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S 000	Initial Comments Annual Licensure and Certification Survey Extended Survey Conducted	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 4 300.3210t) Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidence by: Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from verbal and mental/emotional abuse by staff members for two (R345, R195) of 32 residents reviewed for abuse on the sample list of 48 residents. This failure resulted in fear, emotional harm and mental anguish for both R345 and R195. Findings Include: 1. R345's care plan dated 2/11/25 documents R345 has medical diagnoses of COPD (Chronic Obstructive Pulmonary Disease), Asthma, History of Chronic Respiratory Failure, History of Fracture to the the Right Femur, Arthritis to right hand, Depression, Diabetes Mellitus, Anemia, Pneumonia, and Hypertension. R345's minimum data assessment dated 2/14/25 documents that R345 is cognitively intact and has no signs and symptoms of delirium.	S9999		

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On 3/2/25 at 10:23 AM, R345 was sitting in his wheelchair in his room. When asked how R345 is treated in the facility R345 put his hands together and quietly stated, "I am afraid of retaliation if I tell you." R345 then stated a couple weekends ago (2/22/24 and 2/23/24) he asked for a pain pill and nobody came so he called his daughter (V25) to tell her so that she could get someone to bring him a pain pill. R345 stated a few minutes later V26 (Licensed Practical Nurse) came into his room and was mad and yelled at him that she has 30 other residents to take care of and V26 can't jump every time R345 calls. R345 stated then V26 stated she didn't appreciate being reported two days in a row. R345 began to cry and stated V26 scared R345 and he was afraid of what V26 might do.

On 3/3/25 at 10:44 AM, V25 stated R345 had called her upset that the nurse had not brought his pain pill. V25 stated she called the facility and talked to V26. V25 stated a little bit later R345 called and was crying and stated that V26 came into his room yelling at him and stated V26 doesn't like to be reported and has too many people to take care of.

On 3/06/25 at 9:23 AM, V1 (Administrator) stated that R345 is alert and orientated, makes his own decisions, and, "If he said it happened, it happened." V1 stated V1 would consider V26 yelling at R345 as verbal abuse

2. R195's undated Diagnoses List, documents R195's diagnoses as: Cerebral Infarction due to unspecified occlusion or stenosis of Left Posterior Cerebral Artery, Metabolic Encephalopathy, Rhabdomyolysis, and Hemiplegia, unspecified affecting left nondominant side.

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R195's Care Plan dated 2/6/25, documents R195 requires substantial/maximum assist by one staff member to eat.

R195's Minimum Data Set (MDS) dated 2/10/25, documents R195 has an impairment on one side of both the upper and lower extremities.

On 3/2/25 at 8:57 AM, R195 stated during night shift, unknown CNA told R195 he uses his call light too much and took it away from him so he couldn't get any help. R195 stated the staff laugh at him at night and are rough with him when they transfer and roll him. R195 was visibly upset when speaking about this and stated the interaction made him very distraught as he was not able to get the help he needed without his call light. R195 stated it was hurtful when staff laughed at him and were rough.

On 3/5/25 at 10:30 AM, V2 Interim Director of Nursing (DON) confirmed R195 is at risk for abuse due to him needing assistance with Activities of Daily Living (ADL's) and because of his diagnoses. V2 confirmed staff should never take away a resident's call light or make them feel badly for using it to call for assistance. V2 confirmed staff should treat residents with respect and never be rough or laugh at them.

The facility's Abuse, Neglect and Exploitation Policy dated Revised 2/11/25, documents Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of

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S9999	Continued From page 3 any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, physical abuse, and mental abuse. Mental Abuse includes humiliation, harassment, and deprivation and it is the policy of the facility to provide protection for the health, welfare and rights of each resident. (B) (2 of 4) 300.1010h) 300.1210b) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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These regulations were not as evidence by:
Based on observation, interview, and record review the facility failed to assess a wound, prevent cross contamination during wound care, administer wound treatments as ordered, timely notify the physician of a dehisced surgical wound, monitor bowel movements and hydration, and implement bowel interventions for three (R52, R30, R41) of 24 residents reviewed for quality nursing care in the sample list of 48. These failures resulted in R52 and R41 developing bowel obstruction and fecal impaction requiring hospitalization and treatment.

