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F 000	INITIAL COMMENTS A complaint investigation was conducted on-site from 3/25/25 through 3/26/25. The following intake was investigated: NC00228403. Event ID # R5XQ11. 1 of the 1 complaint allegation resulted in deficiency.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner and Physician interviews, the facility failed to comprehensively assess a resident and failed to identify or recognize the significance of external rotation and shortening of the leg, severe pain, and inability to bear weight after a fall. The resident had external rotation (an outward rotation of the thigh and knee away from the body), was unable to bear weight and experienced pain from 3/4/25 (the day after a fall) through 3/10/25 at which time he was sent to the Emergency Room and identified with a comminuted right intertrochanteric femur fracture (most common type of hip fracture which the long bone of the thigh breaks into multiple pieces caused by a fall and is characterized by severe	F 684	Resident #2 no longer resides in the facility. On April 11, 2025 the Director of Nursing or designee assessed all current residents with a fall since March 26, 2025 to ensure there were no physical injuries that were unreported or unidentified on the initial physical assessment. The Director of Nursing or designee will educate all nurses on ensuring a physical assessment is completed after each incident, the significance of external rotation and shortening of a lower extremity on assessment and reporting	4/16/25

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

Electronically Signed | 04/11/2025

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 684	Continued From page 1 pain in the hip, inability to bear weight on the affected leg, and shortening and external rotation of the leg). The resident underwent intermedullary nailing of the right femur (a procedure in which a metal rod is inserted into the long thigh bone to stabilize the fracture) with no complications as a result of the surgery. This failure to comprehensively assess a resident was observed for 1 of 4 residents reviewed for accidents (Resident #2). Findings included: A review of Resident #2's hospital discharge summary dated 3/3/25 indicated the resident was diagnosed with weakness. The history of the present illness indicated Resident #2 had a total knee replacement one week prior to hospitalization and was unable to make progress at home. The resident was admitted for pain control on 2/28/25 and the hospital course indicated the resident was stable upon discharge with the resident's pain improved. Resident #2 made slow progress with physical therapy at the hospital and was discharged to the skilled nursing facility to continue with therapy. Resident #2 was admitted on 3/3/25 with diagnoses which included: aftercare following knee replacement surgery, muscle weakness and unsteadiness on feet. A diagnosis of dementia was discussed in Resident #2's hospital discharge summary but was not listed as a discharge diagnosis and was not included in the facility diagnosis list. A nursing progress note dated 3/3/25 at 5:40 PM written by Nurse #1 indicated that Resident #2 was admitted for aftercare following a right total	F 684	the findings to the provider once identified. The education was completed by 4/14/2025. The Director of Nursing or designee will review the electronic medical record Monday-Friday for 12 weeks for all residents with a fall to ensure the resident was assessed and that any physical injuries, including external rotation and shortening of the extremities have been reported to the provider. Any issues identified will result in immediate notification to the provider for follow up and re-education or progressive disciplinary action for the nurse. The audits will be reviewed monthly for 3 months in the Quality Assurance Performance Improvement Committee meeting.	

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knee replacement. Resident #2 was alert and oriented to person, place and event with some confusion. Resident #2 transferred with stand and pivot assistance with one person assistance with orders for weight bearing as tolerated. The progress note indicated Resident #2 was noted as continent of bowel and bladder and had been using a urinal and bedpan prior to admission. Resident #2 wore glasses and had a hearing aid which he left at home.

A nursing progress note completed by Nurse #4 dated 3/3/25 at 11:54 PM indicated Resident #2 had a fall in the room. The note indicated Resident #2 reported that he was supplied with a urinal for toileting, but he spilled it before slipping out of bed. The resident was alert and oriented. The right knee, which was recently replaced, had a dressing in place and showed old bruises and slight swelling. Resident #2 reported no new injuries or increased pain. There were no signs of head trauma. Vital signs remained within normal limits. A mechanical lift was used to safely assist the resident back to bed. Close monitoring was to continue for any changes in condition. The note indicated every 4 hour neurological checks were initiated and the on-call provider was contacted.

A focused head to toe observation dated 3/3/25 at 11:45 PM completed by Nurse #4 indicated an observation was made of Resident #2 as a follow up to a fall. The observation indicated that Resident #2 was alert to person, place, time and situation with strong bilateral hand grasps. Foot press strength, a test in which the resident is asked to push against resistance as part of a neurological evaluation, was not assessed due to right knee surgery. The observation noted

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impaired range of motion of Resident #2's right knee and leg with the lower extremities equal in length.

A fall event report dated 3/3/25 at 11:58 PM completed by Nurse #4 indicated Resident #2 had an unwitnessed fall with no injuries. Resident #2 was found in his room on the floor. The report indicated Resident #2 did not complain of or exhibit pain related to the fall. The report indicated the nurse was unable to complete range of motion of his right lower extremity and a rotation deformity or shortening of Resident #2's right lower extremity was observed (an abnormal finding often associated with a femur fracture). This was different than the 11:45 PM observation completed by Nurse #4 which indicated Resident #2's lower extremities were equal in length.

