STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00399801, IN00398351 and IN00392986. This visit resulted in a Partially Extended Survey-Substandard Quality of Care-Immediate Jeopardy. Complaint IN00399801 - Substantiated. Federal/state deficiencies related to the allegations are cited at F580, F600, F609, and F697. Complaint IN00398351 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00392986 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677. Survey dates: January 24, 25, 26, 27, 28, & 30, 2023 Facility number: 000048 Provider number: 155115 AIM number: 100275330 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 5 Medicaid: 60 Other: 9 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 2/10/23.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anne Morgan	Executive Director	02/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §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 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			

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	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 room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure a resident's responsible party was notified in a timely manor of an allegation of physical abuse and also failed to provide notification in advance of obtaining an X-ray, for 1 of 3 residents reviewed for notification, (Resident D). Finding includes: On 1/24/23 at 4:05 P.M., the Executive Director (ED) provided a recorded video dated 12/29/22 at 7:30 P.M., of the area near and around the first floor 2 E Nurses Station. The Video indicated Resident D was at the Nurses Station attempting to approach the Medication Cart. QMA T was observed talking to the resident and pointing to the medication cart. When Resident D approached the medication cart again, QMA T pushed the resident causing him to fall to the floor. QMA T was then observed getting the resident up to his feet and escorted him back to his room with the aide of a walker, an assessment was not performed at that time. Resident D was observed limping with difficulty walking. On 1/25/23 at 2:00 P.M., the clinical record for Resident D was reviewed. Resident D was	F 0580	**F580 Notify of changes** It is the practice of this facility that all changes in resident condition will be communicated to the physician and family/responsible party. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D's MD and POA were notified. ED held a care plan with POA to discuss resident D's condition, orders, and plan of care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. An audit of residents who have had changes in condition and Xray results will be completed to ensure responsible party have been notified. **What measures will be put into**	03/02/2023

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	admitted on 12/3/22 with diagnoses included, but not limited to: alcohol withdrawal related seizures, alcohol induced chronic pancreatitis, Wenicke's encephalopathy, diabetes and acute respiratory failure with hypoxia. An Admission Minimum Data Set (MDS) dated 12/9/22, indicated Resident D was severely cognitively impaired and demonstrated verbal behaviors directed at others 1-3 days during the assessment period. Resident D required limited assistance with bed mobility, was independent with transfers, walking in his room and corridors, locomotion on and off the unit, and dressing. He required supervision with eating and limited assistance with toilet use and personal hygiene. A Significant Change Minimum Data Set dated 1/09/23, indicated Resident D was moderately cognitively impaired and demonstrated verbal behaviors directed at others 1-3 days during the assessment period. Resident D required extensive assistance of 2 people with bed mobility, transfers, and toileting, and extensive assistance of 1 person for locomotion on and off the unit, dressing, and personal hygiene. The resident required a wheelchair for mobility. Diagnoses included but were not limited to hip fracture and other fracture (arm). A review of a Physician's Telephone Order dated 12/29/22 indicated orders for STAT (statim, immediate) X-ray of bilateral hips. A Radiology report, dated 12/30/22 at 7:32 A.M., indicated Resident D had a displaced intertrochanteric fracture of the proximal right femur. Resident D's progress notes indicated on 12/29/23		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff will be in-serviced on notification with all new orders and changes in condition including falls. DNS/designee will review changes in condition and new orders via Facility Activity Report daily, discuss in clinical meeting if indicated. Family will be notified of these changes. Care plans will be updated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “change in condition” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** 3/2/23	