Findings Include:

1.) R52's Minimum Data Set (MDS) dated 12/28/24 documents R52 is dependent on staff for toileting. R52's MDS dated 1/13/25 documents R52 has cognitive impairment and R52 is dependent on staff for toileting. R52's Care Plan dated 11/7/22 documents R52 is at risk for constipation and includes interventions to encourage R52 to sit on the toilet and monitor/report symptoms of constipation. R52's Care Plan dated 5/23/22 documents R52 is incontinent of bowel and bladder and includes an intervention to monitor bowel habits, notify the nurse of bowel concerns, administer bowel management medications as ordered, and notify physician of concerns. R52's care plan has not been updated to include R52's history of bowel obstruction or any new bowel interventions after 10/22/22.

R52's Nursing Note dated 1/13/25 at 1:04 PM documents R52 was transferred to the hospital for seizure like activity. R52's hospital note dated 1/13/25 documents R52 arrived with abdominal distention, abdominal pain, and no bowel

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movements for the past day. R52's Hospital Note dated 1/14/25 documents R52's abdominal computed tomography indicated high-grade small bowel obstruction and low-grade partial colonic obstruction. A nasogastric tube was inserted and R52 was hospitalized until 1/17/25.

R52's January 2025 and March 2025 Medication Administration Records do not document any orders for bowel medications.

R52's January 2025 bowel tracking documents between 1/1/25 and 1/13/25 R52 had three small bowel movements. Bowel incontinence is recorded once on 1/2/25 and 1/6/25, but "not applicable" is recorded for size and consistency of bowel movements. There are no documented bowel movements between 1/1/25 and 1/7/25, 1/11/25, and 1/12/25, besides these entries. R52's February and March 2025 bowel tracking documents R52's last recorded bowel movement was a small bowel movement on 2/22/25, besides bowel incontinence on night shift on 3/11/25. This entry documents "not applicable" for size and consistency.

R52's medical record does not document any assessments of R52's abdomen or that R52's constipation was reported to a physician after 2/22/25.

On 3/04/25 at 9:54 AM V28 Certified Nursing Assistant (CNA) stated V28 is R52's assigned CNA today and R52 had not had a bowel movement. V28 stated bowel movements are documented by the CNAs in the bowel tracking. V28 was unsure when R52's last bowel movement was and V28 would have to look at R52's bowel tracking. On 3/05/25 at 9:31 AM V39 CNA stated V39 is assigned to R52's care today

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and R52 had not had a bowel movement today. On 3/04/25 at 9:58 AM V13 Licensed Practical Nurse stated nothing had been passed on in shift report about R52's bowels. V13 stated the CNAs are suppose to chart bowel movements and if the resident hasn't had a bowel movement in so many days then the nurses are suppose to contact the doctor for orders. R52's bowel tracking was reviewed with V28 who confirmed R52 going three or more days without bowel movements and confirmed R52 has no active orders for bowel medications. V28 stated V28 will follow up and get orders. On 3/4/25 at 10:13 PM V40 CNA confirmed V40 documented incontinent bowel movement for R52 on night shift on 3/3/25. V40 stated the bowel movement was not enough to even consider a bowel movement, it was pate like and a minimal amount. V40 was unsure when R52 last had a bowel movement.

