Notify physician and family .... f. Document all assessments and actions ...."

During a telephone interview on 05/15/23 at 10:00 AM, with the Ombudsman revealed that she had received a call from the family of Resident #1 on 03/11/2023. The family reported concerns of

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neglect and reported that the facility did not timely call for an ambulance to transport their mother to be evaluated and treated. The family did not think that the Resident should have been put in a wheelchair and taken to the dining room to eat breakfast while in pain and possibly with a fracture. The family stated that they had to insist that the facility call 911 after resident had been left sitting in a wheelchair in the dining room for hours after a fall in which the resident stated she thought her right hip was broken and that she was in pain. The family stated that an ambulance should have been called immediately after the fall and that Resident #1 should have been placed in the bed and given pain medications.

In an interview on 03/15/23 at 1:30 P.M. with the Administrator (ADM) revealed that Resident #1 was severely cognitively impaired and had a Brief Interview for Mental Status (BIMS) score of 2 or 3. ADM stated that the resident was verbal and ambulatory without assistance and was able to verbalize to the staff that she had lost her balance and her leg gave way as she was standing at her dresser, and she fell to the floor. ADM stated that Resident #1 did complain of pain immediately after the fall and the staff called the family to report the fall and the family came to the facility and waited with the resident until the ambulance came to transport her to the emergency room (ER) for evaluation. The ADM stated that there was no local hospital near the facility and that there was no local ambulance service in the town where the facility was located. The ADM revealed that the town had a contract with neighboring towns ambulance services and the closest ambulance service was approximately 30 miles away and the closest ER for treatment of injuries was approximately 30 miles away. The ADM confirmed that the ambulance had to come from

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approximately 30 miles away to transport the resident to an ER which was another 30 or more miles away from the facility. The ADM revealed that the incident of the fall of Resident #1 occurred on 03/11/23 at approximately 7:00 AM during the change of shifts on a Saturday morning. Resident #1 did have an un-witnessed fall which resulted in a broken hip. Res #1 had hip surgery and spent three (3) nights in the hospital prior to her return to the facility on 03/14/23.

In an interview on 05/15/23 at 3:00 PM, with Registered Nurse (RN #2) who works the first shift on weekends 7:00 AM-7:00 PM, stated that she did not give any pain medications to Resident #1 on 03/11/23. RN #2 stated that she did not witness any pain medications given to Res #1 on 03/11/23 and RN #2 did not call the physician or the nurse practitioner (NP) to obtain orders for pain medications. RN #2 stated that the family came to the facility early on that Saturday morning of 03/11/23 shortly after they were contacted that the resident had fallen which was approximately 6:45 AM. The family (3-4 people) were at the facility with the resident, and they were upset that an ambulance had not been called to transport Resident #1. The on-call x-ray technician had been called to come do a bed-side portable x-ray, but she had not answered her phone and a voicemail message was left on her phone. At approximately 9:30 AM the x-ray technician called back to the facility, but the ambulance had been called to transport Res #1 to the ER for x-ray and evaluation. Res #1 did complain of pain, but the pain was mild at 7:00 AM and no orders were obtained for pain medications. The pain scale of 1-10 was used and Res #1 stated at 7:00 AM that her pain was a "4" on the pain scale. RN #2 stated that she did not reassess her pain after the initial complaint of

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pain at 7:00 AM. The ambulance was not called until approximately 9:00 AM on 03/11/23 after the family had requested that 911 be called. It took the ambulance approximately 20 minutes to arrive at the facility. The ambulance left the facility with Res #1 at approximately 9:32 AM.

During an interview on 05/15/23 at 3:15 PM, with Licensed Practical Nurse (LPN) #2 she revealed she was the medication nurse on the 7 AM - 7 PM shift on 03/11/23. LPN#2 stated that the resident was sitting in her wheelchair in the dining room with two (2) daughters and one (1) son when they asked LPN #2 for some pain medication for Res #1. LPN#2 stated that she told the family that the only thing that was ordered for Res #1 was Tylenol and that was all that she could give Res #1. LPN #2 stated that Res #1 was complaining of pain and that she gave the Tylenol to Res #1 in the dining room while she sat in her wheelchair. LPN #2 stated that she documented the giving of the Tylenol in the "EMAR" (electronic Medication Administration Record). LPN #2 stated that she gave Res #1 two (2) 325 mg Tylenol because that was all that she had orders to give. LPN #2 stated that the family was insisting that the staff call an ambulance to transport Res #1 to the ER for an x-ray. LPN #2 stated that she had been told that the x-ray technician that was on call had not answered and the facility had left a message on the voicemail for a bedside x-ray. The family expressed that they were tired of waiting on the "on-call x-ray technician" to respond. The family wanted the staff to call 911 and have an ambulance to take Res #1 to the ER for evaluation and x-ray.

