STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255306	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**

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F 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 substantial compliance with the standards for participation in Medicare and Medicaid and cited deficiencies at F600, F656, and F697. The facility was licensed for 66 beds and had a resident census of 59.	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: 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:	F 600	1. Resident #1 was sent to the emergency room on 3/11/23, she returned to facility on 3/14/23 and there were no further issues with pain, services provided or care needs. 2. All residents have the potential to be	6/29/23

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

Electronically Signed | 06/08/2023

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F 600	Continued From page 1 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 left sitting in a wheelchair in the dining room for	F 600	affected by this practice. 3. An immediate Quality Assurance (QA) Meeting was held with the medical Director on 5/15/23. Education was began with all nursing staff on 5/15/23 on pain management, abuse and neglect, lifts and transfers. Director of Nursing (DON) did additional education with Licensed Practical Nurse (LPN)#2, Registered Nurses (RN) #1 and RN #2 on 6/5/23 on addressing resident complaints of pain and follow up for effectiveness. Standing orders education was done by DON with LPN#2 and RN#1 on 6/6/2023. Facility is no longer using the after hours and weekend radiology services at the attached hospital to assure no delay in care awaiting an x-ray beginning 5/16/23. Residents are sent to emergency room of choice during those hours. Nursing staff were educated on use of pain evaluation tool beginning 5/15/23. Pain evaluations are being done with Minimum Data Set (MDS) quarterly, with significant changes and annually beginning 5/16/2023. Nurses began doing pain evaluations with each incident/accident and as needed per residents changes in health status on 5/16/23. Pain intervention will be entered into residents medical record of medication or non-pharmacological method used, of time administered and effectiveness to assure timely effective treatment to meet care needs of resident beginning 5/15/23.	

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F 600	Continued From page 2 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	F 600	4. All incident reports will be brought to interdisciplinary teams daily morning meeting after each incident for verification of pain assessment and ensure resident received treatment in a timely manner beginning 5/17/23. Director of Nursing will monitor incident reports, to assure pain evaluation was done, intervention was put into place and effectiveness of that intervention for five weeks beginning 5/17/23. Results will be presented to the QA/Risk Management committee to assure continued compliance. Quality Assurance Committee will monitor for 3 months for determination of further interventions to assure continued compliance Immediate QA meeting was on 5/15/23 with Medical Director. First monthly Quality Assurance Performance Improvement (QAPI) meeting will be done 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.

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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 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

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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 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,

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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 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

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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 confirmed that the "Standing Orders" for pain medication of Tylenol was not given after Resident #1 fell and confirmed that the

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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 the incident was "Non-Witnessed" Type of Injury: Pain. Narrative of incident and description of

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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. Family then transported resident back to her

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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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(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
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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

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	255306	A. BUILDING _____ B. WING _____	C 05/16/2023

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F 600	Continued From page 12 assess and address Res #1's pain at 9:07 AM 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.	F 600		
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	F 656		6/29/23

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

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F 656	Continued From page 14 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on policy reviews, interviews, and record reviews the facility failed to implement approaches and interventions related to pain and control pain for one (1) of four (4) residents reviewed for care plans and pain management. Resident #1 Fndings 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 ..." Record review of a statement on facility letterhead dated 5/16/23 and signed by the Administrator revealed,"We do not have a policy on pain management." Record review of the "Care Plan" for Resident #1 revealed "Problem Onset: 11/07/2022 I am at risk for Pain R/T (related to) DX (diagnosis) Chronic Pain Due, Osteoarthritis and Diabetic Neuropathy, Osteoporosis Goal & Target Date: My pain will be controlled by use of PRN (as needed) pain medication and non- pharmac (pharmacological) Approaches: Attempt non-pharmaceutical interventions, observe for sign and symptoms (S/S) adverse reactions ... Contact physician as needed, Report any S/S of pain to nurse, Administer my pain medication as ordered, observe for effectiveness and s/e (side	F 656	1. Resident #1 returned from the hospital on 3/14/2023, care plan was reviewed and updated per residents care needs. Care plan was followed per documented care interventions with no further issues. 2.All residents have the potential to be affected by this practice. 3. Nursing staff were educated by Director of Nursing (DON) beginning 5/15/23 on pain evaluations, falls, lifts and transfers on 5/15/23, 5/23/23 and 6/5/23. DON educated nursing staff on 6/4/23 on receiving timely care based on their individually identified needs per care plan and implementation of those care plan interventions with documentation in medical record. 4. Care plan team and Minimum Data Set (MDS) coordinator will meet, review and update care plans as needed to adapt to residents individualized needs beginning 5/18/23, Updates will be communicated to nursing staff and available for access in the electronic chart for their review. DON will review two resident care plans per week for three weeks and one resident care plan per week for two weeks to assure staff are implementing interventions beginning 6/5/23. DON and Administrator will review findings for need	