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	at 8:57 P.M., "QMA reported resident had a fall with complaints of pain. I [Licensed Practical Nurse L] assessed resident...DNS [Director of Nursing Services] was called. ED [Executive Director] was notified. NP [Nurse Practitioner] was notified via voice message." On 12/29/22 at 9:35 P.M., "...STAT X RAY was ordered." On 12/30/22 at 7:39 A.M., "[Ambulance] arrive to transfer resident to [local] ER [emergency room] and are currently in route to hosp. [hospital] DNS and resident father informed..." On 1/25/23 at 11:47 A.M., during an interview, with Resident D's responsible party, he indicated he was notified in the morning of 1/30/23 that Resident D had a fall the previous evening and that an X-ray was obtained by the facility showing the resident fractured his femur and was being transported to a local hospital. Resident D's responsible party indicated he was not notified of an allegation of abuse until the resident returned to the facility after his hospitalization. On 1/25/23 at 3:00 P.M., during an interview, conducted with the Director of Nursing (DON), she indicated she received a call from Licensed Practical Nurse (LPN) L that Resident D had a fall without injuries but was in intense pain. The DON indicated she notified the ED on 12/29/22 at about 7:50 P.M., to report the fall. The DON indicated on 12/30/22 at 6:50 A.M., the X-Ray technician notified her that Resident D had sustained a fracture to his right hip. The DON indicated the Resident D's responsible party was notified of the fractured hip and transport to the hospital on 1/30/22 at 7:39 A.M. The DON indicated the resident's responsible party should have been notified at the time of the fall and when the order for the X-ray was obtained.			

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	A policy titled "Resident Change of Condition Policy," dated 11/28 was provided by the DON on 1/24/23 at 11:30 A.M., indicating it was the current policy, indicated, "...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party...The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken..." This Federal tag relates to complaint IN00399801. 3.1-5(a)(1)(3)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview, record review, the facility failed to ensure an allegation of abuse that resulted in serious bodily injury was reported to the State Agency (SA) in a timely manner for 1 resident, (Resident D). Finding includes: On 1/24/23 at 4:05 P.M., the Executive Director (ED) provided a recorded video dated 12/29/22 at around 7:30 P.M., of the area near and around the first floor 2 E Nurses Station. The Video indicated Resident D was at the Nurses Station attempting to approach the Medication Cart. QMA T was observed talking to the resident and pointing to the medication cart. When Resident D approached the medication cart again, QMA T pushed the resident causing him to fall to the floor. QMA T was then observed getting the resident up to his feet and escorted him back to his room with the aide of a walker, an assessment was not performed at that time. Resident D was observed limping with difficulty walking. On 1/25/23 at 12:03 P.M., during an interview, conducted with a local police detective, they indicated the facility reported an incident that occurred on 12/29/22 at the facility to the police department and on 12/30/22 at an unknown time, the Detective indicated the facility provided a video related to the incident. The Detective	F 0609	**F 609 Reporting of alleged violations** It is the practice of this facility to complete an incident report and submit to ISDH gateway within 2 hours of staff to resident abuse allegations. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Allegation for resident D was reported to ISDH via Gateway **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. Review of allegations of abuse were reviewed by ED and Regional staff to ensure all allegations were reported timely per policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	03/02/2023

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	indicated they observed Resident D near the Nurse's Station and was thrown to the ground by QMA T. The resident was sent to the hospital where they discovered a broken hip and arm. On 1/25/23 at 12:30 P.M., during an observation of Resident D, the resident was observed sitting on the edge of his bed eating lunch utilizing the over bed table. Resident D had a brace to his right forearm and 2 healing incisions both approximately 3 cm (centimeters) long to the right hip. In an interview, conducted at that time, the resident indicated he went to the nurses station one evening, he was not able to recall the date, for something more to eat. The resident indicated the nurse pointed back to the refrigerator behind the nurses station so he thought the nurse wanted him to go get a snack from the refrigerator. Resident D indicated when he opened the door the nurse jumped up and took him out of the Nurse's Station and threw him onto the floor and that's when his leg and arm broke. The resident indicated he couldn't move, was crying, and hurt bad while the nurse was telling him to get back to his room. Resident D indicated he could not move, so the nurse got him up and hand hauled him to his room and threw him in his bed. The resident indicated all he could do was cry. On 1/25/23 at 2:00 P.M., the clinical record for Resident D was reviewed. Resident D was admitted on 12/3/22 with diagnoses included but not limited to: alcohol withdrawal related seizures, alcohol induced chronic pancreatitis, Wenicke's encephalopathy, diabetes and acute respiratory failure with hypoxia. An Admission Minimum Data Set (MDS) dated 12/9/22, indicated Resident D was severely cognitively impaired and demonstrated verbal		Education was provided to the ED regarding timely reporting. ED will send all abuse allegations to regional staff at the time of occurrence for review and to give further instructions as needed. Scheduled evening and weekend managers will round the facility, report any concerns to the ED, and discuss any follow-up needed in AM meeting with IDT. Resident care companions will round daily and report any concerns to ED and discuss any needed follow-up. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Abuse prohibition and investigation” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:**	

