STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. BUILDING _____ B. WING _____	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	600 S 27TH ST BILLINGS, MT 59101

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F 000	INITIAL COMMENTS A Complaint survey was completed on 5/12/21. Facility Reported Incidents were investigated during the survey. The facility census on entrance was __67_____. DEFICIENCIES CITED: Deficient practices were cited for the complaint(s) with Intake number(s): #MT00050598 and MT00050614. Deficient practices were cited for the Facility Reported Incident with Intake number: MT00050573. DEFICIENCIES NOT CITED: Refer to FORM CMS-2567; Event ID: OHPB11 for unsubstantiated findings. Deficient practices were NOT cited for the Facility Reported Incident(s) with Intake number(s): MT00050275 and MT00050276. Glossary CNA Certified Nursing Assistant IDT Interdisciplinary Team mg milligrams	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		6/10/21

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

Electronically Signed | 06/03/2021

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F 657	Continued From page 1 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the care plan timely reflecting new interventions related to a change of condition and pain for a resident who sustained a fall with injury for 1 (#1) of 3 sampled residents. Findings include: During an interview on 5/12/21 at 10:39 a.m., staff member B stated any nurse can update a resident care plan as needed. Staff member B stated the IDT members updated care plans based on discussions had during group meetings, including the weekly meeting to discuss resident falls. During an interview on 5/12/21 at 11:22 a.m., staff member A stated the IDT met weekly to discuss falls. Staff member A stated the IDT discussed resident #1's fall on 4/2/21 and identified a new	F 657	1.Resident #1 has been re-assessed for a change of condition and a pain assessment was also completed on or before 5/29/21. The results of the assessments allowed the IDT to develop a current comprehensive care plan, which has been completed. 2.Any resident who sustains a fall has the potential to have a change of condition, increased pain, and has the potential to be affected by this practice. During the morning meeting, the nurse’s notes will be reviewed to identify any falls or change in conditions 5 days a week. After review, the care plan will be updated as appropriate. Daily, on the weekends and holidays the staff nurse will assess the resident and implement an initial	

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F 657	Continued From page 2 intervention related to toileting. A review of resident #1's nursing progress note, dated 4/3/21 at 3:49 a.m., showed the resident was reluctant to participate in activities and was sore (Refer to F697 for additional details related to resident #1's pain status and F689 for additional details related to resident #1's functional status before and after the fall on 4/1/21). A review of resident #1's care plan, initiated on 4/16/20, failed to show evidence of revisions following her fall on 4/1/21. There was no evidence of changes to resident #1's care related to the source and location of her pain, administration of pain medication, application of ice, an increased need for assistance with ADL's, or how to deal with her refusal to move around in bed or transfer as she had prior to the fall on 4/1/21. A review of the facility's policy titled, "Fall Prevention and Response Policy," dated April 2020, showed, " ... the Interdisciplinary Team Fall Committee will meet and complete a Fall Review on each resident who has fallen during the preceding week. The care plan will be updated with any new or decided interventions." and, "Revise the care plan as required based on the resident's needs." A review of the facility's policy titled, "Pain Assessment and Management Policy," dated March 2019, showed, "2. Pain management interventions shall reflect the sources, type, and severity of pain. 3. Pain management interventions shall address the underlying causes of the resident's pain."	F 657	intervention for any fall/change of condition. This will also be reviewed during the morning meeting on the following Monday. The Care plan will then be updated as appropriate. 3.On or before 6/1/2021 the Regional Clinical Director will re-educate the Case Manager/MDS on reviewing, managing, and updating care plans, as necessary. 4.During the morning meeting, the nurse□s notes will be reviewed to identify any falls or change in conditions. An audit will be completed to track this information. This information will be used to update the care plans for any affected residents. These audits will be completed 5 times per week for 4 weeks and then weekly for 2 months or as deemed necessary by the QAPI team. 5.The results of these audits will be shared with the QAPI team on 6/7/2021. Further action will be completed as deemed necessary by this team. 6.Compliance will be met by 6/10/2021.	