An interview on 05/15/23 at 3:30 PM, with Certified Nursing Assistant (CNA) #1 revealed

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that he was walking down the hall at shift change on Saturday morning at approximately a little before 7:00 AM when he passed Res #1's room and saw her on the floor in front of her dresser. He turned around and went back to check on Res #1 and she stated that she had fallen, and her leg had given out and it was hurting. CNA #1 stated that he was not assigned to Res #1 that morning, but he immediately went and got the nurse and the CNA assigned to Res #1. CNA #1 and CNA #2, RN #1 and LPN #1 all went into Resident #1's room, and she told them all that her leg was hurting and that it had given way and she fell to the floor. CNA #1 stated that the right leg did look shorter than the left leg and when the nurse touched her, she stated that it hurt. CNA #1 stated that the resident did verbalize pain to him and to the nurses. He said the Charge Nurse (RN#1) told us to pick up Res #1 off the floor and place her in her wheelchair and push her to the dining room for breakfast. I did not see any medications given to Res #1 after the fall on 03/11/23 at 6:50 AM. I left the facility at 7:00 AM on 3/11/23. We physically picked the resident up off of the floor and placed her in a wheelchair at the request of the charge nurse RN #1 and took her to the dining room. CNA #1 confirmed that Resident #1 did complain of pain while we were putting her in the wheelchair. We did not use a lift to pick the resident up off the floor.

In an interview on 05/15/23 at 4:10 PM, with RN #1 stated that she was the charge nurse on 03/11/23 on the 7:00 PM-7:00 AM shift. She confirmed that they picked up Res #1 off the floor and did not use a lift. They put Resident #1 in a wheelchair and took her to the dining room so there would be "eyes on her. I did not want to leave her (Res #1) alone in her room after the fall because I thought that there was too much going

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on during shift change and she may try to get up again if she was left alone. Things were very busy at the change of shift." RN#1 confirmed that the resident sat in a wheelchair in the dining room at the breakfast table. Her family was contacted, and 3-4 family members came to the facility to be with her at approximately 7:45 AM. RN#1 stated that Resident #1 did complain of pain and stated, "I did not give her any pain medications and I did not obtain an order from the NP for any pain medications." RN#1 stated, "To my knowledge there were no pain assessments documented for the resident on 3/11/23.

In an interview on 05/15/23 at 4:25 PM, with the two (2) daughters of Resident #1 revealed that they along with their brother had all come to the facility to be with their mother after they were notified that she had a fall. Upon arriving at the facility at approximately 7:40 AM on 03/11/23, they found her sitting in the dining room in a wheelchair at the breakfast table and she was complaining of pain in her right hip and leg. The nurse told the children that they were going to get an x-ray but that the clinic did not open until 10:00 AM and they were waiting for the x-ray person to arrive at the clinic to get the x-ray at that time. Resident #1 told the family that she thought her right hip and leg may be broken and she was having pain. The daughter stated that she was yelling out in pain as she sat in her wheelchair, and we all thought that she should be in her bed lying down and not sitting up. She was asking us to please put her in the bed. We asked the nurse if we could have pain medication given to her and the nurse told us she would give her some Tylenol and she left and never came back with the medication. The daughter confirmed no pain medications were given to Res #1 on 03/11/23 at the facility while the family was there. We asked if

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we could put her in her bed and the nurse told us she needed to sit up and wait for the x-ray. We waited until after 9:00 AM and nothing was done for our mother so we asked if they could call 911 and have her sent to for x-ray and evaluation. We all were not happy with how little consideration the staff gave her and they did not put her to bed. They left her in a wheelchair crying out in pain and never gave her any pain medications. We do not want to get anyone in trouble, but we do not think that any resident should be treated with such disregard. We want proper procedures to be executed for all residents and no one deserved to be treated like they treated our mother. We finally took her to her room, and we put her to bed where she was requesting to be placed. It was hurting her sitting up on that hip in that wheelchair. When we got to the ER, we found that our mother had a broken right hip, and she went to surgery the next day. We also do not feel that the facility gave us an explanation of how the entire incident occurred. The facility did nothing to address her pain after the fall. She should never be placed in a wheelchair to sit on a broken hip.