On 3/04/25 at 10:07 AM V2 Director of Nursing stated the CNAs should be documenting bowel movements in the resident's bowel tracking. V2 stated R52 should have bowel and hydration monitoring and stool softeners ordered since R52 has a history of bowel obstruction. V2 stated fluid intake is documented as part of meal intakes recorded by the CNAs, but is not recorded unless the resident is on strict intake and output monitoring. R52's bowel tracking was reviewed with V2 and confirmed 2/22/25 was the last recorded bowel movement. V2 confirmed no bowel medications or interventions have been implemented. V2 stated physician notification is documented in a progress note. On 3/04/25 at 1:02 PM V2 confirmed R52's December 2024 and January 2025 bowel tracking documents lack of bowel movements and R52 had no bowel medications ordered prior to R52's bowel obstruction. V2 confirmed bowel movement size

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and consistency should be recorded for each bowel movement. On 3/05/25 at 10:56 AM V2 stated the facility does not have a bowel protocol/policy.

On 3/06/25 at 9:36 AM V3 Assistant Director of Nursing was requested to assess R52's abdomen and bowel sounds. R52 denied stomach pain and nausea. V3 asked R52 if R52 had a bowel movement and R52 replied "no." V3 asked R52 when R52 last had a bowel movement and R52 was unsure. V3 palpated R52's abdomen and used a stethoscope to assess R52's bowel sounds. V3 stated R52's abdomen is soft and not distended, and V3 heard bowel sounds in all four quadrants of R52's abdomen. V3 stated V3 will follow up with V18 Nurse Practitioner or V35 Medical Director. V3 told R52 that V3 would get an order and give something for R52 to have a bowel movement. V3 confirmed physical assessments should be noted in a progress note or in the assessment section of R52's electronic medical record.

On 3/03/25 at 1:44 PM R52's January 2025 hospitalization for bowel obstruction was discussed with V18 Nurse Practitioner. V18 stated the facility should have been tracking and monitoring R52's bowel movements and notified the physician so that a stool softener or laxative could be ordered prior to R52's hospitalization. On 3/4/25 at 10:57 AM V18 stated the facility should have informed V18 or V34 (R52's Physician) that R52 was not having routine bowel movements so that R52 could be started on a bowel medication such as Senna. V18 confirmed the staff should be monitoring R52's bowel movements closely and reporting concerns. V18 stated with R52's history of bowel obstruction V18 is prone to developing another obstruction. V18

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stated signs would be complaints of abdominal pain, but R52 has Alzheimer's Disease which makes it complicated due to impaired cognition and communication. V18 stated if a bowel obstruction is left undetected and untreated for a prolonged period it could lead to death, but usually there are signs of symptoms such as abdominal distention/bloating and vomiting. V18 stated the facility should also be monitoring and ensuring adequate hydration for R52, which would also help with R52's constipation.

2.) On 03/02/25 at 9:14 AM R30 had a wound vacuum attached to a dressing on R30's left below knee amputation surgical wound. R30 stated the nurses did not initiate a wound treatment when R30 admitted to the facility and R30 had to have additional surgery for an infection of the surgical incision.

R30's MDS dated 1/2/25 documents R30 as cognitively intact.

R30's nursing notes document R30 admitted to the facility on 12/26/24. R30's Skin Check dated 12/31/2024 at 10:50 PM documents R30 had a new wound to the left knee amputation site that measured 3 centimeters (cm) long by 1.5 cm wide by 0.25 cm deep. This wound had 90% granulation, 100% slough, and purulent pus drainage. R30's Nursing Note dated 1/3/2025 at 10:04 AM documents an open area below R30's left knee measured 3 cm by 1.5 cm by 0.25 cm and physician (V35) was notified. R30's Nursing Noted dated 1/7/2025 at 12:51 PM documents R30's amputation site was warm to touch, and had pus, foul odor, and was larger from prior observation. Antibiotics and would culture was ordered. There is no documentation in R52's

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medical record that this wound was reported to V35 prior to 1/3/25 and reported to V41 (R52's Surgeon) prior to 1/9/25.

R30's Hospital Notes and Operative Report dated 1/10/25 documents dehiscence of amputation surgical site with breakdown exposing muscle and tendon that required debridement and wound vacuum placement.

R30's December 2024 and January 2025 Treatment Administration Records (TARs) do not document any wound treatments were implemented for R30's surgical wound after 12/31/24 until 1/3/25. R30's Physician Order dated 2/16/24 documents negative pressure wound therapy for left below knee amputation and change every Monday, Wednesday, Friday and as needed. There are no orders for a petroleum gauze dressing as part of R30's surgical wound care.

