STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	**4305 S POPLAR CASPER, WY 82601**

(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 A complaint survey was conducted by Healthcare Licensing and Surveys from 3/4/25 through 3/6/25. The survey was prompted by complaint intakes WY00004204, WY00004205, WY00004255, WY00004264, WY00004274, WY00004275, and WY00004284. The following common abbreviations are used throughout this document: DON: Director of Nursing MAR: Medication Administration Record MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to	F 563		4/11/25

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

Electronically Signed | 03/28/2025

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F 563	Continued From page 1 the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on resident, friend and staff interviews, and review of policies and procedures and incident reports, the facility failed to ensure the resident had the right to receive visitors of his/her choosing for 1 of 5 sample residents (#7) reviewed for residents rights/visitation. The findings were: 1. During an interview on 3/5/25 at 3:20 PM resident #7 stated that his/her friend was no longer able to visit because the facility issued a no trespass order with the police. The resident stated in February his/her friend visited in the facility. When the friend was headed to the front door to leave, another resident accused resident #7 of hitting him/her when resident #7 wheeled by in the w/c. The resident stated s/he didn't hit the other resident. The resident stated his/her friend saw the whole thing and was yelling at that other resident "[s/he] didn't hit you." Later, the police called the resident's friend and stated s/he was no longer allowed to visit because a no trespass order was issued by the facility. The resident was upset his/her friend was no longer able to visit. 2. On 3/6/25 at 10:24 AM the friend of resident #7	F 563	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community s policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules o civil procedure and should inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or shareholder of the Community of affiliated companies.	

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F 563	Continued From page 2 was interviewed. The friend stated s/he was told s/he was not allowed to visit anymore. The friend stated in February when s/he visited, another resident accused resident #7 of hitting him/her. The friend stated resident #7 did not hit the other resident. The friend stated s/he went up and tapped the other resident on the shoulder and told the resident that resident #7 did not hit him/her. 3. Review of an incident report reported to Healthcare Licensing and Surveys (HLS) showed on 2/9/25 at 6 PM resident #7 and resident #10 "bumped into each other in the hallway and there were reports of them pushing each other." The report further read "...Additionally, a visitor of one of the residents contributed to the situation by verbally expressing frustration toward the other resident. However, this visitor had left the premises before the arrival of the Casper Police Department. Law enforcement later contacted the visitor and informed [him/her] that [s/he] was no longer permitted to visit the facility." 4. During an interview on 3/6/25 at 3:28 PM the administrator stated the friend of resident #7 yelled at another resident and so a no trespass order was issued by the police. When asked if the visitor threatened the other resident, or was abusive, the administrator stated it did not rise to verbal abuse, but was disrespectful. When asked if this behavior was a pattern of the visitor, the administrator stated the visitor had previously disregarded some facility policies related to pets, but did not state the visitor had any other incidents of yelling at other residents. When asked if the facility had tried any other least restrictive measures to allow some visitation, such as supervised visits or visits only in the	F 563	It is the facility's policy to ensure residents have the right to receive visitors of their choosing at the time of their choosing, subject to reasonable clinical and safety restrictions, in accordance with F563. Corrective Action for Affected Residents: On 3/6/25, the Administrator reviewed the no-trespass order for Resident #7's friend and rescinded it. The Administrator contacted Resident #7's friend on 3/7/25 to apologize and invite them to resume visitation, with an agreement to follow facility policies. Resident #7 was informed of this decision on 3/7/25. Identifying other Residents having the Potential to be Affected:On 3/31/25, the Social Services Director conducted interviews with 10% of alert and oriented residents to assess if any other residents experienced restrictions on their chosen visitors. No other instances of inappropriate visitor restrictions were identified. Measures put into place or Systemic Changes: 1. The Administrator reviewed and revised the facility's visitor restriction policy on 3/9/25 to include a graduated response system for addressing visitor behavioral concerns: " First occurrence: Verbal warning and education " Second occurrence: Written warning " Third occurrence: Meeting with facility leadership " Final step: Supervised visits or visiting restrictions only if documented pattern of	

