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	345286	A. BUILDING _____ B. WING _____	C 09/30/2019

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F 000	INITIAL COMMENTS The survey team entered the facility on 9/22/19 to conduct a complaint investigation revisit and new intake complaint investigation survey and exited on 9/25/19. Additional information was obtained on 9/30/19. Therefore, the exit date was changed to 9/30/19. Tag F609 was corrected as of 9/30/19. However, a new tag was cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. Twenty-four of the twenty-five complaint allegations were not substantiated. The facility is still out of compliance. See event ID# PQ3511 and ID# EUXD12.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and responsible party interview the facility failed to protect a resident (Resident # 8) from neglect by failing to initiate medical	F 600	F600 1. Event was investigated 9/23/19 by DHHS surveyor for resident # 8. Resident	10/16/19

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

Electronically Signed | 10/10/2019

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F 600	Continued From page 1 treatment and effective pain medication for a fracture, for one of four residents reviewed for abuse/neglect. The neglectful act resulted in the resident's delay in the acute care required for the severe fracture and a lack of effective pain medication. Findings included: Resident #8 was originally admitted to the facility on 2/8/17 and was most recently readmitted post hospitalization on 8/12/19 with diagnoses which included: Surgical repair of a right ankle fracture, right fibula (the smaller bone in the lower leg) fracture, chronic obstructive pulmonary disease (COPD), generalized weakness, difficulty in walking, cognitive communication deficit, dementia, lack of coordination, and diabetes. Review of Resident #8's Minimum Data Set (MDS) prior to her hospitalization revealed a quarterly assessment with an Assessment Reference Date (ARD) of 7/4/19. The resident was coded as having had no cognitive loss. The resident had no behaviors coded for the assessment period. The resident was coded as having been independent with no assistance needed for bed mobility, transfer (i.e. from the bed to a chair), walking in the resident's room, toilet use, and required only set up help for eating. The resident was coded as having received as needed pain medication and non-medication intervention for pain. The resident stated she had pain occasionally, it had not limited her sleep, day to day activities, and on a scale of 0-10, with 0 being no pain and 10 being the worse pain imaginable, the resident stated her pain was a 7. The resident was coded as having had one fall without injury since the last	F 600	# 8 still resides in the facility and continues to participate in Plan of Care and receive appropriate pain medication as ordered. 2.All residents have potential to be affected by this deficient practice. 100% audit of all events that have occurred in the last 30 days will be reviewed by the Center Executive Director (CED),and/or Center Nurse Executive (CNE), and /or Unit Managers (UM) to ensure all events were investigated and that timely, required acute care was given for events with injuries and that effective pain medication was administered at time of event. 3. Regional Nurse provided education to CED, CNE and UM on the process for completing a thorough investigation after each event to ensure all events were investigated and that timely, required acute care was given for events with injuries and that effective pain medication was administered at time of event on 10/11/19. 100% of all staff were inserviced on Neglect by Nurse Practice Educator (NPE), CED and Department Heads. All Licensed staff were educated by CNE, UM, NPE on the importance of providing effective pain medication to residents post events and providing acute care for events with injuries. This education includes Full Time, Part time , PRN and agency staff. Events will be reviewed by the clinical Leadership team 5 x weekly in Clinical	

