STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

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F 000	INITIAL COMMENTS A compliant investigation survey was conducted from 8/23/23 through 8/29/23. Event ID #9RM311. The following intakes were investigated NC002004038, NC00204693, NC00204328, NC00206260, NC00204480, NC00203415, NC00204166, NC00203613, NC00206150. 3 of 28 complaint allegations resulted in deficiencies.	F 000		
F 689 SS=D	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 observations, record review, Nurse Practitioner (NP), Medical Director (MD) interviews, the facility failed to provide supervision to prevent Resident #2 who had severe cognitive impairment from exiting the building unattended. This affected 1 of 3 residents reviewed for providing supervision to prevent accidents (Resident #2). Findings included: Resident #2 was admitted to the facility on 07/27/22 with diagnoses that included early onset	F 689	F689 Free of Accident Hazards/ Supervision of Devices. Action taken to immediately correct this alleged deficient practice includes the following: Upon reentering the facility, the charge nurse completed a clinical assessment of Resident#2 to ensure that there were no injuries. None were noted. The Director of Nursing, (DON), initiated a head count of all residents to assure all residents were present in the facility. All residents were present. This action was completed	9/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/18/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 689	Continued From page 1 Alzheimer's disease, non-Alzheimer's dementia, and depression. A review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 04/25/23 revealed Resident #2 had severe cognitive impairment and no behaviors noted. Review of Resident #2's care plan initiated on 07/20/23 read; "It is unsafe for Resident #2 to leave this facility; however, I may attempt to do so. I wander without purpose. I sometimes wander into other rooms or will attempt to get on the elevator. The interventions included: check on Resident #2 often and when you do your hourly safety rounds (07/20/23), deter me from exits and elevator (07/20/23), make sure that Resident #2's picture is in the elopement book on every floor and in the main lobby (07/20/23), make sure that when Resident #2 leaves the unit I am assigned to that I am supervised at all times (07/20/23), perform an elopement assessment on me quarterly and as needed should my cognitive or physical status change (07/20/23), and when you find me trying to leave please check to see if I am looking for a specific place or thing. If appropriate help me to find it. If it is not appropriate distract me (07/20/23)." An Elopement Evaluation was completed dated 07/20/23, Resident #2 scored not at risk for elopement. Two separate Elopement Evaluations forms dated 08/02/23 were started for Resident #2 but were incomplete. Review of a nurse's progress noted dated 08/3/23 at 6:06 PM, read the patient continues with	F 689	on 8-11-23 by the clinical nursing staff, certified nursing assistants, the Unit Nurse Manager and the Director of Nursing. Notifications were made to the facility Medical Director, (MD) and the responsible part of the event involving Resident #2. Directives were given to the Nursing Unit Manager to gather the facility elopement binders from each nursing station and reception areas on 8-11-2023 to monitor them for needed updates. All binders were updated and the staff educated as to the purpose of these books and the resident identified. The updating of the elopement binders occurred on 8-11-2023 and was completed by 8-12-2023 by the Director of Social Work. The Clinical nursing staff began providing 15 minute checks upon Resident#2's reentry into the buildiing on 8-11-2023. Due to the continued exit seeking behavior of Resident #2, the clinical nursing staff were directed to assign 1:1 staffing with Resident #2 to insure that this resident received constant supervision to ensure safety. This action was initiated on 8-11-23 after observation of continued exit seeking was noted by the clinical nursing staff. The Administrator also directed the Director of Maintenance to complete a facility door audit to ensure that all facility doors were functioning as designed. An audit was conducted on 8-11-2023. All exit doors were found to be in proper working order. In addition, the Director of Maintenance installed screamer alarms to the facility exit doors. Inservices, were completed for the clinical staff to communicate the	