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F 563	Continued From page 3 resident's room, the administrator stated no. He stated the facility had talked about setting up a meeting, but that meeting had not happened yet. 5. Review of the facility's policy "Resident Right to Access and Visitation" (copyright date 2025) showed "...The facility will provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time...Reasonable clinical and safety restrictions that protect the health and security of all residents and staff, which may include, but are not limited to:...d. Denying access or providing limited and supervised access to a visitor if that individual has been found to be abusing, exploiting, or coercing a resident..." The facility's policy did not include restricting visitation for behavior that was disrespectful but not abusive.	F 563	disruptive behavior 2. The DON or designee will in-service all staff by 04/07/2025 on: " Residents' rights regarding visitation " Proper procedures for addressing visitor concerns " Documentation requirements for visitor incidents " New graduated response system Plan to Monitor Performance: 1. The Social Services Director will audit 100% of grievance reports related to visitation weekly for 4 weeks, then monthly for 2 months to ensure proper procedures are followed. 2. The Director of Social Services will conduct monthly interviews with 10% of residents regarding satisfaction with visitation rights for 3 months. 3. The Administrator will review all proposed visitor restrictions before implementation. 4. Results will be reported monthly to the Quality Assurance Performance Improvement (QAPI) committee for review and additional interventions as needed until substantial compliance is achieved and maintained for 3 consecutive months.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		4/11/25

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F 580	Continued From page 4	F 580		

physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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F 580	Continued From page 5 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and family interview, the facility failed to ensure the resident's physician was notified of a significant change in condition for 1 of 3 sample residents (#4) reviewed for changes in condition. The findings were: 1. Review of the 1/16/25 admission MDS assessment showed resident #4 had diagnoses including heart failure and diabetes mellitus and did not have any wounds. Review of progress notes dated 1/17/25 showed the resident did not have any edema and had no documented skin concerns. The following concerns were identified: a. Review of a skilled nursing evaluation dated 1/18/25 showed the resident had edema. The resident had +2 pitting edema to the right and left lower legs. b. Review of a skilled nursing evaluation dated 1/19/25 showed the resident had +1 pitting edema to the left lower leg and +2 pitting edema to the right lower leg. c. Review of skilled nursing evaluations dated 1/20/25 and 1/21/25 showed the resident had +1 pitting edema to the left lower leg. d. Review of a wound evaluation dated 1/21/25 showed the resident had a venous wound on the left foot which was being treated with Unna boots. Review of wound evaluations dated 1/28/25 and 2/4/25 showed the venous wound to the left foot remained. e. Review of the medical record showed no evidence the resident's physician was notified of the new edema to the lower legs nor the venous wound on the left foot.	F 580	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community s policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules o civil procedure and should inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or shareholder of the Community of affiliated companies. It is the facility's policy to immediately inform the resident, consult with the resident's physician, and notify the resident representative when there is a significant change in the resident's physical, mental, or psychosocial status, including new or worsening conditions. Corrective Action for Affected Residents:	

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F 580	Continued From page 6 f. During an interview on 3/6/25 at 9:57 AM a family member stated the resident developed edema in the lower extremities while in the facility and also developed a wound on one foot. The family member stated s/he was not aware of the physician being notified. S/he stated a nurse notified the facility's wound team about the wound on the left foot. g. On 3/6/25 at 2:59 PM the DON stated a physician rounded with the wound care team, but it was not the resident's physician. She stated she was not sure if that physician communicated with the resident's physician. She also confirmed there was no physician orders for the wound care on the left foot. The facility did not provide any documentation to show the resident's physician was notified of the new edema on the legs and the wound to the left foot.	F 580	Resident #4 was discharged from the facility. Identifying other Residents having the Potential to be Affected: The Director of Nursing (DON) conducted a review of all current residents to identify any changes in condition requiring physician notification within the past 30 days. Any identified gaps in physician notification were addressed immediately. Measures put into place or Systemic Changes: The DON or designee will in-service all licensed nurses by 04/07/2025 on: " Requirements for physician notification of significant changes in condition " Documentation requirements for physician notification " Process for escalation if unable to reach physician " Proper assessment and documentation of new or worsening conditions The SBAR Communication Form and Progress Note will be used to ensure proper notification and documentation of physician contacts. The Wound Care Team will communicate directly with residents' primary physicians regarding wound care findings and treatments, with documentation in the medical record. Plan to Monitor Performance: The DON or designee will audit 10% of resident records weekly for 4 weeks, then monthly for 2 months to ensure proper physician notification of changes in condition. The DON or designee will review all new	