R30's Skin Checks dated 2/18/25, 2/19/25 and 2/26/25 do not document an assessment and/or measurements of R30's surgical wound. There are no documented wound assessments for R30's surgical wound in R30's electronic medical record after 1/31/25.

On 3/03/25 at 10:35 AM V22 Wound Nurse performed hand hygiene and applied gown and gloves prior to entering R30's room to administer R30's surgical wound treatment. V22 removed the surgical wound dressing and did not remove V22's gloves. V22 handled R30's personal cellular phone to obtain a picture of R30's wound, per R30's request and then cleaned R30's wound while wearing the same gloves. V22 changed gloves, performed hand hygiene, applied a petroleum gauze directly to R30's wound, applied

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foam and attached the wound vacuum.

On 3/3/25 at 10:58 AM V22 stated the floor nurses should be assessing the wound each time the dressing is changed and recording weekly as a skin assessment under the assessments section of R30's electronic medical record (EMR). V22 reviewed R30's EMR and skin assessments 2/19/25 and 2/26/25. V22 confirmed R52's EMR does not contain weekly assessments and/or measurements of R52's wound between 2/1/25 and 3/3/25. V22 stated V22 applied the petroleum dressing because R30 had requested it for comfort. V22 confirmed R30's wound care orders do not include the use of petroleum gauze. On 3/6/25 at 9:26 AM V22 stated gloves should be changed during wound treatments after removing the old dressing, after cleaning the wound, and when the treatment is finished. V22 confirmed V22 did not change gloves and perform hand hygiene after removing R30's wound dressing and handling R30's phone, prior to cleaning R30's wound.

On 3/03/25 at 1:44 PM V18 Nurse Practitioner stated surgical wounds should be assessed regularly and treatments should be initiated when wounds are identified, if this is not implemented it could lead to sepsis. V18 stated R30 should have been evaluated by a wound provider or surgeon (V41) when R30's wound reopened.

On 3/04/25 at 1:25 PM V41 confirmed V41's office was not notified of R30's surgical wound reopening until 1/7/25. V41 stated the facility should have absolutely notified V41's office when the draining wound was first identified so that R30 could have been evaluated in V41's office sooner. V41 stated R30 could have had an internal infection brewing over the prior two weeks that

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finally blew open and may have required incision and drainage regardless.

The facility's Wound Treatment Management Policy dated 2/1/25 documents notify the physician to obtain treatment orders when wounds are identified, treatments are documented on the TAR, follow physician's orders when administering wound care, and monitor the progression of the wound through regular assessments.

The facility's Dressing Change Clean policy dated 8/23/24 documents remove gloves after removing the dressing, perform hand hygiene and apply clean gloves prior to cleansing the wound.

3.) On 3/5/25 at 10:50 AM, R41 was lying in bed and appeared alert. R41 stated she has suffered from constipation for months since coming to the facility. R41 stated they now have her on a stool softener, and she feels she is having more regular bowel movements, but prior to her hospitalization in January of this year she couldn't even recall how long it would be between bowel movements. R41 stated it was long enough that using the bed pan was very painful but that is what is offered. R41 stated prior to hospitalization in January, she had days of horrible chest and stomach pain that wouldn't subside and finally her niece had to tell facility staff to send her to the hospital. R41 stated she had an infection at that time as well and remembers having to have multiple tests done.

R41's minimum data sheet (MDS) dated 1/20/25 documents R41 is cognitively intact.

R41's care plan with print date of 3/5/25 documents a plan of care for constipation related

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to decreased mobility and use/side effects of medication (tramadol) with an initiation date of 1/16/25.

R41's Physician Visit Notes dated 12/17/24 document constipation as an active diagnosis.