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F 689	Continued From page 2 wandering, urinating / defecating in inappropriate places. He has wandered today and has been exit seeking. Patient redirected as able. Will continue to observe and note behaviors as they occur. Will redirect patient as able during times of these behaviors and provide hygiene and safety measures as necessary. The note was written by Nurse #4. Review of a nurse's progress note dated 08/9/23 at 12:37 AM read, wandering, urinating /defecating in inappropriate places. Resident resting in bed with eyes closed. Wandering on and off unit, not in any inappropriate areas noted so far this shift. The note was written Nurse #6. Review of a nurse's progress note dated 08/11/23 at 12:00 PM, read patient has been wandering hallways per usual. The resident had abnormal urination or defecation and was not noted to be in places he should not be. However, he does have bladder incontinence then walks through the hallways. Staff redirects the patient to toilet, then incontinence care. No complaints or complications noted. No exit seeking behaviors currently. Review of an Incident Report dated 08/11/23 at 6:33 PM, revealed that Resident #2 was found outside of the building, and he was returned to the building and assessed. No other information or details were provided about the elopement. The incident report was completed by the Unit Manager. In an interview on 08/24/23 at 9:42 AM with the Business Office Manager, he reported that since April 2023, when he started working at the facility, Resident #2 had been a wanderer but hadn't tried	F 689	interventions put into place including the specifics about the event, what interventions were put into place and why. The screamer alarms were place on the exit doors on 8-11-2023 by the Mantenance Director. The interdisciplinary team were informed of the residents event and the residents care plan was reviewed and modified to note the additional interventions that were put into place to ensure the resident's safety. This inservice began on 8-11-2023 and was communicated to the nursing staff by the Nurse Unit Manager. The facility acknowledges that all residents that are cognitively impaired are at risk of this alleged deficient practice. The Nursing Unit Manager conducted a facility audit of 100% of the residents was completed on 8-11-2023 to ensure that all residents that had been identified as an elopement risk were identified and their information placed in the facility elopement risk books. These books were placed at each nursing station. Measures put into place to ensure that this alleged deficient practice does not recur includes: Education and inservicing was provided to the facility staff by the Nurse Unit Manager on 8-11-2023. The information reviewed was pertaining to the policy and procedures explaining the expectations for any exit seeking resident and will be added to the new hire orientation packet so that all newly hired staff will received the education needed for executing interventions for this	

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F 689 Continued From page 3

to get outside until about 2 weeks ago and was becoming more aggressive in his attempts to elope. He stated he recalled that on 08/11/23 it was a hot day and around 6:00PM - 6:01 PM and he was going to his car to go home. He stated he saw Resident #2 walking down the gravel/dirt pathway on the 400 hall side of the building. He stated Resident #2 was approximately 150 yards from the exit doors and approximately 100 yards from the main road when he intercepted Resident #2. He stated there were no staff members following behind him. He stated Resident #2 was wearing pants, t-shirt, tennis shoes, and carrying a coffee cup. He stated he was at the bottom of the pathway, and he yelled out to Resident #2 asking him where he was going. He stated Resident #2 pointed towards the main road, which was about 100 yards away and he kept walking at a fast pace towards the road. The Business Office Manager stated he went to Resident #2 and was able to re-direct him and walked him back into the main entrance and took him up the elevator back to the 200 hallway and he notified the nursing staff.

An interview on 08/23/23 at 2:33 PM with Nurse #4, she stated she worked on the 100-200 hallway and took care of Resident #2 almost every day. She stated she was Resident #2's nurse and worked on 08/11/23 when he eloped. She recalled the Business Office Manager brought Resident #2 back to the 200 - hallway from outside and told everyone at the nurses' desk where he found Resident #2. She stated they did not know Resident #2 had gotten out of the building until the Business Office Manager brought him back to the floor. The Director of Nursing (DON) and UM came to the desk and were told about the elopement. The DON and UM

F 689

behavior. This educational inservice covered the content of increasing the awareness and knowledge of the staffing expectations and techniques when intervening with residents that are exhibiting exit seeking behaviors. The Unit Manager also audited the Elopement Risk Binders at each nursing station on 8-11-2023 to ensure that updates were taking place. All elopement risk binders were made current and accurate. These binders will be reviewed and updated upon any new admission. The discharges will also be removed from the binders o n a weekly basis to ensure accuracy. The elopement books will be reviewed on a weekly basis to ensure that the books are updated and pictures are currently reflective of the resident. The Minimum Data Set (MDS) will ensure that all residents identified as a elopement risk has a proper care plan initiated with the proper interventions noted and kept current. This will happen by reviewing the necessary assessments upon newly admitted residents. In addition, any significant changes will also reflect the accurate interventions as it related to interventions to prevent any potential elopements. AGency staff will receive educatiaon prior to beginning work by the charge nurse. The charge nuse will notify the oncoming agency staff of the alarm presence. Education will be provided to the agency staff of the purpose and intent of the door alarms. In addition, the expectation of the staff responsibilities will be reviewed. Any unscheduled agency staff will receive this education by

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F 689 Continued From page 4

stated Resident #2 would be a 1:1 for a while. She stated nothing seemed different about his behavior that day before he exited the building.