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	behaviors directed at others 1-3 days during the assessment period. Resident D required limited assistance with bed mobility, was independent with transfers, walking in his room and corridors, locomotion on and off the unit, and dressing. He required supervision with eating and limited assistance with toilet use and personal hygiene. A Significant Change Minimum Data Set dated 1/09/23, indicated Resident D was moderately cognitively impaired and demonstrated verbal behaviors directed at others 1-3 days during the assessment period. Resident D required extensive assistance of 2 people with bed mobility, transfers, and toileting, and extensive assistance of 1 person for locomotion on and off the unit, dressing, and personal hygiene. The resident required a wheelchair for mobility. Diagnoses included but were not limited to hip fracture and other fracture (arm). An Incident Report Number: 117, with a report date of 12/30/22 at 8:02 P.M., was provided by the ED on 1/25/23 at 2:09 P.M. The report indicated an incident date of 12/29/22 at 7:30 P.M., indicating, "... the resident approached the Nurses Station and Medication Cart demanding medications. As staff member attempted to redirect resident, the resident became increasingly agitated and persistent, pulling med cart and trying to open. Staff member continued to redirect resulting in a physical altercation with resident falling to floor. Staff member contacted Nurse for assessment...Moble X-ray was completed on morning of 12/30 indicating a Right hip fracture... New orders received to send to ER for further evaluation and treatment..." On 1/25/23 at 3:00 P.M., during an interview, conducted with the Director of Nursing (DON),		3/2/23	

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	she indicated she received a call from Licensed Practical Nurse (LPN) L that Resident D had a fall without injuries but was in intense pain. The DON indicated LPN L told her that QMA T indicated he had made a mistake and that was an odd thing to say. The DON indicated she notified the ED on 12/29/22 at about 7:50 P.M., to report the fall and that LPN L had indicated QMA T had made a mistake and told the ED there was something missing in LPN L's report. The DON indicated she asked the ED if she should go to the facility, but was not directed to do so. The DON indicated she did not receive any notifications regarding Resident D until the following morning on 12/30/22 at 6:50 A.M. when the X-Ray technician notified her that Resident D had sustained a fracture to his right hip. The DON indicated she should have gone into the facility when she received the call from LPN L about the resident's fall and the comment made by QMA T indicating he had made a mistake. On 1/25/23 at 3:07 P.M., during an interview, conducted with the ED, she indicated she received a call from the DON indicating Resident D had sustained a fall and there was some concern about what had happened. The ED indicated she called the facility and spoke with LPN L and had QMA T removed from the facility pending an investigation. The ED indicated she was notified of Resident D's hip fracture on 12/30/22 at 6:50 A.M., when it was reported to the DON. The ED indicated the State Agency was was notified of the allegation of abuse on 1/30/22 at 8:02 P.M., and that the State Agency should have been notified sooner. A policy, titled "Abuse Prohibition, Reporting, and Investigating" dated 1/23 was provided by the DON on 1/24/23 at 11:15 A.M. The policy			

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	indicated, "...Resident Abuse-Staff member...An incident report will be initiated within 2 hours of the allegation, following the guidelines for 'Unusual Occurrence Reporting' via ISDH [Indiana State Department of Health] gateway portal..." This Federal tag relates to complaint IN00399801. 3.1-28(c)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for Activities of Daily Living and neglect, received showers as scheduled, (Resident B). Findings include: On 1/27/22 at 1:00 P.M., the clinical record for Resident B was reviewed. Resident B was most recently admitted on 7/28/21 with diagnoses that included, but were not limited to: hemiplegia and hemiparesis following a stroke, chronic obstructive pulmonary disease, diabetes, stage 4 chronic kidney disease, and muscle weakness. Review of the most recent Minimum Data Set (MDS) dated 10/06/22 for significant change indicated Resident B had moderate cognitive impairment, demonstrated no behaviors, was totally dependent on staff for bathing, and indicated daily preference for choosing between tub bath, shower, bed bath and sponge bath were very important to her.	F 0677	**F 677 ADL care provided for dependent residents** It is the practice of this facility to ensure residents receive treatment and care in accordance with professional standards, comprehensive plan of care, and residents' choices. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B no longer resides in the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be impacted by this deficient practice. An audit of shower	03/02/2023