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F 580	Continued From page 7	F 580	wounds and significant changes in condition daily during clinical morning meetings to ensure physician notification occurred. The DON or designee will report audit findings to the Quality Assurance Performance Improvement (QAPI) committee monthly for three months. The committee will evaluate the effectiveness of interventions and make adjustments as needed until substantial compliance is achieved and maintained.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and family interviews, and review of policies and procedures, the facility failed to ensure care was provided in accordance with physician orders and professional standards for non pressure-related wounds for 2 of 3 sample residents (#4, #7) reviewed for wounds. The findings were: 1. Review of the 1/16/25 admission MDS assessment showed resident #4 had diagnoses including heart failure and diabetes mellitus and did not have any wounds. The following concerns	F 684	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any	4/11/25

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F 684	Continued From page 8 were identified: a. Review of a wound evaluation dated 1/21/25 showed the resident had a venous wound on the left foot which was treated with Unna boots [type of compression bandage] and Coban. The evaluation was signed by a physical therapist. b. Review of a wound evaluation dated 1/28/25 showed the venous wound on the left foot remained and was being treated with Unna boots and Coban. The evaluation was signed by a physical therapist. c. Review of wound evaluation dated 2/4/25 showed the venous wound on the left foot remained. The treatment was changed to "Cleanse with wound cleanser, apply zinc to bases, cover with bordered gauze." The evaluation was signed by a physical therapist. d. Review of the medical record showed no evidence the resident's physician was notified of the wound to the left foot. e. Further review of the medical record showed no evidence of physician's orders for the treatment of the wound. f. During an interview on 3/6/25 at 9:57 AM a family member stated the resident developed edema in the lower extremities while in the facility and also developed a wound on one foot. The family member stated s/he was not aware of the physician being notified. S/he stated a nurse notified the facility's wound team about the wound on the left foot. g. On 3/6/25 at 2:59 PM the DON stated a physician rounded with the wound care team weekly, but it was not the resident's physician. She stated she was not sure if that physician communicated with the resident's physician. She also confirmed there was no physician orders for the wound care on the left foot. She stated the physical therapist was the wound specialist and	F 684	changes to the Community□s policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules o civil procedure and should inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or shareholder of the Community of affiliated companies. It is the facility's policy to ensure that residents receive treatment and care in accordance with professional standards of practice, physician orders, the comprehensive person-centered care plan, and residents' choices, including proper wound care management and physician notification. Corrective Action for Affected Residents: Resident #4 was discharged from the facility. Resident #7s right thumb amputation site was healed. Identifying other Residents having the Potential to be Affected: The DON or designee will conduct a facility-wide audit of all residents with non-pressure wounds to ensure proper physician orders were in place and treatments were documented appropriately by 4/2/25. Any identified discrepancies were immediately addressed with the attending physician and proper orders obtained. Measures put into place or Systemic Changes: The DON or designee will	

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F 684	Continued From page 9 recommended the treatment. The facility did not provide any physician orders for wound care, nor evidence the resident's physician was notified of the wound. 2. Review of the 1/17/25 admission MDS assessment showed resident #7 had a surgical wound. Review of a 1/15/25 progress note showed the resident had a surgical wound to the right thumb amputation site. The wound was covered and orders were to keep the dressing intact until a follow-up in 1 week with orthopedics. Review of a 1/23/25 progress note from orthopedics showed the resident was seen for follow-up for partial right thumb amputation. The examination showed the site was healing well and sutures were in place. The documented plan was for daily dressing changes and to return in 2 weeks. The following concerns were identified: a. Review of the medical record showed no physician orders for daily dressing changes. b. Further review of the medical record showed no documentation that daily dressing changes were completed. c. During an interview on 3/6/25 at 2:59 PM the DON confirmed there were no physician orders for the daily dressing changes. She stated the facility had not seen that note from orthopedics until this week and the resident did not say anything when s/he returned from the appointment that day. She stated during that time period the resident would occasionally ask nursing staff for a band-aid. 3. Review of the facility's policy "Wound Treatment Management" (copyright date at bottom of 2024) showed "...Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing,	F 684	in-service all licensed nurses by 04/07/2025 on: " Proper wound care documentation requirements " Protocol for obtaining and implementing physician orders for wound treatments " Communication requirements between wound care team and attending physicians " Documentation requirements in the Treatment Administration Record The facility's wound care policy has been revised to include: " Required documentation of physician notification for all new wounds " Ensuring proper orders are obtained before initiating treatments " Communication between wound care team and attending physicians " Weekly wound care team rounds must include documentation of physician communication when needed. Plan to Monitor Performance: The DON or designee will audit 100% of residents with non-pressure wounds weekly for 4 weeks, then 50% of residents with non-pressure wounds weekly for 8 weeks to ensure: " Physician orders are in place for all wound treatments " Treatments are documented appropriately on the TAR " Proper physician notification is documented The DON or designee will review audit results weekly and report findings to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee will analyze data	