In an interview on 08/23/23 at 3:40 PM with a Nurse Aide (NA) #1, she stated they discussed the residents who were elopement risks in report before their shifts started. She stated she worked the day Resident #2 exited the building on 08/11/23. She stated she didn't know how he got outside without being seen. She stated the permanent NAs knew the residents well but not all the agency NAs knew them as residents well.

An interview with the Unit Manager (UM) on 08/23/23 at 1:15 PM revealed Resident #2 had been wandering for a long time, but just started trying to get outside about 2 months ago and he was getting worse. She stated he roamed all day/night, and all the staff knew to watch out for him. She stated they had started him on new medications less than a week ago and hoped it would help with his wandering and agitation behaviors. She stated the elevator and stairwell, that led down to the lobby were next to the 300 nurses' station and were secured. She stated the elevator was key controlled and the key was kept in a drawer on the 300 nurses' station. The UM stated the stairwell was code pad controlled and they had to push 2 numbers at one time and then a single number which made it harder to manipulate. She stated all their exit/emergency doors that led outside had a regular alarm and an extra loud screamer alarm. She stated if anyone pushed the door push bar the first alarm would go off, and if the door was pushed open the screamer alarm would go off. She stated their Social Worker (SW) was trying to find Resident #2 placement at a facility with a locked unit. The

F 689

telephone. This contact will made by the Director of Nursing/ Designee.

Monitoring will occur by the Unit Manager and/or Director of Nursing reviewing the elopement assessments for all new admissions within 24 hours of the admission. This will be reviewed during the clinical meeting , as well as, the weekly risk meeting. The Social Work Director will conduct a weekly review of the facility residents list that have triggered for cognitive diagnoses, dementia, behaviors and exit seeking to ensure that any psychological consults are recommended and scheduled as needed. The elopement binders will also be updated with updated photographs during this process. The MDS Coordinator will complete a weekly review of the care plans for all identified residents that are at risk of elopement to ensure accurate care plans are being completed. the Maintenance Director / Assistant will conduct weekly door checks to ensure that the door closures are operating as designed.

The Unit Manager Director of Nursing will audit the elopement books 3 times a week for 1 month and then monthly for 2 months. The Director of Nursing will report the results of these audits to the Quality Assurance and Process Improvement Committee monthly x 3 months.

The Maintenance Director will audit the door closures weekly x 3 months and present a report to the Quality Assurance

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F 689	Continued From page 5 UM stated Resident #2 had gotten out of the building on 08/11/23, and he left the building through the 400 exit/emergency doors. She stated after Resident #2 exited through the 400 hallway doors he walked down a gravel path when the Business Office Manager saw Resident #2 walking down the path. She stated they did not use Wander Guards because even with that system, residents still could elope. She stated she felt Resident #2 was able to elope because the staff got complacent in watching him. She stated they had an elopement book at each nurse's station, and all the departments discussed at the beginning of each shift which residents were elopement risks, so everyone knew who to keep an eye on. She stated after Resident #2 got outside on 08/11/23, they put him on 1:1 supervision and they continued that until his behaviors were under control and then they started every 15-minute safety checks. The exit/emergency door alarm went off, but the screamer alarms were not in place until after he eloped. Review of the recorded weather on 08/11/23 for the facility revealed at 6:00 PM, it was 80 degrees Fahrenheit with fair skies and winds at 3 miles per hour. Source - weatherunderground.com. On 08/24/23 at 9:00 AM an observation of the area where Resident #2 was located revealed a gravel/dirt path that descended towards the main road. This path was also used as the ambulance/emergency pick-up location. From the top of the path where the hallway 400 doors open, is approximately 250-300 yards to the main road which is located on a blind curve. An interview was conducted on 08/23/23 at 12:52	F 689	and Process Improvement Committee monthly x 3 months.	