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	Review of Resident B's Care Plans included but were not limited to; Activites, most recently revised on 10/20/22, that indicated resident preferences while in the facility was to choose between a shower, bed bath, sponge bath, or tub bath, and that the resident prefers to bath more than twice a week in the A.M. ADL (activities of daily living) care, most recently revised on 7/28/21, indicated the resident required assistance with ADLs including assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Review of Resident B's Shower Report Sheet from 8/29/22 to 11/11/22, indicated the resident's documentation regarding showers or baths were as follows: 9/29/22 Refused Shower 9/15/22 Refused Shower 9/26/22 Partial Bed Bath Given 9/27/22 Complete Bed Bath Given 10/20/22 Refused Shower, attempted 2 times 10/25/22 Refused Shower There was no other document regarding Resident B's bathing or showering at the facility. On 1/27/23 at 1:30 P.M., during an interview with the Director of Nursing, she indicated residents at the facility were supposed to be showered 2 times per week or per preference. The Director of Nursing indicated Resident D should have been offered showers more than 2 times weekly due to her preferences and when showers were not given, the reason should have been documented. The Director of Nursing indicated the only records of showers or refusals were provided and noted above.		preferences and frequency per shower schedule will be completed for all residents by DNS/Designee **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff will be educated on shower preferences and frequency by DNS/designee. The DNS/designee will ensure Shower schedules are established. The DNS/Designee will review Shower Sheets daily to ensure showers are provided per resident preference. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Accommodation of Needs” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	155115	A. BUILDING 00 B. WING	01/30/2023

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	This Federal tag relates to complaint IN00392986. 3.1-38(a)(2)(A)		**By what date the systemic changes will be completed:** 3/2/23	
F 0697 SS=G Bldg. 00	483.25(k) Pain Management §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. Based on observation, interviews and record review, the facility failed to ensure pain management was in place for a resident who sustained injuries following an altercation with a facility Qualified Medication Aide (QMA) when the resident was pushed to the ground and sustained a fracture to the hip and arm. (Resident D) Finding includes: On 1/24/23 at 4:05 P.M., the Executive Director (ED) provided a recorded video dated 12/29/22, of the area near and around the first floor 2 E Nurses Station. The Video indicated Resident D was at the Nurses Station attempting to approach the Medication Cart. QMA T was observed talking to the resident and pointing to the medication cart. When Resident D approached the medication cart again, QMA T pushed the resident causing him to fall to the floor. QMA T was then observed getting the resident up to his feet and escorted him back to his room with the aide of a walker, an assessment was not performed at that time. Resident D was observed limping with difficulty walking.	F 0697	**F697 Pain management** It is the practice of this facility to ensure that pain management is provided to residents consistent with professional standards of practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D upon return to the facility was assessed for pain. Pain medications were reviewed with MD and he is currently receiving routine and PRN pain medication which is effective. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All other residents have the potential to be affected by this deficient practice. Nursing staff will be educated to call DNS with	03/02/2023

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	On 1/25/23 at 12:30 P.M., during an observation of Resident D, the resident was observed sitting on the edge of his bed eating lunch utilizing the over bed table. Resident D had a brace to his right forearm and 2 healing incisions both approximately 3 cm (centimeters) long to the right hip. In an interview, conducted at that time, the resident indicated he went to the nurses station one evening, he was not able to recall the date, for something more to eat. The resident indicated the nurse pointed back to the refrigerator behind the nurses station so he thought the nurse wanted him to go get a snack from the refrigerator. Resident D indicated when he opened the door the nurse jumped up and took him out of the Nurse's Station and threw him onto the floor and that's when his leg and arm broke. The resident indicated he couldn't move, was crying, and hurt bad while the nurse was telling him to get back to his room. Resident D indicated he could not move, so the nurse got him up and hand hauled him to his room and threw him in his bed. The resident indicated all he could do was cry. On 1/25/23 at 2:00 P.M., the clinical record for Resident D was reviewed. Resident D was admitted on 12/3/22 with diagnoses included, but not limited to: alcohol withdrawal related seizures, alcohol induced chronic pancreatitis, Wenicke's encephalopathy, diabetes and acute respiratory failure with hypoxia. An Admission Minimum Data Set (MDS) dated 12/9/22, indicated Resident D was severely cognitively impaired and demonstrated verbal behaviors directed at others 1-3 days during the assessment period. Resident D required limited assistance with bed mobility, was independent with transfers, walking in his room and corridors,		unresolved pain resulting from falls to receive further instruction. Residents who had a fall within the last 30 days were assessed for pain to ensure pain was addressed by the DNS/Designee **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff will be in-serviced on monitoring for signs of pain and MD notification with any abnormal findings or unresolved pain including when falls occur. Pain will be assessed on admission, quarterly, and with changes including falls. MD and POA will be updated with any abnormal findings. DNS/designee will review falls via Facility Activity Report daily, discuss in clinical meeting, MD and family with be updated with any signs of pain and/or unresolved pain. Care plans will be updated. MD will be notified in a timely manner for further orders to address any new or unresolved pain. If medication is not effective facility will request an order to send residents to the ER for further evaluation **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this	