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were adequately assessed for changes in their physical and neurological condition after an unwitnessed fall, for acute pain after an unwitnessed fall, and for deterioration in functional ability; the facility failed to notify the medical provider when a diagnostic x-ray was not completed as ordered, resulting in a delay in treatment; and the facility failed to update the resident care plan with interventions related to monitoring and documentation of changes in physical, mental, and psychosocial status, management of acute pain, and when to notify a medical provider, for 1 (#1) of 5 sampled residents. Findings include: During an interview on 5/11/21 at 2:25 p.m., resident #1 stated she remembered the circumstances of her fall but did not remember much about the days which followed because she was, "kind of in a daze," and did not remember many details. Resident #1 stated she was trying to get something out of her clothes closet, lost her balance, and fell backwards hitting her left hip and her head. She stated she needed help getting up and took pain pills for her hip pain. Resident #1 stated she had the pain pills for use	F 689	1.Resident #1 has been thoroughly reassessed for change in condition and pain. These assessments were completed on or before 5/29/2021. The neurological checks are not indicated at this point. The care plan was reviewed and updated on or before 5/29/21, for ADL abilities and indicated needs. The pain care plan was updated, and appropriate interventions are in place. 2.Any resident that sustains a fall or has a change in condition has the potential to be affected by this practice. During the morning meeting, the nurse's notes will be reviewed to identify any falls or change in conditions 5 days a week. After review, the care plan will be updated as appropriate. Daily, on the weekends and holidays the staff nurse will assess the resident and implement an initial intervention and initiate neuro-checks as appropriate for any fall/change of condition. This will also be reviewed during the morning meeting on the following Monday. The Care plan will then be updated as appropriate.	6/10/21

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F 689	Continued From page 4 after having a tooth pulled approximately a week earlier. Resident #1 was found to be alert and able to answer general questions easily. Resident #1 was not able to recall specific details regarding her pain or ability to move around in the days after her fall. During an interview on 5/11/21 at 10:10 p.m., staff member F stated although resident #1 was in a lot of pain and did not want to logroll or get out of bed during his shifts on 4/2/21 and 4/3/21, resident #1 had been examined by a provider on 4/2/21 and he (staff member F) did not feel there was anything new to tell the provider. Staff member F stated resident #1 "yelped" when her leg or hip was touched, but when she was asleep, she was able to cross her legs without waking up. Staff member F stated despite her pain and reluctance to move, he believed her flexibility when sleeping confirmed there was no reason to be concerned. During an interview on 5/12/21 at 9:50 a.m., staff member G stated she was the nurse on duty when resident #1 was found on the floor in her room. Staff member G stated she believed neurological checks were started after resident #1's fall on 4/1/21. Staff member G stated neurological checks were indicated because resident #1 had hit her head during the fall. and it was an unwitnessed fall. When staff member G was told there was no documentation of neurological checks in resident #1's medical record, she was not able to explain why. Staff member G stated the neurological checks should have been continued on the night shift. During an interview on 5/12/21 at 10:10 a.m., staff member C stated when a Medication Aide	F 689	3.The Regional Clinical Director will educate the staff licensed nurses on or before 6/1/2021 regarding the policies on falls, neuro checks, updating care plans and pain management. 4.The IDT team will audit 5 times per week for 4 weeks and then weekly for 2 months or as deemed necessary by the QAPI team, to determine if residents that have fallen, have had a change of condition, have increased pain, or the need for further interventions to include neuro checks and physician notification. 5.The results of these audits will be shared with the QAPI team on 6/7/2021. Further action will be completed as deemed necessary by this team. 6.Compliance will be met by 6/10/2021.	

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F 689	Continued From page 5	F 689		

was assigned to administer medications to residents on a specific wing, a nurse was assigned to complete any assessments or other nursing duties for the residents. After consulting the assignment sheet for 4/1/21, the date of resident #1's fall, staff member C stated staff member G had been responsible for any assessments and documentation required after resident #1 fell.

During an interview on 5/12/21 at 10:39 a.m., staff member B stated it was the facility's expectation nursing was supposed to perform a resident assessment, including their neurological status at least once a shift for 72 hours after an unwitnessed fall. Staff member B stated sometimes the neurological checks were documented on a paper form first and then transferred to the electronic medical record later. Staff member B stated it was the responsibility of the nurse assigned to the resident to complete all necessary post-fall documentation. Staff member B stated he was told the neurological checks were documented on paper, but no one was able to locate the document. Staff member B stated he was not aware of resident #1's fall on 4/1/21 and subsequent hospitalization on 4/5/21 for a left hip fracture until he returned from vacation. Staff member B stated he talked with the resident's primary provider as part of his post-fall investigation. Staff member B was told, by the primary provider, the provider who saw resident #1 on Friday, 4/2/21, called the facility on Monday 4/5/21 at 1:21 p.m. to check on resident #1's condition. Staff member B was told the staff felt she was worse and an x-ray of resident #1's left knee and hip was requested. The primary provider also told staff member B he was not aware resident #1 had refused the hip x-ray until

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F 689	Continued From page 6	F 689		

after she had already been admitted to the hospital. Staff member B stated care plans were updated by the IDT after an event, and any nurse was also able to update care plans.