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F 689 Continued From page 6 F 689

PM with Nurse #3 and stated she usually worked the day shift on the 100-200 hallway and cared for Resident #2 frequently. She stated Resident #2 is known for wandering halls and had tried to exit the building. She stated he has always wandered a lot, but the exiting behaviors had started recently. She stated the permanent staff knew him well and watched him closely.

In an interview with the DON on 08/24/23 at 1:43 PM, she stated although she had not been working at the facility for very long, she was familiar with Resident #2. The DON stated he was a wanderer and exit seeking resident. She stated she was aware he had gotten out of the facility a few weeks ago and knew they placed him on 1:1 supervision until the exit seeking behaviors ceased. The DON stated his behaviors of going to the exit doors or standing by the elevator, had slowed down so now was on every 15-minute safety checks.

In an interview on 08/24/23 at 11:38 AM with the Central Supply-Maintenance Manager, he stated all the exit/emergency doors had their own alarms. He stated when the door push bars were pushed on all exit/emergency doors the regular alarms would sound at 15 seconds and the regular alarm was not very loud. He stated after Resident #2 exited the 400 hallways exit/emergency doors, he suggested they add screamer alarms, in addition to the regular alarms, to all the exit/emergency doors. He stated the screamer alarms had now been put into place on all the exit/emergency doors and they were disturbingly loud at 120 decibels, and they would sound off the minute the door opened.

Observation on 08/23/24 at 11:50 AM with the

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F 689	Continued From page 7 Central Supply-Maintenance Manager, revealed the regular alarm on hallway 400 exit/emergency doors worked after 15 seconds of pushing the door push bar, but when the door was opened the screamer alarm did not work. The Central Supply-Maintenance Manager noticed that the screamer alarm was not set. The Central Supply-Maintenance Manager then re-set the alarm so it would sound off if the doors were opened. He stated the batteries and alarms are to be checked by the Manager on Duty on the weekends, after any elopement, and a minimum of once a week. He stated he just developed and initiated a log for the alarm checks to be documented. He stated education about checking the screamers and how to set them to the ready to activate had been by word of mouth, but he was going to put together some formal education. A phone interview was conducted on 08/28/23 at 5:41 PM with the MD. She stated that the day after the elopement, the DON had called her to report the elopement and they discussed changing medications and possible care plan interventions. The MD stated Resident #2 would not be safe outside unattended as he could be injured or much worse, and an elopement was no small thing.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		9/22/23

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This REQUIREMENT is not met as evidenced by:

Based on observations, record review, and staff and Physician Assistant (PA) #1 interviews the facility failed to administer pain medication to Resident #1 after he yelled out loudly in pain and grabbed his right hip. A mobile x-ray completed at the facility noted a right hip fracture. No pain medication was administered to Resident #1 until he was evaluated at the hospital emergency department for treatment of the right hip fracture later that day. This deficient practice occurred for 1 of 4 residents reviewed for supervision to prevent accidents (Resident #1).

The findings included:

Resident #1 admitted to the facility on 7/30/2023. He had diagnosis that included history of pulmonary embolism, dementia, acute deep vein thrombosis, anxiety, restlessness, and agitation.

Review of a physician order dated 07/30/23 read; Acetaminophen (Tylenol) 325 milligram (mg) give 650 mg by mouth every four hours as needed for pain.

Review of the admission Minimum Data Set (MDS) assessment dated 8/5/23 revealed Resident #1 was severely cognitively impaired and required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The staff assessment of pain revealed no signs verbal or nonverbal reported by Resident #1 during the lookback period.

Review of Resident #1's Medication Administration Record (MAR) dated August 2023 revealed that no Acetaminophen was

F 697

F697 Pain Management

The immediate actions taken to correct this alleged deficient practice includes: Resident #1 was discharged to hospital emergency department from the facility on 8-16-23. On 8-16-23 100% of the facility resident progress notes and 100% of facility residents pain assessment were reviewed. This review was completed by the Nurse Unit Manager and the Director of Nursing. This review was completed to ensure that any additional reports of residents with complaints of pain were being addressed. No additional reports were found. On 8-17-23 the Director of Rehabilitation completed inservices with clinical staffing on body mechanics, transfers and gait belt use. On 8-17-2023 inservices for clinical nursing staff was initiated on assessments of residents complaining of pain, notification fo the medical Director with follow-ups and medication requirements for residents expressing pain.