An interview was conducted with Nurse #4 on 3/25/25 at 3:00 PM. Nurse #4 stated she worked night shift the night that Resident #2 had an unwitnessed fall (3/3/25) in which he slipped out of bed when he was using the urinal. Nurse #4 indicated she assessed the resident, and he did not have any injury, so he was transferred back to the bed using a mechanical lift. Resident #2 stated he did not hit his head. Nurse #4 indicated that throughout the night, Resident #2 complained of spasms in his back, and he was unable to get comfortable. Nurse #4 stated she did not recall if she administered pain medication that night, but she stated that she and the staff repositioned the resident frequently to try to make him comfortable. Nurse #4 could not explain why she documented at 11:45 PM on 3/3/25 that Resident #2's lower extremities were equal in length and then at 11:58 PM on the event report she indicated a rotation deformity or shortening of

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the right lower extremity. Nurse #4 stated she knew that rotation and shortening of the leg was abnormal, but she was unable to explain why she did not report the observation to the on-call provider nor did she report that he complained of spasms in his back although she acknowledged that she should have.

An interview was conducted with Nursing Assistant (NA) #1 on 3/25/25 at 2:30 PM. NA #1 stated she was assigned to Resident #2 on 3/3/25 from 3:00 PM to 7:00 PM, on 3/4/25 from 7:00 AM to 7:00 PM and 3/8/25 from 7:00 AM to 7:00 PM. NA #1 stated Resident #2 was pleasant and cooperative when he was admitted on 3/3/25 and did not complain of pain. NA #1 stated when she came in on 3/4/25 she was told by the previous NA that the resident had a fall. Later that day when she was providing care for him, Resident #2 yelled out in pain when she turned or rolled him in bed. NA #1 stated Resident #2 complained of pain in the right leg and described the pain as pulling or a burning pain. NA #1 stated it took 2 people to provide care for Resident #2 due to the pain he had in his right leg. NA #1 indicated Resident #2 was only able to tolerate sitting up in a wheelchair for a short time due to the pain. NA #1 stated she observed swelling in Resident #2's right thigh about a day or 2 after he was admitted, and she reported this to the floor nurse who she thought was Nurse #4. NA #1 stated Resident #2 would get aggravated during care due to the pain in his groin area and upper leg. Resident #2 stayed in bed when he was not receiving therapy due to the pain and the inability to sit comfortably in a wheelchair. NA #1 indicated she would try to position the resident in bed with pillows for comfort.

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An interview was conducted with NA #4 on 3/25/25 at 5:00 PM. NA #4 indicated that she worked from 7:00 PM to 7:00 AM and was assigned to Resident #2 on 3/3/25, 3/7/25, 3/8/25 and 3/9/25. NA #4 stated when Resident #2 fell on 3/3/25 he had pain and required 2-person assistance to get him up and provide his care. Prior to fall, NA #4 stated Resident #2 seemed fine and did not have pain. NA #4 indicated she observed that his right thigh area had swelling on the nights she was assigned to Resident #2 after the fall, and he complained of hip pain. NA #4 stated she checked on Resident #2 often, tried to talk to him to calm him down and reassure him. NA #4 stated that she thought Resident #2 was restless due to pain. NA #4 stated she reported his pain to the floor nurse each time she worked but she did not know if the nurse administered pain medication or assessed the resident.

Resident #2's physical therapy evaluation and plan of care dated 3/4/25 indicated the resident verbalized a pain level of 10 out of 10 with constant and sharp pain to the right knee and shin which limited mobility, standing and ambulation. Resident #2 reported a 10 out of 10 pain level at rest and with movement and was unable to bear weight on the right lower extremity during transfers, which was a change from his admission on 3/3/25 when he transferred with stand and pivot assistance of 1 person.

An interview was conducted with the Physical Therapist (PT) on 3/26/25 at 10:26 AM. PT stated that he was aware that Resident #2 had a fall on 3/3/25 after admission. PT stated Resident #2 had a lot of pain and difficulty with weight shifting. PT stated Resident #2 had cognitive impairment and it was difficult to discern if the resident's pain

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was out of proportion to the activity or as intense as it seemed or if it was more behavioral. PT indicated he did not recognize that Resident #2 not bearing weight when he was evaluated and during his therapy sessions as an indication of a problem. PT stated Resident #2's therapy had to be modified due to his pain level and his inability to bear weight. PT stated from what he was told, Resident #2 did not progress at home with home health therapy so he assumed the resident probably would not do well with the therapy in the facility. PT indicated Resident #2's right leg was externally rotated (a condition in which the leg is outwardly rotated with the thigh and knee pointed away from the body) which he acknowledged is a sign of a fracture, but he assumed this was caused by the resident staying in bed a lot and not participating in therapy at home. PT stated he did not report Resident #2's increased pain level, inability to bear weight or the external rotation of his right leg to the nursing staff or the medical provider. PT stated he assumed the pain he noted that Resident #2 demonstrated was related to his dementia and was not an abnormal finding. PT stated that some residents with dementia demonstrate intense pain but it is more of an exaggerated response than actual pain and he assumed that was the case with Resident #2.