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F 656	Continued From page 15 effects) of medication, Observe for worsening of resident's pain symptoms and report to physician." On 05/15/23 at 10:00 AM, the Ombudsman reported via a telephone interview that she had received a call from the family of Resident #1 on 03/11/2023. They wanted to issue concerns that the 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. The Administrator (ADM) revealed during an interview on 05/15/23 at 1:30 PM, that Resident #1 did complain of pain immediately after the fall. 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. During an interview on 05/15/23 at 3:00 PM, with Registered Nurse (RN) #2 that was working the first shift and came in at 7:00 AM immediately after Resident #1 had fallen, stated that she did not give any pain medications to Resident #1 on 03/11/23 and stated that she did not witness any pain medications given to the resident on 03/11/23 by the previous nurse who was leaving her shift at 7:00 AM. RN #2 stated that she did not call the physician or the Nurse Practitioner (NP) to obtain orders for pain medications. RN #2 confirmed that the resident 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 Resident #1 stated at	F 656	of further interventions weekly beginning 6/9/23. All findings will be brought to the Quality Assurance(QA)/Risk Management Committee for three months for review, discussion and determination of further interventions to assure continued substantial compliance. Immediate QA meeting was held with Medical Director on 5/15/23, First monthly QA meeting is on 6/28/23.	

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7:00 AM that her pain was a "4" on the pain scale. RN #2 stated that she did not assess her pain again after the initial complaint of pain at 7:00 AM.

On 05/15/23 at 3:15 PM, in an interview with Licensed Practical Nurse (LPN) #2 who was the medication nurse on first shift on 03/11/23, stated that Res #1 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 Resident #1. LPN #2 stated that the resident was complaining of pain, and she told the family that all that was ordered for Resident #1 was Tylenol and that was all that she could give her. LPN #2 confirmed that she gave the Tylenol to the resident in the dining room while the resident was sitting in her wheelchair and the family watched her give the medication to the resident. LPN #2 stated that she documented that she gave Tylenol in the "EMAR" (Electronic Medication Administration Record). LPN #2 stated that she gave the resident two (2) 325 milligrams (mg) Tylenol because that was all that she had orders to give. The family expressed that they were tired of waiting and wanted the staff to call 911 and have an ambulance to take the resident to the ER for evaluation and x-ray because the resident was in pain

During 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 Resident #1's room and saw her on the floor in front of her dresser. He turned around and went back to check on her and she stated that she had fallen. She stated her leg had given out and it was

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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 Resident #1. CNA #1, CNA #2, RN #1, and LPN #1 all went into the resident'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 Resident #1 did verbalize pain to him and to the nurses. I did not see any medications given to Resident #1 after the fall on 03/11/23 at 6:50 AM. The resident did complain of pain in her leg while we were putting her in the wheelchair.

On 05/15/23 at 4:10 PM,during an interview with RN #1, revealed that she was serving as the charge nurse on 03/11/23 on the 7:00 PM-7:00 AM shift on the weekends and confirmed 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 Nurse Practitioner for pain medications and to my knowledge there were no pain assessments documented for her 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 their mother sitting in the dining room in a wheelchair at the breakfast table and she was complaining of pain in her right hip and leg. 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 Resident

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#1 was yelling out in pain as she sat in her wheelchair in the dining room. 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 stated that no pain medications were given to Resident #1 on 03/11/23 at the facility. They did not put her to bed, and they left her in a wheelchair calling out in pain and never gave pain medications. It was hurting her sitting up on that hip in that wheelchair.