R41's bowel and bladder elimination document dated December 2024 documents R41 had no bowel movements for the following dates: 12/1, 12/2, 12/3-12/7, 12/9, 12/11, 12/13-12/17, 12/20, 12/22, 12/25-12/26, and 12/28-12/29/24 and documents no response for 12/8, 12/18 and 12/23/24.

R41's bowel and bladder elimination document dated January 2025 documents R41 had no bowel movements for the following dates: 1/1-1/3, 1/5-1/8, 1/11-1/13, 1/21-1/24, 1/26-1/27 and 1/29/25 and documents no response for the dates of 1/4, 1/10 and 1/18/25. The document documents from 1/13-1/16/25 R41 was out of the facility.

R41's bowel and bladder elimination document dated 2/3/25 through 3/5/25 documents no bowel movement for the following dates: 2/8, 2/9, 2/10, 2/12, 2/13, 2/16-2/19, 2/24-2/26, 3/1, 3/2, and 3/5 and documents no response for the dates of 2/14, 2/27, 2/28, and 3/4/25.

R41's December 2024 Medication Administration Record (MAR) documents no orders or medications administered for constipation management and that R41 received Tramadol twice daily and as needed. R41's January 2025 MAR documents R41 received Tramadol 50mg by mouth twice daily and as needed and documents no orders or medications administered for constipation management until

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1/17/24 when Colace 100mg by mouth twice daily was started.

R41's progress notes dated 1/12/25 at 10:09 PM document R41 complained of chest heaviness and the medical provider ordered to send R41 to the emergency room if R41 continued to complain of chest pain. At 11:22 PM on 1/12/25 progress notes document R41 complained of chest heaviness at a rate of 5/10 but documents R41 declined to go to the hospital. On 1/13/25 at 5:37 PM progress notes document R41 complained of pain radiating down the right thigh, lower back, and chest. The Progress Notes document R41's power of attorney (POA) requested R41 be sent to the hospital. At 6:01 PM on 1/13/25, notes document R41 was sent to the local emergency department. On 1/14/25 at 5:44 am, nursing notes document R41 was admitted to the hospital for pyelonephritis and fecal impaction.

R41 hospital records dated 1/14/25 document admission diagnoses of pyelonephritis and fecal impaction. Hospital Records document an admission date of 1/13/25 with complaints of left flank pain radiating into R41's abdomen and chest, as well as left leg pain that shoots up her side and into her arm for the last couple days, but that pain was increased and constant on this date. Computed Tomography of the abdomen documents large amounts of stool noted in the colon with distension and probable fecal impaction.

On 3/5/25 at 11:30 AM, V17, Pharmacist, stated there are no recommendations or orders for bowel protocol medications prior to 1/13/25 (hospital admission) for R41.

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S9999	Continued From page 14 On 3/5/25 at 1:50 PM, V18, Nurse Practitioner stated the facility has bowel standing orders for "Colace and MiraLAX" for constipation to give and increase as needed. V18 stated R41 should be assisted to the toilet and not using bed pan for elimination. (A) (3 of 4) 300.1010e) 300.1010h) Section 300.1010 Medical Care Policies e) All resident shall be seen by their physician as often as necessary to assure adequate health care. h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. These regulations were not met as evidence by: Based on interview and record review the facility failed to identify significant weight loss, notify a physician or registered dietician regarding significant weight loss or implement interventions to prevent further weight loss for one of five residents (R45) reviewed for Nutrition on the sample list of 48. This failure resulted in continued weight loss even after a severe weight loss was identified.	S9999		

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S9999	Continued From page 15 Findings Include: The facility's Weight Monitoring policy dated 2/10/25 documents Based on the resident's comprehensive assessment; the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight. Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. Newly recorded resident weights should be compared to the previous recorded weight. A significant change in weight is defined as 5% change in weight in one month, 7.5% change in weight in three months, 10% change in weight in six months. The physician should be informed of a significant change in weight and may order nutritional interventions. The Registered Dietitian or Dietary Manager should be consulted to assist with interventions and any actions should be recorded in the nutrition progress notes. Specific interventions should be noted on the care plan and any new orders should be administered as directed. R45's Medical Diagnoses List dated March 2025 documents R45 is diagnosed with Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Anemia, Protein Calorie Malnutrition, Vitamin D Deficiency, History of other Endocrine, Nutritional and Metabolic Disease, and Hypokalemia. R45's Physician Order Sheet (POS) dated March 2025 documents an order for a regular diet and monthly weights.	S9999		