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F 600	Continued From page 2 assessment. The resident was coded as having received and opioid medication one day out of the seven-day assessment period. A phone interview was conducted with Nurse #1 on 9/30/19 at 2:51 PM. The nurse stated Resident #8 had fallen at about 1:00 AM on 8/7/19 and after assisting the resident back into bed the resident's right knee was facing normally, however her right foot was lying flat on the bed, and the resident was reporting her pain level was a 10. The nurse stated she had not initially provided pain medication for the resident because she believed providing pain medication prior to an X-ray would skew the X-ray results. She recalled the X-ray technician had shown her the X-rays and the fracture was visible on the X-rays. She said she had communicated what she had seen on the X-ray, the resident's complaints of pain, and how the resident's foot appeared to Nurse Practitioner (NP) #1 at about 4:30 AM but the NP refused to send the resident to the hospital until the official X-ray results were received, after having been read by a radiologist. The nurse remembered calling the resident's RP at about 4:30 AM but did not remember if the RP had asked for the resident to have been sent to the hospital. She stated she was very busy that night, she had to go do something for another resident, and time had gotten away from her. She said she did not have access to the automated medication machine and another nurse had told her the resident had acetaminophen #3 and she had given the resident on of them at about 6:00 AM. The nurse added she had called the X-ray company to inquire as to the X-ray results and the person who answered did not know if there were results for the X-ray, so she continued to wait for them to	F 600	Morning Meeting using the Event Tracking Log to ensure all events were investigated and that timely, required acute care was given for events with injuries and that effective pain medication was administered at time of event. . 4. Regional Nurse will audit events weekly x 4 weeks to ensure complete and thorough investigations are completed and all events were investigated to ensure timely, required acute care was given for events with injuries and that effective pain medication was administered at time of event. . Results of these audits will be shared with CED to report at the Quality Assurance and Performance Improvement (QAPI) Committee monthly with QAPI Committee responsible for ongoing compliance. Date of compliance: 10/16/19	

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arrive via the fax machine. The nurse stated she had not contacted the Director of Nursing (DON) nor the Administrator regarding Resident #8 and her fracture. The nurse stated the resident continued to report her pain level as a 10 through the night and morning but did not appear to be in pain except when she had to be repositioned. The nurse stated in hindsight she should have sent the resident out to the hospital sooner.

An interview was conducted on 9/24/19 at 4:59 PM with Nursing Assistant (NA) #1. She stated she had been assigned to Resident #8 on 8/7/19, the night she had fallen. She stated she was out in the hall and she heard something in the resident's room and when she went into the room, she saw Resident #8 had fallen. She said she went and got the nurse and her and the nurse assisted the resident back to bed. She explained she had observed the resident's right foot was turned outwards, pointing out sideways, or was externally rotated, below the knee. She stated she had told Nurse #1 the resident's foot looked visibly disfigured from what she knew what it had looked like, before the fall. She stated the resident was hollering in pain and asking for pain medication. The NA stated Nurse #1 informed her she was going to have a nurse from another floor come over to look at the resident's foot to find out what the resident's foot usually looked like. The NA recounted she had assisted positioning the resident for an X-ray which was taken of the resident's right foot at approximately 2:30 AM by a contract company. She said the resident continue to complain of pain through positioning the resident for the X-ray, requesting pain medication, and the resident's right foot continued to stick out sideways. Shortly after the X-ray was completed the nurse informed the NA it

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appeared the resident's leg was broken in two places and would have to go out to the hospital, but she was going to go address another resident's needs first prior to sending the resident out to the hospital. The NA recalled she had assisted in providing care for the resident such as putting a clean, dry brief on the resident and some bathing to make sure the resident was clean when she went to the hospital. The NA explained the resident continued to complain of pain through her assisting with care and repositioning. The NA continued and stated she then went to another hall to provide care to her other assigned residents. The NA when she returned to Resident #8's hall at approximately 5:00 AM and saw she was still in the facility and the resident continued to complain of pain. The NA clarified the resident was not crying from the pain, but the resident was showing visible signs of pain such as grimacing, it appeared to her the pain the resident was experiencing was very intense and was close to crying from the pain. The NA continued she observed Nurse #1 take pain medication to Resident #8 at approximately 6:30 AM. The NA stated her shift ended at 7:00 AM and she was unaware of what happened after that. The NA added she had worked with the resident for about a year, had given the resident a shower every Wednesday, and she knew the resident's foot did not look right and she had informed Nurse #1 of that several times through the night.

Review of an incident report dated 8/7/19 and timed 1:00 AM completed by Nurse #1 revealed a fall by Resident #8. A physician was documented as having been notified at 1:00 AM and the resident's responsibly party was documented as having been notified at 4:00 AM. In addition, it

