STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255287	A. BUILDING _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASS CHRISTIAN HEALTH AND REHABILIATION CENTER	538 MENGE AVENUE PASS CHRISTIAN, MS 39571

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CIs), MS #21741, MS #21950, and MS #22032, at the facility from 7/31/23 through 8/1/23. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated MS #21741 for neglect and MS #22032 for environment, infection control, and facility not clean and there were no deficiencies cited for those complaints. The SA investigated MS #21950 for physical environment, client services not performed per plan of care, cold food, and resident food preferences not honored and cited F697. At the time of survey the facility had a census of 54 residents and was licensed for 60 beds.	F 000		
F 697 SS=D	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 interviews, record review, and facility policy review the facility failed to ensure pain management was provided to treat a newly admitted resident's pain for one (1) of three (3) sampled residents. Resident #1. Findings Include: Record review of the facility's policy, "Policies and	F 697	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by the provisions of State and Federal laws.	8/31/23

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

Electronically Signed | 08/15/2023

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F 697	Continued From page 1 Procedures: Subject: Pain Management Guideline", with a Revision Date of 08/28/2017, revealed, "Policy: The center strives to improve patient/resident comfort and minimize pain in order to help a resident attain or maintain his or her highest practicable level of well-being. Purpose: To ensure residents receive the treatment and care in accordance with professional standards of practice ..." Record review of the facility's policy, "Administering Medications", revised April 2019, revealed, " ...Medications are administered in a safe and timely manner, and as prescribed ...4. Medications are administered in accordance with prescriber orders, including any required time frame ..." Record review of the "Admission Record" revealed the facility admitted Resident #1 on 6/23/23 with a diagnosis of Encounter for Surgical Aftercare following surgery on the nervous system and fusion of the spine, lumbar region. Record review of the "Order Summary Report" with "active orders as of: 06/24/2023" revealed Resident #1 had a Physician's Order with an order date of 6/23/23 for "Oxycodone-Acetaminophen Oral Tablet 10-325 MG (milligram) Give 1 tablet by mouth every 6 hours as needed for moderate pain ..." and an order for "Oxycodone-Acetaminophen Oral Tablet 10-325 MG Give 2 tablet by mouth every 6 hours as needed for pain ..." Record review of the "Medication Administration Record" for June 2023 revealed Oxycodone-Acetaminophen was not documented as administered to Resident #1.	F 697	F 697 1. On August 3,2023, Director of Nursing and Registered Nurse Unit Manager assessed all residents for pain management, no adverse findings. On August 1, 2023, Director of Nursing performed check to ensure all nurses have proper automated medication dispensary access. Our audit findings revealed 2 Nurses access needed to be reset and 2 Nurses were added into system. All Nurses have full access at this time. 2. All residents that receive pain management have the potential to be affected. 3. All nurses in-serviced on pain management, medication administration, residents rights, physician notification, and following plan of care, by Registered Nurse, on August 2,2023. On August 2,2023, Director of Nursing and Registered Nurse checked all pain management medications for availability, no adverse findings. 4. Director of Nursing will monitor pain management for (3) residents weekly x 3 weeks then (2) residents weekly x 2 weeks, then (3) residents monthly for 3 months, to ensure resident is receiving pain management, beginning August 10,2023. Findings were brought to the Quality	

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F 697	Continued From page 2 Record review of the "Progress Notes" for Resident #1 revealed a "Discharge Planning/Discharge" note, dated 6/24/2023, for "Resident was discharged home with her husband ...pain medication availability was discussed and attempted to be resolved at that time ..." On 7/31/23 at 1:40 PM, an interview with License Practical Nurse (LPN) #1, she explained that Resident #1 was admitted late in the day on 6/23/23. Since it was late, all her medication had to be pulled through the automated medication dispenser at the facility that is used after pharmacy hours. She confirmed that Resident #1 was discharged to home on 6/24/23 around 10:30 AM. LPN #1 stated that Resident #1 did not request any pain medication the morning of 6/24/23. On 7/31/23 at 1:53 PM, an interview with Resident #1 revealed she was transferred from the local hospital to the facility about 9:00 PM on 6/23/23. She stated she had back surgery four (4) days prior to the admission to the facility. Resident #1 stated, "My pain score was approximately a four (4) on a 1-10 pain scale, and I requested pain medication, but my nurse told me she could not get one from the (Proper Name of automated medication dispenser)." Resident #1 confirmed that the nurse informed her that she had no way of retrieving the medication because it was after hours, and the pharmacy was not available. On 7/31/23 at 2:00 PM, an interview with the interim Director of Nurses (DON) confirmed that it is her expectation that if a resident complains of	F 697	Assurance Performance Improvement Committee Meeting by Director of Nursing, on August 4,2023, and will continue monthly for 3 months to determine the effectiveness and make necessary changes as indicated. The next monthly Quality Assurance Performance Improvement meeting will be held on 8/31/23.	

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F 697	Continued From page 3	F 697		

pain, the nursing staff should assist the resident, such as giving them pain medication as prescribed, comfort measures, and phone their physician if further orders are required. The DON confirmed the facility faxed the hard copy of the prescription to the pharmacy and the facility had the medication in their (Proper Name of automated medication dispenser). The nurse on duty would have to call the pharmacy on-call person and obtain a code to obtain the medication out of the medication dispenser. During the interview, the DON confirmed that LPN #2 was educated during orientation on how to receive medication after hours through the pharmacy and medication dispenser and that LPN #2 did not perform her duties assigned.

On 8/1/23 at 12:15 PM, an interview with the Nurse Practioner (NP) revealed her expectation is for nurses to medicate the resident if they complain of pain and or provide comfort measures.

On 8/1/23 at 12:40 PM, an interview with LPN #2 confirmed that Resident #1 was admitted late on 6/23/23 and she did not remember seeing the hard copy prescription for the narcotic medication. She also mentioned that since it was the night shift, that she was unable to contact the pharmacy to obtain the code for the medication to retrieve out of the automated medication dispenser. LPN #2 revealed Resident #1 did not exhibit any type of sweating, being anxious, or crying regarding her pain.