Interview on 05/16/23 at 10:30 AM, with the Director of Nurses (DON) revealed that the Res #1 should have had her pain 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 the resident fell. DON confirmed that the MAR had not been documented on 03/11/23 for the administrating of pain medications to Resident #1. The DON confirmed that the resident's care plan was not followed for the pain management as outlined in her care plan.

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

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assessed for injuries and assisted up to wheelchair ... Pain Scale: 4

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.... 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)... 0709-Fall with c/o rt. leg pain...3/11/2023 at 10:46 AM: Late charting for 9:07 AM: Resident had started yelling out in pain... Nursing note dated 3/11/2023 at 1:43 PM : Late charting for 8:20 AM... Resident had started yelling due to pain because she was lying on the affected side...."

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.... 20ga(gauge) IV(intravenous) RAC (right antecubital). 100mcg (micrograms) fentanyl given. 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

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F 656	Continued From page 20 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... 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..." 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.	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 facility policy reviews, interviews, and record reviews the facility failed to treat pain for Resident #1 after a fall with vocalization of pain. The facility did not assess or provide pain	F 697	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.	6/29/23

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F 697	Continued From page 21 management for the resident after voiced pain from 6:50-9:32 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). Resident #1 was one (1) of four (4) residents reviewed for pain management. Findings 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 ..." Record review of a typed statement on letterhead dated 5/16/23 and signed by the Administrator (ADM) revealed, " We do not have a policy on pain management." 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 ...." Interview on 05/15/23 at 10:00 AM, with the Ombudsman via telephone revealed that she had received a call from the family of Resident #1 on 03/11/2023. The family reported that they wanted	F 697	2. All residents have the potential to be affected by this practice. 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	

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to issue concerns of neglect and report that the facility did not timely call for an ambulance to transport the resident 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 the 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.

Interview on 05/15/23 at 1:30 PM, with the ADM stated that Resident #1 was severely cognitively impaired and had a Brief Interview for Mental Status(BIMS) score of two (2) or three (3). ADM stated that the resident was verbal and ambulatory without assistance. She was able to verbalize to the staff that she had lost her balance and her leg gave away as she was standing at her dresser, and she fell to the floor. The ADM stated that Resident #1 did complain of pain immediately after the fall. 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 confirmed that there was no local hospital or local ambulance service near the facility. The ADM confirmed that the town had a contract with the neighboring town for 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

proper pain management based on assessment/resident needs. Committee will determine if further interventions needed to assure that consistent 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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ADM confirmed that the incident of the fall for 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 femoral fracture of the hip and that the resident had hip surgery at the hospital on 03/12/23. Resident #1 spent three (3) nights in the hospital prior to her return to the facility on 03/14/23.

Interview on 05/15/23 at 3:00 PM, with Registered Nurse (RN) #2 that was working the first shift and came in at 7:00 AM immediately after Resident #1 had fallen, stated that she did not give any pain medications to Resident #1 on 03/11/23 and stated that she did not witness any pain medications given to the resident on 03/11/23 by the previous nurse who was leaving her shift at 7:00 AM. RN #2 stated that she 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 Resident #1 had fallen at approximately 6:45 AM. The on-call x-ray technician had been called to come do a bedside portable x-ray. At approximately 9:30 AM the x-ray technician called back to the facility, but the ambulance had been called to transport the resident to the ER for x-ray and evaluation. RN #2 confirmed that the resident 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 Resident #1 stated at 7:00 AM that her pain was a "4" on the pain scale. RN #2 stated that she did not assess her pain again after the initial complaint of pain at 7:00 AM.