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was documented new orders were received from a Nurse Practitioner (NP) at 8:00 AM. The description of the event included: Resident #8 was observed on her back on the floor with complaints of right hip pain, right ankle pain, and back pain. The resident's description of the incident included she was walking in her room, fell, and was hurting in her back, right hip, and right ankle. When the resident attempted to move her right leg, she was documented as yelling out in pain. The nurse documented she informed the resident they needed to get her into bed, and it was going to be very uncomfortable. The nurse observed the resident's right foot with another nurse but was unable to touch the resident's foot due to her pain level having been reported by the resident as a 10 on a 0-10 scale. The resident was given the choice of going out to the hospital for an X-ray or staying at the facility and the resident chose to stay at the facility. She documented she called a physician and had obtained orders to get X-rays of the right hip and ankle through a mobile X-ray company who would come to the facility stat (a medical term meaning as soon as possible if not immediately). The X-ray company arrived at approximately 4:00 AM and upon completion of the X-ray the technician informed the nurse she had believed the X-ray image indicated fracture and dislocation. The Nurse communicated the information regarding the fracture and dislocation to the Nurse Practitioner at approximately 4:15 AM and a request was made to send the resident to the hospital. Nurse #1's documentation revealed she believed the radiologist's report of the X-ray had to be received prior to sending the resident to the hospital. The documentation further revealed she nor any other nurse at the facility was able to access to pain medication through the facility's

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automated medication supply machine and she was told to give acetaminophen 1,000 milligrams (mg) orally for pain. The nurse discovered the resident had an order for acetaminophen #3 (300 mg acetaminophen and 30 mg of codeine) and she administered that to the resident instead. Interventions documented in the incident report included the resident was assisted back to bed, orders for X-ray were obtained, the resident was assessed by the NP at approximately 8:00 AM along with reviewing the X-ray results, and orders were obtained to send the resident out to the hospital.

Review Resident #8's physician's orders revealed a physician's order dated 8/7/19 and timed 1:50 AM for X-rays of the right hip and the right ankle to rule out fracture of each stat (a medical term meaning as soon as possible if not immediately). The signature of the receiving nurse was Nurse #1.

Review was completed of an SBAR (Situation Background Assessment Recommendation) Communication Form dated 8/7/19 regarding Resident #8 and was completed by Nurse #1. The form documented the resident had a fall, had pain at a level of 10 on a 0-10 scale in her right ankle, the RP was notified at 6:00 AM, the recommendation of the NP at 8:00 AM was to send the resident out to the hospital and to call her back with the results of the X-ray.

Review of Resident #8's Medical Record (MR) revealed a Radiology Results Report for a right ankle X-ray with an examination date of 8/7/19 at 4:00 AM and reported date of 8/7/19 at 9:19 AM. The results of the X-ray were there was an acute (sudden onset) fracture of the distal fibula (the

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part of the small bone in the lower leg near the ankle/foot), a fracture in the tibia (the part of the large bone in the lower leg near ankle/foot), and the ankle was dislocated (the bones of the ankle were displaced from the joint).

Review of NP#1' morning report dated 8/7/19 and timed 5:58 AM revealed Nurse #1 had reported to the on-call NP Resident #8 had fallen at approximately 1:00 AM. The resident's right ankle was out of line, the resident was complaining of right hip and right ankle pain as a 10 on a 0-10 scale. The facility physician was called, and orders were obtained to obtain X-rays of the right hip and right ankle. No pain medication was administered. An order was given if the ankle was fractured then to send the resident to the hospital and to administer 1,000 mg of acetaminophen due to having been unable to obtain stronger pain medication from the facility's automated medication administration machine. Call with X-ray results as soon as possible and if the right leg foot/ankle is fractured send the resident to the hospital to stabilize. The NP documented she called the facility at 5:58 AM and the results of the final results of the x-ray were pending, the RP was aware and if the resident had a fracture, the resident was to be transferred to the hospital.

Review of Resident #8's October 2019 Medication Administration Record revealed there was no recorded administration of acetaminophen #3 on 8/7/19. Review of the Narcotic Control sheet for Resident #8 revealed one acetaminophen #3 was dispensed on 8/7/19 at 6:15 AM.