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R45's Care Plan dated 10/14/24 documents R45 has had a significant weight loss and staff should monitor R45's weight for any further loss and notify the medical doctor and registered dietician. The registered dietician needs to evaluate and make recommendations as needed. The same care plan dated 5/22/24 documents R45 requires assistance with eating including supervision by staff, finger foods when having difficulty with utensils, and milkshakes or liquid food supplements when the resident refuses or has difficulty with solid food; or provide nutritious foods that can be taken from a cup or a mug where appropriate.

R45's Weight Log documents R45 weighed 158.4 pounds on 7/5/24 and six months later, on 1/7/25 R45 weighed 137.4 pounds. This is a -13.26% weight loss in six months' time. R45 continued to lose weight and in February 2025 her weight was 135.8 pounds.

R45's Nutrition/Dietary Note dated 1/14/25 documents R45's current weight as 137 pounds. This is noted to be a significant weight loss. The note documents R45's physician (V35) would be notified and staff would request extra calories with meals. (This notification was not documented/completed and no new interventions were implemented).

R45's Mini Nutrition Assessment dated 1/14/25 documents R45's weight loss is greater 6.6 pounds in the last 3 months. R45's Mini Nutrition Score is 8 which puts her in the at risk of malnutrition category.

On 3/6/25 at 1:00 PM V36 Certified Nurses Assistant reported R45's March weight was 134.2 pounds.

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S9999	Continued From page 17 On 3/05/25 at 1:00 PM V20 Registered Dietician confirmed R45 had significant weight loss from July to January 2025 and V20 was not notified and did not have the opportunity to implement any interventions to prevent further weight loss. V20 confirmed she could have added more calories or implemented other interventions had she been notified but she was not and has not assessed R45 since October of 2024. V20 confirmed R45 could be at risk nutritionally due to her diagnoses and staff should be monitoring monthly weights closely and making proper notifications. On 3/5/25 at 1:45 PM V18 Nurse Practitioner stated he was never notified of R45's weight loss and did not have the opportunity to put any interventions in place to prevent further weight loss. V18 stated staff should be monitoring resident's weights on a regular basis. V18 confirmed if new interventions would have been implemented it could have prevented further weight loss. On 3/5/25 at 3:00 PM V2 Interim Regional Director of Nurses confirmed staff need to be monitoring resident's weights and if there is a consistent unplanned weight loss or significant weight loss the physician should be notified and the registered dietician should be consulted. V2 confirmed there is no documentation in R45's record that V35 physician or V20 dietician were notified of R45's consistent unplanned or significant weight loss and no new interventions were put into place. R45 continued to lose weight over the next two months. (B) (4 of 4)	S9999		

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300.1010e)
300.1010h)

Section 300.1010 Medical Care Policies

e) All residentsshall be seen by their physician as often as necessary to assure adequate health care.
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

These regulations were not met as evidence by:

Based on observation, interview and record review the facility failed to effectively manage pain by failing to accurately assess for pain, notify the physician of pain and implement orders for pain medications for two (R52, R84) of two residents reviewed for pain in the sample list of 48. This failure resulted in R52 experiencing uncontrolled pain as evidenced by moaning, grimacing, tearfulness, clenched fists and complaints of pain.

Findings Include:

The facility's Pain Management policy dated 2/10/25 documents the facility will recognize when a resident is experiencing pain, observe for nonverbal signs of pain, identify circumstances

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when pain can be anticipated, conduct ongoing pain assessments using a tool that is appropriate for the resident's cognitive status, and collaborate with the resident's physician to manage or prevent pain in accordance with the resident's care plan, assessment, and current standard of practice.