The resident's primary provider was not available for direct interview during the survey.

During an interview on 5/12/21 at 11:22 a.m., staff member A stated the IDT reviewed the circumstances and documentation related to resident #1's fall on the following day, 4/2/21. Staff member A stated it was the facility's expectation neurological checks and an overall assessment was required at least once a shift for 72 hours after an unwitnessed fall or a fall with a head injury. Staff member A stated a thorough assessment of the resident included the interventions implemented, the response to the interventions, the resident's physical and neurological condition, and pain. Staff member A stated the IDT was not aware there were no neurological checks or thorough resident assessments present for resident #1 following her fall on 4/1/21.

A review of resident #1's nursing progress note, dated 4/1/21 at 6:03 p.m., showed resident #1 had been found on the floor at 4:50 p.m. by a CNA. The note showed resident #1, "... felt dizzy from hitting her head. and Left hip is causing pain however is still able to rotate and extend her legs. CNA and I had to use a hoier [sic] to pick her up. Neuros will be monitored." The note showed no evidence of a thorough physical or neurological assessment.

A review of resident #1's IDT progress note, dated 4/2/21 at 9:30 a.m., showed, "IDT reviewed

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F 689	Continued From page 7	F 689		

incident Re: 4/2/21 [sic] Fall without injury, Resident is occasionally incontinent of Bowel and Bladder, but takes herself to the bathroom. Staff to check resident during care rounds, and offer toileting and assistance." The note showed no evidence of a loss of balance being part of the root cause for the fall, as reported by resident #1 during an interview on 5/11/21.

A review of resident #1's nursing progress note, dated 4/3/21 at 3:49 a.m., showed, "Resident reluctant to do activities. She states she fell two days ago and she is sore. Tramadol given for pain with some relief." The note showed no evidence of the location of resident #1's pain or an assessment of her overall condition.

A review of resident #1's nursing progress note, dated 4/5/21 at 5:25 p.m., showed, "Provider ordered an Xray of pts (patient's) L hip and knee. Mobile imaging was only able to get pts knee and not hip, they will be back tomorrow to get an image of pts hip." The note showed no evidence a provider was notified regarding the inability to obtain the hip x-ray as ordered.

A review of resident #1's Change in Condition progress note, dated 4/5/21 at 10:16 p.m., showed the resident was found to have an oxygen saturation reading of 52%, and was to be transferred to the emergency room per the on-call provider. The note showed no documentation related to the resident's recent fall with left hip pain.

A review of resident #1's medical record failed to show any neurological checks documented between her initial fall on 4/1/21 and 4/5/21 when resident #1 was transferred to the hospital. The

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F 689	Continued From page 8	F 689		

medical record showed no evidence of a physical assessment, including the location and quality of her pain, and her response to non-pharmacological interventions other than the brief nursing notes on 4/1/21 at 6:03 p.m., 4/2/21 at 9:30 a.m., 4/3/21 at 3:49 a.m., 4/5/21 at 5:25 p.m., and 4/5/21 at 10:16 p.m., referenced above.

A review of resident #1's CNA Task Completion records, dated March 2021, showed the resident's functional ability and assistance required before the fall on 4/1/21 to be the following:

-Bed Mobility, primarily independent to limited assistance of one staff member
-Dressing, primarily limited assistance of one staff member
-Personal Hygiene, primarily limited assistance of one staff member
-Toileting, primarily limited to extensive assistance of one staff
-Transferring, primarily independent to supervision with setup help only
-Walk in Room, primarily independent to supervision without assistance

A review of resident #1's CNA Task Completion records, dated April 2021, showed the resident's functional ability and assistance required after the fall on 4/1/21 to be the following:

-Bed Mobility, primarily extensive assistance of one to two staff members
-Dressing, primarily extensive assistance of one staff member
-Personal Hygiene, primarily extensive assistance of one staff member
-Toileting, primarily extensive assistance of one

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F 689	Continued From page 9 staff -Transferring, refused or extensive assistance of two staff members -Walk in Room, activity did not occur until after surgical repair of fracture A review of resident #1's Fall Care Plan, initiated 4/16/20 on admission, showed no revisions or updates related to the fall which occurred on 4/1/21. The revisions noted occurred on 4/8/21 when resident #1 returned from a hospital stay where she had a surgical repair of her fractured left femur. The care plan showed no evidence of interventions related to neurological checks, assessment of physical condition, pain management, new fall prevention precautions, or to notify the resident's medical provider of worsening of her condition. A review of the facility's policy titled, "Fall Prevention and Response Policy," dated April 2020, showed the following, "... 3. Initiate Neuro checks if resident hit head or if unwitnessed fall. ... 6. Post-fall documentation includes ... interventions, response to interventions, effectiveness of interventions, and injuries noted. 7. Documentation of post-fall status will occur in progress notes q (every)-shift for at least 72 hours and as needed." A request for any documentation of Neurological Checks for Resident #1 was requested on 5/11/21 at 2:00 p.m. Nothing was received prior to the end of the survey.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F 697		6/10/21

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F 697	Continued From page 10 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident experiencing a sudden onset of pain after a fall had a comprehensive nursing assessment and ongoing monitoring intended to provide necessary resident information leading to an effective pain management plan for 1 (#1) of 4 sampled residents. The deficient practice resulted in a decline in functional ability and potentially resulted in a delay in treatment for an unidentified hip fracture requiring surgical repair. Findings include: During an interview on 5/11/21 at 11:30 a.m., staff member D stated resident #1 was, "difficult to read." Staff member D stated resident #1 would sometimes say her pain was okay and rate it as a 7 on a 1 to 10 scale. Staff member D stated she used more non-verbal indicators for resident #1. She stated this was due to resident #1's dementia and contradictory statements associated with pain. During an interview on 5/11/21 at 2:25 p.m., resident #1 stated she remembered the circumstances of her fall but did not remember much about the days which followed because she was, "kind of in a daze," and did not remember many details. Resident #1 stated she was trying to get something out of her clothes closet, lost her balance, and fell backwards hitting her left hip and her head. She stated she needed help	F 697	1.Resident #1 has been re-assessed for pain. Her pain is managed at a level that meets her pain expectations and goals. Her care plan has been updated to reflect the needs for pain management. The nursing staff are monitoring her pain during medication administration and as needed. Her functional ability is stable and is not affected by pain. 2. Any resident that falls or has an injury has the potential for injury causing a need for a pain management plan. During the morning meeting, the nurse's notes will be reviewed to identify any falls or change in conditions that result in pain 5 days a week. After review, pain management interventions will be initiated as appropriate. Daily, on the weekends, and holidays the staff nurse will assess the resident and implement an initial pain intervention as appropriate for any fall/change of condition. This will also be reviewed during the morning meeting on the following Monday. The Care plan will then be updated as appropriate. 3.On or before 6/1/2021, the Regional Clinical Director will educate the nursing staff on assessing and managing residents pain post incident or injury. The education will include the need to monitor	