A review was completed of a written statement

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provided by Nurse #1 dated 8/9/19 and timed 2:38 PM regarding the events of 8/7/19 for Resident #8. She documented she had responded to suspicious noises coming from the room of Resident #8 with Nursing Assistant (NA) #1 and discovered Resident #8's right foot was visibly turned in an outward position. The resident was assisted back to bed. The nurse recorded she called the facility physician at approximately 1:15 AM and received orders to obtain an X-ray and to notify the Nurse Practitioner (NP) in the morning, she additionally called the resident's RP, left a message, and contacted the X-ray company regarding stat X-rays. The statement continued between 4:20 AM and 4:25 AM she contacted the on-call NP and the on-call NP had wanted to order hydrocodone (a strong narcotic pain medication) but the nurse was unable to access the medication in the facility's automated medication supply machine, so she obtained an order to administer 1,000 milligrams (mg) of acetaminophen. The nurse further documented the NP told the nurse not to send the resident to the hospital until there was a confirmation (of a fracture).

Review Resident #8's physician's orders revealed a physician's order dated 8/7/19 and timed 8:10 AM to send the resident out to the hospital. The signature of the physician was the resident's Nurse Practitioner (NP). An interview was conducted on 9/25/19 at 11:38 AM with the resident's NP, NP #2. She stated she had received and reviewed NP #1's report regarding Resident #8 the morning of 8/7/19 and there was no mention of the nurse having communicated the severity of the injury, deformity, dislocation of the right ankle, or what the X-ray technician had

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shared with her regarding the likelihood multiple fractures. She stated she had spoken with Resident #8's RP around 8:00 AM on 8/7/19 and the RP stated the resident's right ankle was very swollen and she needed to go to the hospital. NP #2 stated she called the facility and spoke to Nurse #1 and the nurse was unable to access the resident's medical record because she was charting, but she did tell her the resident had fallen and the right ankle looked really bad. The NP stated when she arrived to the facility at approximately 8:00 AM she assessed Resident #8 and had found her right ankle to be extremely swollen, deformed, clearly dislocated, obviously fractured, the resident had decreased sensitivity to her foot/toes, decreased pulses in her right foot, and Nurse #1 told her the X-ray technician had told her she believed the ankle had multiple fractures. The resident continued to have complaints of pain and it had been about 2 hours since she had received the acetaminophen #3. NP #2 recalled the nurse was unable to provide a reason for having not informed the on-call nurse the severity of the injury but was attempting to explain to the NP the reason for the resident having only received an acetaminophen #3 at approximately 6:00 AM and how come the resident had not been sent to the hospital. NP #2 stated had the on-call NP, NP #1, been made aware of the severity of the injury, high likelihood of a fracture, or extreme discomfort of the resident an order to send the resident out to the hospital would have been ordered immediately, however that information was not communicated, and the resident was not sent out to the hospital. The NP stated as soon as the X-ray technician communicated there was a fracture it was her expectation for a nurse to immediately contact NP #1 to obtain an order to send the resident to a

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hospital and it was her expectation for a nurse to initiate care for a resident including pain management. NP #2 stated due to the severity of the resident's injury acetaminophen #3 was not an acceptable nor effective pain medication for the resident but the nurse stated she was unable to provide any other medication or provide medication to the resident sooner due to her lack of access to the facility's automated medication supply machine. NP #2 further stated through conversations with the resident's RP the RP had requested the resident have been sent out to the hospital when the nurse had informed the RP about the fall and possible injury, but the nurse had told NP#1 the RP had asked the resident to not be sent out.

An interview was conducted on 9/25/19 at 10:48 AM with Nurse #3. She stated she was the nurse who had received report from Nurse #1 and was assigned to Resident #8 on 8/7/19. She stated after she had received report, she went to see Resident #1 and the resident's right foot was turned out to the side, was warm to the touch, swollen, and the resident was complaining of pain. She also recalled the resident's RP arrived the facility due to having received a phone call and was asking how come the resident had not been sent out to the hospital? She stated the resident's RP came to her and asked for the resident to be sent out to the hospital. She further added the resident's NP had also arrived to the facility and went to the resident's room to assess the resident. She stated she had not given the resident any pain medication, but she had obtained the resident's vital signs and the resident reported to her, that her pain level was at a 10 at the time she obtained her vital signs at 7:51 AM. She recalled they had put ice on her

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foot at about that time as well. It was determined to hold off administering further pain medication at that time because it was believed the resident may require surgery. She recounted Nurse #1 stated she had not sent the resident out to the hospital because she was awaiting the results of the X-ray to see what to do next.