The facility acknowledges that all residents that are at risk for pain will have the potential to be affected by this alleged deficient practice. A 100% resident review was completed on the exsisting residents to ensure that pain evaluations and charting noting pain has been completed. This review was completed by the facility contracted regional nurse consultant. A report was provided to the Administrative nursing staff and the Administrator on

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administered to Resident #1 while he was in the facility during the month of August. Further review of the MAR revealed that Resident #1's pain was assessed every shift and was recorded as a 0 as having no pain the entire month of August that Resident #1 was in the facility.

Review of a late entry nursing note dated 8/16/23 written by Nurse #1 at 5:44 PM read in part, Resident #1 was noted to be yelling and screaming with combative behaviors upon arrival on shift. Resident #1 unable to be consoled with drinks, snacks, or one on one supervision. He continues to yell for his family. Nothing effective at this time. Staff attempted to stand Resident #1 to reposition, and he yelled loudly in pain and grabbed at right hip and grimaced then immediately sat back down in his wheelchair. Therapy was asked to evaluate Resident #1 as did PA #1 and ordered a mobile X-ray of right hip, pelvis, and femur. The mobile x-ray company was in the building and was able to obtain one view that showed a right femoral fracture. No reports of fall were noted. New order obtained to send Resident #1 to the ED for evaluation. Resident #1 was transported via stretcher to the local ED (emergency department) with all appropriate paperwork. This nurse later spoke with ED nurse who confirmed right hip fracture with surgery pending.

Nurse #1 was interviewed via phone on 8/23/23 at 9:00 PM and revealed that she had worked on 8/16/23 from 7:00 AM to 7:00 PM. Nurse #1 stated that Resident #1 was already up in his wheelchair with no pants on when she arrived at work at 7:00AM, while sitting at the nursing station. She stated that Resident #1 was yelling however that he yells at his baseline. Nurse #1

F 697

9-9-2023,9-10-23 and 9-12-2023. Pain 3.0 scale is completed on admission to cognitive residents with verbal ability to communicate their pain scale. Non verbal residents will be assigned by a Pain Aid Scale. The Pain Aid Scale uses visual observations of the residents non verbal responses. Assessments for pain are completed daily by the assigned nurse for both verbal and non-verbal communication. These pain assessments will be completed upon admission. The Director of Nursing /Desginee will ensure that pain assessments are reviewed and completed daily after admission.
Residents with a high risk of pain further identified by the completion of pain assessments. These pain assessments will be completed up on admission. The Director of Nursing / Designee will ensure pain assessments are reviewed and compeleted daily after admission.

Measures put into place to ensure that this alleged deficient practice does not recur includes:
All newly admitted admissions will be monitored the day following admission to ensure that proper interventions have been completed to address any risk of pain. After admission, all resident will receive pain assessments every shift. Upon any administration of a pain medication all resdients will have a completed pain assessment before and after the administration of the medication to ensure that it has been effective. The Scheduler, Director of Nursing / Designee will ensure that all new hires receive