1.) On 3/03/25 at 9:32 AM R52 was sitting in a wheelchair in R52's room. R52 stated R52 thinks R52 has a sore on R52's bottom, but was unable to give any additional information about R52's wound and wound care. On 3/3/25 intermittent observations were conducted from 9:32 AM until 3:12 PM of R52 sitting in a wheelchair in R52's room. There was a foam cushion on R52's wheelchair seat.

On 3/03/25 at 2:19 PM V11 Certified Nursing Assistant (CNA) stated V11 last offered to lay R52 down and provide toileting assistance at 10:00 AM and R52 refused at that time. At 2:41 PM R52 was in R52's room scooted down in the wheelchair. V10 and V11 CNAs entered R52's room and attempted to transfer R52 from the wheelchair. R52 was tearful, moaning and shaking. R52's fists were clenched and R52 complained of buttock pain when V11 and V10 CNAs attempted to transfer R52. V10 and V11 stated R52 acts like this when R52 is in pain from sitting in the wheelchair too long, they will need to allow R52 time to calm down and reapproach later. At 3:12 PM V11 and V19 CNA transferred R52 into bed and provided incontinence care. R52 was tearful, anxious, shaking, moaning, and complaining of R52's bottom hurting. R52's brief was saturated with urine and R52 had a golf ball sized sacral pressure ulcer.

R52's Minimum Data Set (MDS) dated 1/13/25

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documents R52 has cognitive impairment, R52 does not receive scheduled or as needed (PRN) pain medications, R52 is dependent on staff for toileting and transfers, and R52 needs partial/moderate assistance with bed mobility.

R52's (active) Care Plan documents R52 has Parkinson's Disease and Alzheimer's Disease, R52 is at risk for pain and has sacral moisture associated skin damage (MASD). This care plan includes interventions to administer pain medications as ordered, assist to reposition frequently for comfort, notify the physician of changes in pain, report nonverbal expressions of pain, and treat pain prior to treatments and turning to ensure resident comfort.

R52's Wound Assessment dated 2/13/25 documents R52's sacral wound measured 1.5 cm by 0.8 cm by 0.1 cm deep. R52's March 2025 Treatment Administration Record (TAR) documents to cleanse sacral wound and apply honey hydrocolloid dressing every three days on night shift as of 2/9/25. R52's February and March TARs document R52's pain is assessed every shift and rates R52's pain as "0" on a 1-10 scale.

There are no active physician orders for pain medication in R52's medical record as of 3/3/25 or that R52's pain was reported to a physician prior to 3/4/25 when Tylenol 650 milligrams every eight hours was ordered.

R52's Wound Evaluation and Management Summary dated 3/5/25, recorded by V21 Wound Nurse Practitioner, documents R52's sacral wound as a stage four pressure ulcer that measured 2.3 cm by 1.3 cm by 2.1 cm deep. This wound contained 30% necrotic (dead) tissue and

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40% slough (dead tissue). The wound is described as being odorous with gray colored drainage, periwound is erythematous and painful to palpation. This wound required debridement to remove the dead tissue. V21 ordered Doxycycline (antibiotic) 100 milligrams twice daily by mouth for 14 days and a new treatment for 0.125% Dakins (bleach) solution soaked gauze packed into the wound and covered with a dressing twice daily. V21 recommended offloading the wound, repositioning per facility protocol, using an air inflated wheelchair cushion, and limiting time in the wheelchair to two hours at a time.

On 3/3/25 at 2:36 PM V10 CNA stated R52's wound was present three weeks ago when V10 started working for the facility, the wound has gotten worse and R52 complains of pain. V10 stated the nurses were aware of this.

On 3/4/25 at 3:25 PM V23 Licensed Practical Nurse (LPN) stated the last time V23 administered R52's sacral wound treatment the wound was deeper, had slough, and was draining. R52's February 2025 TAR documents V23 administered R52's sacral wound treatment on 2/24/25 and 2/27/25, the last times that V23 administered R52's wound treatment.