Review of Resident #8's MR revealed a nursing progress note dated 8/7/19 and timed 8:00 AM by Nurse #1 documenting Resident #8 had a change in condition, the change had been reported to the NP, and an order was obtained to send the resident out to the hospital.

An interview was conducted on 9/25/19 at 9:38 AM with Nurse #2. Nurse #2 stated she was the Unit Manager (UM) and had arrived to the facility at approximately 8:00 AM on 8/7/19. The UM said Nurse #1 had informed her when she arrived, she had just received orders to send Resident #8 out to the hospital. The UM further stated she had obtained statements regarding Resident #8 at the direction of the Director of Nursing (DON) and she had informed Nurse #1 to complete her charting completed on everything which happened regarding Resident #8.

Review of a letter from NP #2 revealed she had spoken to Nurse #1 on 8/7/19 after having received a call from the resident's RP at 7:46 AM expressing concern regarding the resident's very swollen right leg and foot and she thought the resident needed to go to the hospital. The NP documented Nurse #1 was unwilling to attempt to find the resident's X-ray results in the computer system because she was charting on the resident and if she exited her charting, the computer would not retain her documentation. Nurse #4

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

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reviewed the resident's Electronic Medical Record and the resident's X-ray results had not been received. The NP informed Nurse #4 regardless of lack of X-ray results to send the resident to the hospital due to the delay in care and the RP's wishes. The NP further documented when she arrived to the facility the resident was still at the facility, Emergency Medical Services (EMS) and the RP were outside of the resident's door waiting for the resident to receive a clean brief. The NP assessed the resident and found the resident's right ankle to have had 4+ pitting edema (swelling where when a finger is depressed on the skin an indentation remains) and she was told by Nurse #3 the resident had not received any pain medication until approximately 6:00 AM. The RP informed the NP she had informed Nurse #1 when she had initially called about the fall and injury, she believed the resident should have gone to the hospital. The NP documented that information had not been communicated to the on-call NP through updates through the night. The NP documented a conversation between her, and Nurse #1 and the nurse informed her the X-ray technician has informed her at approximately 4:30 AM there were multiple fractures in the right ankle, however this was not communicated to the on-call NP. The nurse further stated the on-call NP had told her to await the official results of the X-ray. Regarding the delay in the resident receiving pain medication the nurse told the NP the on-call nurse did not have access to the facility's EMR and if she did, she could have easily looked up the resident had been prescribed acetaminophen #3. The NP documented throughout her conversation with Nurse #1 the nurse continued to say the on-call NP would not let her send out the resident.

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A phone interview was conducted on 9/25/19 at 10:02 AM with Resident #8's Responsibly Party (RP). The RP stated she was called and made aware of Resident #8's fall and injury via phone call during the night and had requested the resident be sent to the hospital. She said she was again called later and informed the resident had not been discharged to the hospital and she decided to come to the facility and arrived to the facility at approximately 8:00 AM. The RP stated when she saw the resident the resident had told her she was in pain. The RP explained the nurse had told her the resident could not be sent to the hospital because the resident had refused to be sent to the hospital and the X-ray report had not been received through the fax machine yet confirming the fracture. The RP said the resident was confused and had told the RP if she went to the hospital, she would have to pay a big bill for ambulance. The RP recalled another nurse told Nurse #1 she did not need to wait for the faxed copy of the report, the X-ray report came to the facility a different way. The RP then stated she told Nurse #1 to send the resident to the hospital after Nurse #1 informed her none of the nurses at the facility could make the decision to send the resident to the hospital. The RP described the resident's foot as turned outward and it did not look normal. The RP said the resident had fallen at approximately 1:00 AM and had not received pain medication until about 6:00 AM.

Review of Resident #8's MR revealed a nursing progress note dated 8/7/19 and timed 8:16 AM by Nurse #1 documenting Resident #8 had an unplanned discharge to the hospital.

During an interview conducted on 9/25/19 at 11:30 AM with the Unit Clerk she stated Resident

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#8 went out with EMS on 8/7/19 at approximately 8:30 AM or 8:35 AM.