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F 697	Continued From page 10 stated that Nurse Aide (NA) #2 assisted Resident #1 back to his room to put on his pants. However, NA #2 was only able to get his pants on to his knees because Resident #1 would not stand up on his right leg to bear weight. Nurse #1 stated that she conducted a body assessment that revealed no bruising and no nonverbal cues of pain, nor did he verbalize any pain at that time, while he continued to be in his wheelchair. Nurse #1 stated that she attempted to assist Resident #1 to go to the bathroom, offered him snacks and drinks hoping that would help calm him down due to his yelling that was different. Resident #1 did not calm down initially however he began to self-propel in his wheelchair down the hall. Nurse #1 stated that Resident #1 self-propelled around the hallway with both of his feet in his wheelchair, but she wanted the Physical Therapy Assistant (PTA) to evaluate Resident #1's right hip. Nurse #1 stated that she knew something was wrong with his right hip as he could not bear weight on his right leg. When the PTA arrived at work, she took Resident #1 to the therapy gym to evaluate him at 9:45AM. After the PTA evaluated Resident #1, she reported to Nurse #1 that he would not bear weight and had complained of pain in the right hip area. So, Nurse #1 stated she contacted PA #1 who had just arrived at the facility around 10:00 AM to 10:30 AM. PA #1 evaluated Resident #1 and ordered an X-ray of the right hip, femur, and pelvis. Nurse #1 stated that the PTA assisted Resident #1 back to bed for the X-ray and he could lay comfortably on his left side but if turned on his back or right side would scream very loud (louder than usual) and verbally say "that hurts, ouch" and grabbed his right hip in pain. Nurse #1 stated that 45 minutes later, the x-ray results confirmed that it was a fracture of his right hip, and she obtained an order to send Resident #1 to	F 697	inservice training on the expectations of all clinical and line staff and that they are educated on the proper steps of addressing any expressed and perceived pain. Agency staffing will receive this education before starting their scheduled shifts to ensure that expectations for intervening with any residents expressing pain or noticing any changes in resident's condition to include changes in resident behaviors. Monitoring will be completed by the Nurse Unit Manager/ Director of Nursing auditing the pain assessments on all new admissions. Pain assessments will be reviewed daily for completion by the Interdisciplinary Team. In addition, the Director of Nursing /Designee will monitor daily pain assessments and documentation to ensure that appropriate interventions are in place. The Director of Nursing / Designee will monitor the pain assessments 3 x weekly for 1 month and then weekly x 2 months. The Director of Nursing / Designee will compile a report from these audits and present the findings to the monthly Quality Assurance and Process Improvement Committee for 3 months.	

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the ED for evaluation. Resident #1 remained in bed until EMS arrived to transfer him to the ED. Nurse #1 confirmed that she did not administer anything to Resident #1 for pain despite being aware that he was hurting. Nurse #1 could not provide a reason why she had not administered any pain medication to Resident #1 on 08/16/23.

NA #2 that worked with Resident #1 on 8/16/23 from 7AM until 7PM was unavailable for an interview.

Review of a therapy encounter note dated 8/16/23 read Resident #1 demonstrated inability to take a step and favoring right lower extremity. Physical therapy assistant (PTA) asked Resident #1 if he was in pain and he stated, "Yes," and indicated his right hip. Upon inspection Resident #1's demonstrated slight external rotation and edema to the right lower extremity when compared to the left lower extremity and pain with passive range of motion hip flex. The note was electronically signed by the PTA.

An interview with the PTA was conducted on 8/24/23 at 2:19 PM and revealed that on the morning of 8/16/23 at 9:45 AM, she was asked by Nurse #1 to evaluate Resident #1 because he was not able to stand that morning. The PTA stated she took Resident #1 in his wheelchair to the therapy gym and asked the Occupational Therapy Assistant (OTA) to assist her in the evaluation of Resident #1. She stated that they stood Resident #1 up in the parallel bars but Resident #1 would lean to the left side and not stand on his right leg. The PTA stated she asked Resident #1 to stand on his right leg and he stated that he could not because it hurt. Resident #1 was assisted back to his wheelchair and

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gentle attempt at passive range of motion Resident #1 would verbalize pain and point to the right hip area. She added that she asked Resident #1 several times about his pain, and he consistently reported verbally pain in the right hip area and would point to the area. Upon closer inspection the PTA stated she noted Resident #1's right lower extremity to be swollen and slightly externally rotated. The PTA stated that the information from their assessment was relayed to Nurse #1 who then obtained an order for an X-ray.

An interview was conducted with the Occupational Therapist Assistant (OTA) on 08/24/23 at 9:58AM and revealed on the morning of 08/16/23 she was asked to evaluate Resident #1 because he would not stand on his right leg. The OTA stated that she and the PTA took Resident #1 to the therapy gym in his wheelchair and stood him up in the parallel bars where he would not bear weight on his right leg. The OTA stated she asked Resident #1 to stand on his right leg and he stated he could not, so he was assisted back to his wheelchair. She added that the PTA attempted to lift Resident #1's right leg off the seat of the wheelchair and Resident #1 stated "ouch that hurts." The OTA stated that they noted some swelling to his right leg and that it was externally rotated. She added that they reported their findings to Nurse #1 who obtained an order for an X-ray which showed a right hip fracture.