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	locomotion on and off the unit, and dressing. He required supervision with eating and limited assistance with toilet use and personal hygiene. Review of Resident D's Progress Notes, indicated on 12/29/22 at 8:57 P.M., "...QMA reported resident had a fall with complaints of pain. I [Licence Practical Nurse (LPN) L] assessed resident rang of motion and resident was in intense pain..." 12/29/22 at 9:35 P.M., "...spoke with resident.. He complained of pain in his hip. A STAT X RAY was ordered." 12/30/22 at 6:44 A.M., "[Resident D] has been in pain, yelling out and on the call light most of the night d/t [due to] right leg having s/s [signs and symptoms] of a fracture from a fall. Noted to be externally rotated, and swollen at the hip ball joint area. Given him PRN [as needed] Butal-Acetam-Caff (primary use to relieve symptoms of tension headaches) at 0030 [10:30 P.M] which did not help much. PRN Loazepam (an antianxiety medication) 0.25 ml given at 0202 [2:02 A.M.] which did help and had been comfortable until [mobile unit X Ray] came to do his x-ray." 12/30/22 at 7:21 A.M., "Resident noted with severe pain, calling out in pain. Per report...R [right] leg noted with external rotation, unable to move leg and screaming out when touched and moved..." Review of physicians orders indicate Resident D's orders included, but were not limited to: Loazepam 0.25 ml 2 times a day for anxiety disorder, from 7:00 A.M. to 11:00 A.M., and from 7:00 P.M, to 11:00 P.M., dated 12/20/22, Tylenol 650 mg, for pain every 6 hours as needed, dated 12/13/22,		corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Pain management” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** 3/2/23	

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	Butalbital-acetaminophen-caff 50-300-40 mg for headache every 6 hours as needed, dated 12/20/22. Review of Resident D's Medication Administration Record (MAR) indicated the resident did not received Loazepam 0.25 ml as ordered on 1/29/22 sometime between 7:00 P.M. and 11:00 P.M. Reason/Comments on the MAR indicated the medication was not administered because the medication was unavailable. Resident D received Loazepam 0.5 ml on 1/30/22 at 2:04 A.M. with the Reason/Comment documented as "...yelling out d/t pain." The MAR indicated Butalbital-acetaminophen-caff 50-300-40 mg capsule was given one time on 1/30/22 at 12:31 A.M. No documentation for Reason/Comment was noted. No other pain medications or interventions were documented to address the resident's pain. On 1/25/23 at 3:00 P.M., during an interview, conducted with the Director of Nursing (DON), she indicated she received a call from Licensed Practical Nurse (LPN) L that Resident D had a fall without injuries but was in intense pain. The DON indicated she did not receive any notifications regarding Resident D until the following morning on 12/30/22 at 6:50 A.M. when the X-Ray technician notified her that Resident D had sustained a fracture to his right hip. The DON indicated no one called her about the resident's pain level in the night but that they should have addressed his pain better and the Nurse Practitioner should have been notified of the pain but was not. A policy, titled "Pain Management," dated 10/20 was provided by the DON on 1/27/23 at 11:30			

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	A.M. and indicated it was the current facility policy. The policy indicated, "...It is the policy...to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being, including pain management...Pain medications will be prescribed and given based upon the intensity of the pain...The physician will be notified [for] unrelieved or worsening pain..." This Federal tag relates to complaint IN00399801. 3.1-37(a)			