On 3/4/25 at 10:07 AM V2 Director of Nursing (DON) confirmed R52 would have potential for pain related to R52's wound, R52 has no pain medication ordered, and R52's pain assessments document no pain. V2 stated physician notification would be documented in a nursing note.

On 3/4/25 at 10:57 AM V18 Nurse Practitioner stated the nurses should have reported R52's pain so that we could implement pain medication

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orders for R52. V18 stated "(R52) should not be in pain."

On 3/5/25 at 3:48 PM V21 Wound Nurse Practitioner stated V21 just evaluated R52's wound which presented as an unstageable pressure ulcer with slough and necrosis that required debridement. After debridement (mechanical removal of dead tissue) it is a stage four pressure ulcer that measured 2.3 cm by 1.3 cm by 2.1 cm deep. V21 stated V21 had to stop the debridement due to the amount of pain R52 experienced. V21 stated V21 is ordering Doxycycline and additional blood work due to R52's pain and concern for infection.

2.) On 3/02/25 at 9:46 AM R84 stated R84 has frequent pain to lower back and knees, which the nurses are aware of, and R84 had recent back surgery. R84 stated R84's pain medications help "take the edge off." On 03/02/25 at 9:57 AM R84 was lying in bed with legs elevated on a pillow. R84 yelled out and moaned when V7 CNA lifted R84's legs off of the pillow and with turning when V7 provided R84's incontinence cares. R84 yelled out, R84's breathing was heavy, R84 whimpered, and R84 had tears in R84's eyes during R84's cares. There was a dressing on R84's lower back. V7 told R84 "I'm sorry." R84 stated R84's knees hurt and the pain travels up R84's back. R84 told V7 that R84 needed a pain pill from the nurse and R84 rated R84's pain as a "10". On 3/02/25 at 1:55 PM and on 3/3/25 at 9:23 AM R84 was lying in bed asleep.

R84's MDS dated 1/30/25 documents R84 as cognitively intact, R84 does not receive scheduled pain medication, and R84 has moderate pain frequently. R84's active Care Plan documents R84 has pain related to radiculopathy,

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spinal stenosis and osteoarthritis. This care plan includes interventions to administer pain medication as ordered, assess pain, discuss precipitating factors, and notify the physician of any changes in pain.

R84's February and March 2025 Medication Administration Records document R84's pain is assessed every shift and R84's pain rating was between 4 and 8 on nine occasions between 2/1/25 and 3/2/25. Norco 5-325 milligrams (mg) was given 16 times and Tramadol 50 mg was given nine times between 2/1/25 and 3/2/25. R84's March MAR does not document pain medication was administered until 2:03 PM on 3/2/25.

On 3/02/25 at 1:28 PM V6 LPN stated R84 mostly complains of pain during R84's cares and during therapy. V6 stated V6 offered R84 a pain pill at 7:30 AM and again at 12:47 PM, but R84 declined the pain medication. V6 stated R84 has orders for Tramadol and Norco PRN and no scheduled pain medications ordered. V6 stated R84 will deny being in pain and then 15-20 minutes later will complain of pain during therapy. V6 stated that no one had reported that R84 requested a pain pill today and R84 had not received any pain medication during V6's shift today.

On 3/03/25 at 1:14 PM V37 Certified Occupational Therapy Assistant stated R84 has back pain and pretty severe pain in R84's legs causing R84 to be sensitive to touch. V37 stated R84's pain affects R84's ability to participate in therapy and it is difficult for R84 to stand in the lift device. V38 Physical Therapy Assistant stated R84 has constant pain to both knees and back pain that comes and goes. V38 stated R84's knees are "bone on bone" and R84 was

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S9999	Continued From page 24 supposed to have knee replacement surgery prior to R84's back surgery. V37 and V38 stated they both have discussed R84's pain with the nurses, but R84 only has PRN pain medication which R84 often doesn't request until R84 is in therapy already and in pain. (B)	S9999		