During an interview on 05/16/23 at 10:30 AM, with the Director of Nurses (DON) revealed that Resident #1 should not have been physically picked up off the floor and placed in a wheelchair. She should have been placed in bed and assessed. The DON stated that Resident #1 should have been put in the bed and her pain should have been assessed and monitored until she left the facility for the ER. "We teach this in our employee training," but we have no written training records and no written policies and procedures for the monitoring of pain. "We do not have any pain assessments on this resident, and we should have done them." The DON

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confirmed that the "Standing Orders" for pain medication of Tylenol was not given after Resident #1 fell and confirmed that the Medication Administration Record (MAR) had not been documented on 03/11/23 for the administrating of pain medications to Resident #1.

On 05/16/23 at 12:20 PM, in an interview with the NP she revealed that she does not recall the details of the incident with Resident #1 on 03/11/23 but she does remember that she was asked if they could get a bed side portable x-ray ordered. NP stated that this was early on a Saturday morning when she was called, and she does not have any notes from the call, so she does not recall the details. The details of Resident #1's pain were not relayed to the NP by the facility staff, and she confirmed that the "Standing Orders" should have been implemented and the nurses at the facility could have called for an ambulance or for additional orders as soon as the fall occurred.

On 05/16/23 at 2:30 PM, an interview with CNA #2, revealed that she was assigned to Res #1 on the third shift on 03/11/23. She was on her way out of the facility when she was notified that one of her assigned residents had fallen. Upon entering the room there were two (2) nurses and another CNA (CNA #1) in the room with Res #1 on the floor. The nurse told them to pick up the resident and put her in the wheelchair and take her to the dining room to eat breakfast. CNA #2 did not witness the fall of Res #1 and she did not witness any pain assessments or pain medications given to Res #1.

Record review of the facility "Resident Incident Report" dated 3/11/23 at 06:50 AM, revealed that

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M 500	Continued From page 23	M 500		

the incident was "Non-Witnessed" Type of Injury: Pain. Narrative of incident and description of injuries: (CNA #1) Reported resident was found sitting on floor in her room. No injuries noted resident has c/o (complaint of) pain to rt. (right) leg. Immediate Actions Taken: Resident was assessed for injuries and assisted up to wheelchair ... Pain Scale: 4 ...Family notified, and Nurse Practitioner notified 3/11/23. Exam by Physician: No. Taken to Hospital: No. Report prepared by RN#1.

Record review of the facility Departmental Notes dated 03/11/23 at 7:14 AM revealed, "0650-(CNA #1) reported to nurse that resident was found sitting on the floor in her room. Resident reported that she did fall, she stated "My Leg gave out", resident was assessed for injuries. Has c/o (complaint of) pain to Rt (right) leg when touch or moved/lifted. Resident stated, "that's the leg I hit when I fell." 0655-Fall with c/o rt. leg pain was reported to FNP- (Family Nurse Practitioner) Order was obtained for x-ray of RT/hip/leg. 0709-Fall with c/o rt. leg pain was reported to son -he was informed that x-ray was ordered. Nurses note signed by the third shift Charge Nurse (RN #1). The nursing note 3/11/23 9:32 AM Leaving via ambulance to ER for eval and treatment. Signed by the first shift Charge Nurse (RN #2). 3/11/2023 9:50 AM Called report to ER. Signed by (RN#2). The nursing note dated 3/11/2023 at 10:46 AM read: Late charting for 9:07 AM: Resident had started yelling out in pain, radiology not available at this time. Family agreed that this nurse should call 911. Called FNP and received order to call (EMS) Emergency Management Services. Signed by (RN #2). Nursing note dated 3/11/2023 at 1:43 PM "Late charting for 8:20 AM: Resident sitting up in wheelchair in the dining room and has eaten breakfast with her family.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09FD	A. BUILDING: _____ B. WING _____	C 05/16/2023

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Family then transported resident back to her room in her wheelchair. Asked by her son and CNA if she should go to bed. This nurse advised against putting her back to bed due to resident needed an x-ray of her right hip, right femur and right knee. Came back to check on resident later and family member had put her in bed. Resident had started yelling due to pain because she was lying on the affected side. This nurse then called FNP to get order to send resident to the ER." Signed by RN#2.