Review of a hospital Discharge Summary for Resident #8 dated 8/12/19 revealed the resident arrived at the hospital on 8/7/19 at 9:02 AM via ambulance. The resident was documented as having been admitted for a right (Trimalleolar) ankle fracture and subsequently had surgical repair of the ankle fracture on 8/8/19. The resident was documented as having received multiple doses of pain medication at the hospital from the date of admission through date of discharge. The resident was documented as having had complaints of pain at the time of admission. The resident's pain was documented at the time of admission as moderate achy/burning/throbbing/dull/sharp in nature. The resident's pain was further documented as having been consistent since the initiation of symptoms and the symptoms were unchanged.

An interview was conducted on 9/24/19 at 3:23 PM with the DON and she stated Nurse #1 was assigned to Resident #8 on 8/7/19 at the time of the fall was an agency nurse and she was not familiar with the resident and was not aware of how the resident's legs normally looked. She added the nurse had another nurse come assess the resident's leg after the fall at about 1:00 AM. The nurse had called the physician and obtained an order to have an X-ray of the resident's foot and leg. She went on to explain the nurse discovered the resident was not under the care of the physician but another group, she then called the on-call line and informed their Nurse Practitioner (NP) #1 of the fall, the deformity of the resident's leg, and the pending X-ray. She stated the resident was documented as having

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had pain from the injury she had sustained from the fall. The DON explained Nurse #1 believed she had needed to receive the results of the X-ray prior to sending the resident out to the hospital. The resident's Responsible Party (RP) and the resident's NP were at the facility at approximately 8:00 AM and that was when the process of sending the resident out to the hospital was initiated. An allegation of neglect was received from the resident's RP on 8/8/19 when the resident's RP stated she felt it was neglectful for not providing pain medication for the resident after she had experienced an injury from the fall. The DON stated an investigation was conducted and the allegation was substantiated based on the fall and injury having occurred at approximately 1:00 AM and the resident did not receive pain medication until approximately 6:00 AM. The DON explained there were other pain medications available in the facility's automated medication supply machine, but at the time it was believed only one person had access and in order to obtain a narcotic or controlled medication, there would have needed to have been two nurses, one to remove the medication and the second as a witness. The DON further explained it was discovered a second nurse did have access. The DON said Nurse #1 had counted the narcotics, reported off to the 7:00 AM to 3:00 PM nurse, was clocked out, and was getting ready to leave. The DON added it was at that point when it was discovered what the nurse said had transpired and what she had documented did not agree. The nurse was asked to clock back in and complete the documentation regarding the incident regarding Resident #8. The DON stated she nor the Administrator were called or made aware of Resident #8's fall and it was when she arrived to the facility, she discovered situation.

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An interview was conducted on 9/25/19 at 8:58 AM with the Administrator. The Administrator stated Resident #8 had fallen and had experienced an injury as evidenced by her foot appeared abnormal and was complaining of pain. During the investigation of the incident it was discovered Nurse #1 believed if pain medication was administered prior to an X-ray it would skew the results, so she had been holding off administering pain medication until the X-ray was completed. The Administrator said the X-ray technician had informed the nurse she believed resident had a fracture to her right lower leg/foot but they would have to wait for a radiologist to review the X-ray for an official diagnosis. The nurse communicated the information to the NP. The Administrator stated the nurse had explained she was unable to retrieve pain medication from the automated medication supply machine due to not have access. The Administrator further stated the nurse called the NP again around 8:00 AM because the X-ray results had not been received via the fax machine yet at that time. It was at that time it was determined to send the resident out to the hospital according to the Administrator. The Administrator also detailed the resident's RP had expressed dissatisfaction the resident had not been sent out to the hospital sooner and had made an allegation of neglect based on the amount of time it had taken for the resident to be medicated for pain. Through the investigation it was discovered the nurse had overlooked the order for acetaminophen #3 and truly felt administering pain medication prior to the X-ray would skew the results. The Administrator stated the nurse was suspended upon receiving the allegation and the investigation substantiated the allegation and the nurse was not allowed to

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F 600	Continued From page 17 return to work at the facility. The Administrator stated the facility initiated in-service education regarding administration of pain medication for pain and it was his expectation for resident's to be appropriately medicated for pain to provide comfort and relief.	F 600		