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F 697	Continued From page 11 getting up and took pain pills, originally ordered for tooth pain, for her hip pain. During an interview on 5/11/21 at 10:07 p.m., staff member F stated resident #1 was in a lot of pain and tried to refuse cares which involved rolling from side to side or getting out of bed during his night shifts on 4/2/21 and 4/3/21. Staff member F stated he did not think resident #1's level of pain or inability to perform ADL's was a reason for concern because the provider had examined her the day after she fell (4/2/21) and did not think there was a fracture. Staff member F stated resident #1 would "yelp" when her hip or leg was touched. He stated the resident had an order for tramadol for tooth extraction pain, and they (facility staff) were using the tramadol for resident #1's hip pain as well. During an interview on 5/12/21 at 9:50 a.m., staff member G stated other than her single nursing progress note identifying the resident's fall, dizziness, and hip pain, she did not have any specific memories related to resident #1's fall on 4/1/21. Staff member G was assigned to nursing assessments for resident #1 on 4/1/21 and 4/5/21. Staff member G had no memory of resident #1 having pain or demonstrating behaviors associated with pain on 4/5/21. Even though she was assigned to resident #1, staff member G stated she believed someone else had given resident #1 pain medication during the day shift on 4/5/21. Staff member G was not able to explain why there was no pain assessment for resident #1 on 4/1/21 or 4/5/21. Although staff member G entered the verbal order and documented the hip x-ray was not obtained on 4/5/21, she could not remember what precipitated the order for a knee and hip x-ray, or if she	F 697	residents at least 72 hours post fall with an emphasis on pain management and neuro checks. 4.The IDT team will monitor/audit 5 times per week by reviewing the nurses note3s and shift report. The audit will include monitoring for fall, and pain assessment completion. The audit will also monitor to ensure that the care plan reflects the needed changes in care to include pain management and neurological assessments at a minimum standard and the effectiveness of the interventions. These audits will be completed 5 times per week for 4 weeks and then monthly for 2 months as deemed necessary by the QAPI team. 5.The results of these audits will be presented to the QAPI team on 6/7/2021. Further action will be completed as deemed necessary by this team. 6.Compliance will be met by 6/10/2021.	

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F 697	Continued From page 12	F 697		

notified the provider about the hip x-ray not being obtained.

A review of resident #1's nursing progress note, dated 4/1/21 at 6:03 p.m., written by staff member G showed no description of the resident's left hip pain following an unwitnessed fall. The note showed a mechanical lift was required to get resident #1 off the floor and back in bed.

A review of resident #1's nursing progress note, dated 4/3/21 at 3:49 a.m., written by staff member F showed the resident was reluctant to do activities, and she was sore. Tramadol was given with some relief of her pain. The note showed no evidence of a pain assessment which should have included the intensity, pattern, location, frequency, timing, and duration of her pain.

A review of resident #1's CNA Task Completion records, dated March and April of 2021, showed a decline in her functional abilities, and an increased need for assistance. Please refer to F689 for additional detail related to this documentation.

A review of resident #1's Medication Administration Records, dated March and April of 2021, showed an order for tramadol 50 mg every four hours as needed for post tooth extraction pain. The following showed the administration of tramadol and follow-up evaluation of effectiveness:

-3/30/21 at 8:44 p.m., tramadol 50 mg given for post tooth extraction pain rated as a 6 on a 1 to 10 scale. This was the last dose given until after resident #1's fall on 4/1/21.
-4/1/21 at 5:31 p.m., tramadol 50 mg given for

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F 697	Continued From page 13	F 697		

pain rated as 8 on a 1 to 10 scale. No documentation of the characteristics of the pain except it was in her left hip.
-4/1/21 at 7:37 p.m., effective, rated as a 4 on a 1 to 10 scale, no documentation of location or any other pain characteristics found.
-4/2/21 at 3:12 a.m., tramadol 50 mg given for pain rated as a 5 on a 1 to 10 scale, no documentation of location or any other pain characteristics found.
-4/2/21 at 6:29 p.m., effectiveness unknown
-4/2/21 at 8:47 p.m., tramadol 50 mg given for pain rated as a 3 on a 1 to 10 scale, no documentation of location or any other pain characteristics found.
-4/3/21 at 3:49 a.m., effective, no rating on 1 to 10 scale documented.
-4/3/21 at 10:46 a.m., tramadol 50 mg given for pain rated as an 8 on a 1 to 10 scale, no documentation of location or any other pain characteristics found.
-4/3/21 at 7:01 p.m., effectiveness unknown
-4/5/21 at 8:28 p.m., tramadol 50 mg given for pain rated as a 5 on a 1 to 10 scale, no documentation of location or any other pain characteristics found.

A review of resident #1's Medication Administration Record for April of 2021, showed an order, dated 3/16/21, for Pain Monitoring: Monitor for verbal and/or non-verbal signs of pain every shift. The day shift monitoring documentation was blank from 4/1/21 through 4/5/21. The night shift monitoring documentation showed a rating of 6 for 4/1/21 and a 5 for 4/5/21. The night shift pain monitoring documentation for 4/2/21 through 4/4/21 showed a rating of 0.