Record review of the Electronic Medication Administration Record (eMAR) for March 2023 revealed no documentation that Resident #1 had not been given pain medications on 03/11/23 including Tylenol from the "Standing Orders".

Record review of the undated facility "Standing Orders" revealed "Pain: Tylenol 500 mg (milligrams) PO (by mouth) Q (every) 4HRS (hours) PRN (as needed). Notify Provider within 24 hours if pain persists or worsens." The facility did not implement the facility's standing orders for the PRN pain medications of Tylenol 500 mg PO Q 4 HRS PRN.

Record review of the Emergency Department report dated 03/11/23 at 1009 revealed: "RN/Triage Created: 3/11/23 1009 Last Entry: 1011 EMS (Emergency Medical Services) enroute with a 89 yo (year old) F (female) with fall. Additional Information: Fall, unwitnessed. C/O Right Hip pain. Denies LOC (loss of consciousness), no blood thinners. Alert but confused. 20ga(gauge) IV(intravenous) RAC (right antecubital). 100mcg (micrograms) fentanyl given. FSBG(Fingerstick blood glucose) 203. Emergency Alert: Alert Called: Pre-Hospital Care: Patient was not medicated for

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pain... HPI: Fall: Occurred at 2 hours ago. Fall from standing height onto floor approx. (approximately) 0 feet injuring RLE (right lower extremity)... Chief Complaint: Fall, leg pain HPI: Patient complaining of prior to arrival of the following symptoms: Patient presents the emergency room from nursing home and apparently an unwitnessed fall confused at baseline with dementia but complaining of right hip leg pain no other evidence of trauma. 3/11/23 at 1151 doctor wrote: Provider Note: I reviewed x-ray finding fracture with family. Patient was given pain medications she has a right femoral neck fracture I consulted orthopedics. Patient will be admitted to the hospital service..."

Record review of the Face Sheet of Resident #1 revealed that she was admitted to the facility on 06/18/2013 and was discharged on 03/30/2023. Resident #1 had diagnoses of Type I Diabetes, Alzheimer's Disease, Dementia unspecified severity and Poly osteoarthritis unspecified.

Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 03/21/23 revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating that the resident was unable to complete the interview.

The record review of the nursing notes for 03/11/2023 documented that Res #1 was found on the floor of her room at 6:50 AM and she complained of pain upon discovery at 6:50 AM and Resident was yelling out in pain at 9:07 AM. The record review of the nursing notes revealed that the nursing staff did not address Res #1's pain upon her first complaint at 6:55 AM or assess and address Res #1's pain at 9:07 AM

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when she began yelling out in pain. There was no written documentation that the facility staff had given Res #1 Tylenol as per the facility's Standing Physician's Orders."

The facility did not assess or provide pain management for Res #1's voiced pain from 0650-9:32 AM which was a minimum of two (2) hours and 42 minutes prior to leaving in the ambulance to travel 30 plus miles away to the Emergency Room (ER). The facility neglected to obtain an order for pain management for Res #1. The record review also revealed that the facility nursing staff placed Res #1 in a wheelchair to sit rather than place her in the bed for assessment and there was no pain management issued for Res #1. The record review documented that Res #1 was voicing pain for over two hours, and the staff did not obtain orders for pain management.

The record review of the ER reports dated 3/11/23 confirmed that (Res #1) was not medicated or given pain medications prior to leaving the nursing home for evaluation at the ER. The ER reported that Resident #1 was complaining of right hip and leg pain at the nursing home following the unwitnessed fall. The ER report confirmed that the resident had a fracture of the right hip and leg and that pain medications were given.