Review of a progress note dated 8/16/23 at 1:00 PM written by Physician Assistant (PA) #1 stated that the chief complaint was, "inability to ambulate, right hip and leg pain." His note further stated that, "Resident #1 had advanced

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dementia, behavior disturbance and agitation presented for evaluation due to the inability to bear weight on his right leg with hip pain." "Resident #1's Nurse and PTA noted that he was not able to bear weight and seemed to be in pain today when attempting to do so." "He seems to be in apparent pain when moving his right lower extremity when sitting." "Patient was unable to quantify or describe pain but does seem to grimace when palpating the right hip and when extending the right leg."

Review of a physician order dated 8/16/23 at 11:17AM read: Right Hip and pelvis x-ray femur, tibia, and fibula.

Review of an x-ray report dated 8/16/23 at 12:50 PM read: Acute intertrochanteric right femoral fracture as noted.

Review of physician order dated 8/16/23 at 2:15PM read: Send to ER for right hip break.

PA #1 was interviewed via phone on 08/25/23 at 3:30 PM and stated that Resident #1 did not verbalize his pain however Resident #1 grimaced during PA #1's assessment. he explained Resident #1 had behaviors and at that point he would not have prescribed any significant pain medication. He stated the X-ray was positive for a right hip fracture so he gave an order to send him to the hospital and would "let EMS handle the pain medication."

Review of an EMS run report dated 08/16/23 at 2:30 PM indicated that they were called to the facility for reports that Resident #1 had hip fracture. The report stated, "Staff (facility) heard Resident #1 crying out in pain and found him lying

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on his bed." The physical exam revealed Resident #1 had pain on palpation at site of fracture. The EMS reported stated that EMS left the facility at 3:11PM and no there was no documentation of medications administered to Resident #1.

Review of hospital records dated 8/16/23 through 8/18/23 revealed per the ED note on 8/16/23 at 3:27 PM Resident #1 was sent for an evaluation after a fall and a mobile x-ray that noted a right hip fracture. The Physician documented Resident #1's pain was worse with movement, improved with rest and there was no attempted treatment prior to arrival. The ED note stated that the goal was to manage his pain. Resident #1 was prescribed Acetaminophen 650mg every six hours as needed by mouth and Morphine 2mg/1ml intravenously every four hours as needed for pain. He had noted pain control while at the hospital. X-rays completed on 8/16/23 noted a comminuted mildly displaced intertrochanteric fracture of the right femur. A CT scan of the head completed on 8/17/23 was negative. Per the Orthopedic consult report on 8/17/23 at 8:30AM, Resident #1's wife declined to have surgery and preferred hospice services as she did not want any significant aggressive interventions. On 8/18/23, he was discharged from the hospital to the local hospice house for comfort measures.

The DON was interviewed on 08/25/23 at 3:26 PM via phone who stated that she became aware on 08/16/23 around 1:00 PM that Resident #1 had a hip fracture and was going to be sent to the ED. The DON she assisted Nurse #1 in getting the needed documentation together to send Resident #1 to the ED. The DON did not state if

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F 697	Continued From page 15 she assessed Resident #1 or if she observed him for pain or behaviors before he was sent out to the hospital. The DON indicated if a resident vocalized pain or had nonverbal cues of pain like grimacing then the nurse assigned to the resident should complete a pain assessment and medicate the resident for pain. If the resident did not have anything ordered for pain, then the medical provider should be notified for orders. The DON could not explain why Resident #1 did not receive anything for pain but stated she would be looking into it. The Administrator was interviewed via phone on 08/25/23 at 3:01 PM who stated that she felt very fortunate that PA #1 was in the facility and Nurse #1 had him assess Resident #1 so quickly. After the x-ray was ordered it was obtained quickly and so where the results. Administrator did not speak to Resident #1's pain or his lack of pain medication. The Administrator was interviewed via phone on 08/25/23 at 3:01 PM who stated that she felt very fortunate that PA #1 was in the facility and Nurse #1 had him assess Resident #1 so quickly. After the x-ray was ordered it was obtained quickly and so where the results. Administrator did not speak to Resident #1's pain or his lack of pain medication.	F 697		