A review of the facility's policy titled, "Pain

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F 697	Continued From page 14 Assessment and Management Policy," dated March 2019, showed a comprehensive pain assessment should include the resident's history of pain and its treatment, characteristics of pain which include intensity, descriptors, patterns, location, frequency, timing, and duration of pain, impact of pain on daily life, triggers, and accompanying symptoms. The policy showed a resident's pain is monitored to determine if it is being adequately controlled, if interventions are effective, and for how long.	F 697		
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:	F 757		6/10/21

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F 757	Continued From page 15 Based on interview and record review, the facility failed to ensure the resident's medication regimen was free of unnecessary medications by failing to obtain an order clarification for pain medication which included the indication for use with hip pain following a fall for 1 (#1) of 7 sampled residents. The deficient practice made evaluation of the effectiveness of pain interventions difficult because documentation did not identify the location of the pain was being treated with each dose. Findings include: During an interview on 5/11/21 at 2:25 p.m., resident #1 stated she remembered the circumstances of her fall but did not remember much about the days which followed because she was, "kind of in a daze," and did not remember many details. Resident #1 stated she had the pain pills for use after having a tooth pulled approximately a week earlier and was given them for her left hip pain which began at the time of her fall on 4/1/21. During an interview on 5/11/21 at 10:07 p.m., staff member F stated although the order specified the medication was to be given for tooth extraction pain, he gave it to resident #1 for her left hip pain. Staff member F stated, "We were lucky we had it and used it for both (tooth extraction and hip pain)." During an interview on 5/12/21 at 10:10 a.m., staff member C stated it was expected staff should have gotten a clarification on the pain medication ordered for resident #1. She stated if she had given resident #1 the pain medication, she would have called the provider to get a clarification saying the medication could be used for hip pain also.	F 757	1.Resident #1□s pain regimen is free of unnecessary medications and the pain medication regimen has been updated and is managed in a manner that meets her expectations and goals. The care plan was reviewed and updated to provide pain medication in the even that non-pharmacological pain interventions are unsuccessful. The pain medication is ordered for the indications of pain and not for a specific diagnosis. 2. Any resident that has an order for medications has the potential to be affected due to having unnecessary medications ordered due to lack of diagnosis. All residents receiving a drug regimen for pain have been reviewed, and an audit has been completed to ensure that an appropriate diagnosis is in place for the use of the medication. For ongoing monitoring, during the morning meeting, residents who have started a new pain medication will be reviewed. This review will be to ensure that the proper diagnosis is in place for the indication of use 5 days a week. After review, the medical record will be updated as appropriate. Daily, on the weekends, and holidays the staff nurse will ensure that any newly implemented pain interventions for a fall/change in condition have an appropriate diagnosis for the use of the medication. This will also be reviewed during the morning meeting on the following Monday. The Care plan will then be updated as appropriate. 3.The Regional Clinical Director will	

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F 757	Continued From page 16 During an interview on 5/12/21 at 11:22 a.m., staff member A stated the nursing staff should have gotten an order clarification when they started using the pain medication for a different location. A review of resident #1's physician order, dated 3/25/21, showed, "Ultram (tramadol) 50 mg Give 1 tablet by mouth every 4 hours as needed for post tooth extraction pain." A review of resident #1's Medication Administration Record, dated April 2021, showed resident #1 received tramadol five times between her fall on 4/1/21 and when she was transferred to the hospital on 4/5/21. None of the entries indicated the location of the pain being treated. A review of resident #1's medication administration progress notes, dated between her fall on 4/1/21 and when she was transferred to the hospital on 4/5/21, failed to show the location of the pain being treated. A review of the facility's policy titled, "Pain Assessment and Management Policy," dated March 2019, showed documentation of the resident's reported level of pain must contain, " ... adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary ..." The documentation related to resident #1's pain contained only a number value. The documentation did not contain detail information related to location, quality, duration, and triggers.	F 757	educate the nurses on or before 6/1/2021 on the regulation of drug regimen and the indication for the drug use. This will include the need for the nurses to monitor and document the location and severity of the pain at least every shift. 4.The IDT will monitor weekly for 4 weeks the pain medication regimes to ensure that the location of pain is documented, and the pain score is being completed. The pain policy will be reviewed, and the Medication Administration Record template will be altered to reflect the changes in policy. The audit will be shared with the QAPI team on 6/7/2021 and monthly for two months or until deemed unnecessary by the QAPI team. 5.The results of these audits will be presented to the QAPI team on 6/7/2021. Further action will be completed as deemed necessary by this team. 6.Compliance will be met by 6/10/2021.	