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Interview on 05/15/23 at 3:15 PM, with Licensed Practical Nurse (LPN) #2 who was the medication nurse on first shift for 03/11/23. LPN #2 stated that Res #1 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 Resident #1. LPN #2 stated that the resident was complaining of pain, and she told the family that all that was ordered for Resident #1 was Tylenol and that was all that she could give her. LPN #2 confirmed that she gave the Tylenol to the resident in the dining room while the resident was sitting in her wheelchair and the family watched her give the medication to the resident. LPN #2 stated that she documented that she gave Tylenol in the "EMAR" (Electronic Medication Administration Record). LPN #2 stated that she gave the resident two (2) 325 milligrams (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 Resident #1 to the ER for an x-ray. LPN #2 confirmed 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 portable x-ray but that they had not arrived at the facility yet at this point. The family expressed that they were tired of waiting on the on-call x-ray technician to respond and wanted the staff to call 911 and have an ambulance to take the resident to the ER for evaluation and x-ray because the resident was in pain.

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 Resident #1's room and saw her

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on the floor in front of her dresser. He turned around and went back to check on her and she stated that she had fallen. She stated 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 Resident #1. CNA #1, CNA #2, RN #1, and LPN #1 all went into the resident'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 Resident #1 did verbalize pain to him and to the nurses. The Charge Nurse told us to pick the resident up 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 Resident #1 after the fall on 03/11/23 at 6:50 AM. I left the facility at 7:00 AM on 3/11/23 and I have not worked at the facility since 03/24/23. We physically picked the resident up off the floor and placed her in a wheelchair at the request of the charge nurse RN #1 and the resident did complain of pain in her leg while we were putting her in the wheelchair. CNA #1 confirmed that they did not use a lift to pick her up off the floor.

Interview on 05/15/23 at 4:10 PM, with RN #1 revealed that she was serving as the charge nurse on 03/11/23 on the 7:00 PM-7:00 AM shift on the weekends and confirmed that they picked Resident #1 up 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

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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 and her family was contacted and they came to the facility to be with the resident at approximately 7:45 AM. 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 Nurse Practitioner for pain medications. An order was placed for an in-house x-ray. The neurological assessments were completed by the first shift nurse (RN#2) and to my knowledge there were no pain assessments documented for her on 3/11/23."

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 their mother 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 us 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 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 Resident #1 was yelling out in pain as she sat in her wheelchair in the dining room. We all thought that she should be in her bed lying down and not sitting up and 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 stated that no

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pain medications were given to Resident #1 on 03/11/23 at the facility. We asked if we could put her in her bed and the nurse told us she needed to sit up and wait for the portable 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 the hospital for x-ray and evaluation. We all were not happy with how little consideration the staff gave our mother. They did not put her to bed, and they left her in a wheelchair calling out in pain and never gave 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 deserves to be treated like they treated our mother. We finally took our mother 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 she had a broken right hip, and she went to surgery the next day on a Sunday. We also do not feel that the facility gave us an explanation of how the entire incident occurred. The facility neglected to properly care for her after the fall and they should never place her in a wheelchair to sit on a broken hip.

Interview on 05/16/23 at 10:30 AM, with the Director of Nurses (DON) revealed that Res #1 should not have been bodily picked up off the floor and placed in a wheelchair. DON stated that the Res #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

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not have any pain assessments on this resident and we should have done them." The DON confirmed that the "Standing Orders" for pain medication for Tylenol was not given after the resident fell. The DON confirmed that the MAR had not been documented on 03/11/23 for the administration of pain medications to Resident #1.

Interview on 05/16/23 at 12:20 PM, with the NP revealed that she does not recall the details of the incident with the resident on 03/11/23 but she does remember that she was asked if they could get a bed side portable x-ray ordered because the resident had fell. The 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 NP confirmed that the facility did not let her know that the resident was in pain, or she would have given them an order to treat the pain. The NP stated 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.

Interview on 05/16/23 at 2:30 PM with CNA #2, revealed that she was assigned to the resident on the third shift (11-7) on 03/11/23. She stated that 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 (2) nurses and CNA #1 in the room with Resident#1 and she was 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 Resident #1 and she did not witness any pain assessments or pain medications given to

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resident. CNA #2 stated that she had never had a resident to fall during her shift prior to this fall on 3/11/23. CNA #2 stated that a lift should be used for picking the resident up after a fall, but they picked her up according to the charge nurse's (RN #1) instructions.

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 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

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(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 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:

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"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 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.

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