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F 684	Continued From page 10 and frequency of dressing change...in the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders...Treatments will be documented on the Treatment Administration Record or in the electronic health record."	F 684	and make recommendations for additional interventions if compliance is less than 90%. Monitoring will continue until substantial compliance is achieved for 3 consecutive months.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and family interview, the facility failed to ensure the drug regimen was free from unnecessary drugs for 1 of 3 sample residents (#5) reviewed for medications. Resident #5 received a drug without	F 757	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy	4/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASPER MOUNTAIN REHABILITATION AND CARE CENTER	4305 S POPLAR CASPER, WY 82601

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F 757	Continued From page 11	F 757		

adequate indication for its use. The findings were:

1. Review of the 2/9/25 admission MDS assessment showed resident #5 had diagnoses which included history of falling and unspecified pain. The assessment further showed the resident did not have pain during the look-back period. Review of the original admission orders dated 2/3/25 showed an order for Tramadol 50 milligrams (mg), 1 tab, every 6 hours as needed [PRN] for pain. The instructions further read "pt normally takes 1 tab at bedtime, but frequency was increased after a fall about a week prior to 1/28/25 admit to every [sic] 6 hours PRN." The following concerns were identified:

a. Review of the February MAR showed the Tramadol order was transcribed as 50 mg every 6 hours. The order was put in as a routine order, and not as a PRN order. The order was in place until 2/14/25 when it was changed to every 6 hours PRN. Further review of the MAR for 2/3/25 through 2/14/25 showed the resident was given the Tramadol 7 times when his/her pain level was "0."

b. Review of progress notes showed on 2/9/25 the family requested no scheduled Tramadol except at bedtime. The family requested scheduled Tylenol Arthritis.

c. During an interview on 3/5/25 at 3:10 PM a family member stated the facility had been giving the resident Tramadol 4 times a day. The family member stated they noticed the resident was "out of it" so they requested the Tramadol not be given so much.

d. On 3/6/25 at 2:59 PM the DON confirmed the order was for PRN, but was incorrectly transcribed as every 6 hours routinely.

of the surveyors findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community s policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules o civil procedure and should inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community, or any employee, agent, officer, director, attorney, or shareholder of the Community of affiliated companies.

It is the facility's policy that each resident's drug regimen must be free from unnecessary drugs, including medications given in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences.
Corrective Action for Affected Residents:
On 2/14/25, Resident #5's Tramadol order was corrected to reflect PRN administration every 6 hours as originally ordered. The Director of Nursing conducted a medication regimen review for Resident #5 on 3/6/25, which included assessment of pain levels, medication administration records, and effectiveness of current pain management approach.

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F 757	Continued From page 12	F 757	The resident's care plan was updated to reflect the correct pain management protocol. Identifying other Residents having the Potential to be Affected: On 3/7/25, the Director of Nursing and Unit Managers conducted an audit of all current residents receiving PRN pain medications to ensure proper order transcription and administration. The audit included review of medication administration records, pain assessments, and verification of proper documentation of PRN medication effectiveness. Measures put into place or Systemic Changes: The Director of Nursing or designee will in-service all Licensed nurses by 04/07/2025 on: " Proper transcription of medication orders, specifically distinguishing between routine and PRN orders " Documentation requirements for pain assessment before administering PRN pain medications " Monitoring and documenting effectiveness of pain medications " Communication with families regarding medication changes The Order Listing Report will be reviewed daily to assess for discrepancies. Plan to Monitor Performance: The DON or designee will conduct weekly audits of 10% of residents receiving PRN pain medications for 4 weeks, then monthly for 3 months to ensure: " Accurate transcription of medication orders " Proper documentation of pain assessments	

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F 757	Continued From page 13	F 757	" Appropriate administration of PRN medications " Documentation of medication effectiveness The Director of Nursing or designee will review audit results weekly and report the findings to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The QAPI committee will analyze data for patterns and trends, and implement additional interventions as needed until substantial compliance is achieved and maintained.	