An interview was conducted with the Physical Therapy Assistant (PTA) on 3/26/25 at 10:40 AM. PTA stated that she worked with Resident #2 for therapy during his stay and she recalled that his right leg was very painful. PTA indicated Resident #2 could not tolerate standing due to pain and was not able to bear weight on the right leg. PTA stated Resident #2 was difficult to work with, but she assumed this was because he was not motivated. PTA stated she did not report

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Resident's pain level or inability to bear weight to the therapist or the nursing staff as she assumed this was normal for the resident. PTA indicated she had not noticed Resident #2's leg to be externally rotated or shortened.

Review of Resident #2's electronic health record revealed that on 3/4/25 there was no nursing progress note regarding an assessment of Resident #2 post fall, his pain level, participation with the therapy evaluations or ability to bear weight on the right lower extremity.

A physician progress note dated 3/4/25 at 7:58 PM by Physician #1 documented Resident #2 indicated he had 8 out of 10 right leg pain. The progress note did not reference Resident #2's fall that occurred on 3/3/25 nor was an assessment made due to the fall. The progress note indicated for Resident #2 was to continue pain management with the pain medications that were prescribed from the hospital.

An interview was conducted with Nurse #5 on 3/25/25 at 2:00 PM. Nurse #5 was an agency nurse assigned to Resident #2 on 3/4/25, 3/8/25 and 3/9/25 from 7:00 PM to 7:00 AM. Nurse #5 stated she did not know that Resident #2 had a fall on 3/3/25 and that information regarding falls was normally communicated verbally during shift report. Nurse #5 stated she found out after Resident #2 was transferred to the hospital that he had fallen. Nurse #5 stated Resident #2 had a lot of pain and required 2 people to provide care for him. Nurse #5 stated she assumed that his complaints of pain were more of a behavior or were related to his dementia and did not require medication or further evaluation. Nurse #5 indicated she only administered pain medication

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to Resident #2 once because she assumed his complaint of pain was a behavior and he was just being difficult. Nurse #5 stated Resident #2 yelled at her one of the nights when she entered his room, so she did not attempt to complete an assessment. Nurse #5 indicated that if she had assessed Resident #2 and observed swelling in his upper thigh or hip area she would have notified the provider. Nurse #5 stated she probably should have assessed Resident #2 and evaluated his pain.

A Nurse Practitioner progress note dated 3/5/25 at 6:50 AM indicated in part that she evaluated Resident #2 due to the resident screaming and giving the Nursing Assistant and Nurse difficulty with care. The progress note indicated Resident #2 was agitated and incontinent. The note indicated Resident #2 was to continue with the prescribed pain medication and stated that the resident's mild dementia was affecting his ability to comply with therapy and was impacting his recovery. The progress note did not reference Resident #2's fall that occurred on 3/3/25 nor was an assessment made due to the fall. The progress note did not reference a pain level or an assessment of Resident #2's right lower extremity.

An interview was conducted with the Nurse Practitioner (NP) on 3/26/25 at 10:00 AM. The NP stated she went into Resident #2's room early on the morning of 3/5/25 when she heard him hollering and screaming during care. The NP stated Resident #2 was calm after the incontinence care was provided so she assumed he was exhibiting behaviors related to his dementia. The NP stated she was not aware that Resident #2 was having pain at an intensity of 10

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out of 10, that he was unable to bear weight on his right leg and that his leg was externally rotated with shortening. The NP stated she did not complete a full physical exam of the resident. The NP stated if she had been made aware of Resident #2's pain intensity of 10 and inability to bear weight she would have evaluated the resident further as these are signs of a serious condition such as a fracture.

A care plan for falls was created on 3/5/25 and revealed Resident #2 was at risk for falls related to pain. The interventions dated 3/5/25 included to administer medications as ordered, assist with mobility as needed, and ensure the resident was wearing non-skid footwear when out of bed.

A skilled nursing note dated 3/5/25 at 7:49 PM by Nurse #1 indicated Resident #2 was pleasant, cooperative, anxious, and combative or resistive to care with no changes in condition in the past 24 hours. The note gave no indication of Resident #2's pain level, participation with therapy or assessment of his right leg. Resident #2 was not previously documented as combative or resistive to care.

An interview was conducted with NA # 6 on 3/26/25 at 8:40 AM. NA #6 indicated that she worked from 3:00 PM to 11:00 PM and was assigned to Resident #2 on 3/5/25. NA #6 stated that when she attempted to provide incontinence care, Resident #2 began screaming. NA #6 stated she did not know what was wrong but could tell Resident #2 was in a lot of pain. NA #6 stated she asked another NA to assist her and they were able to provide incontinence care to Resident #2 by providing increased time and support with moving him. NA #6 indicated she

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informed the assigned nurse, Nurse #2, that Resident #2 was having severe pain during care. NA #6 stated she did not know if the nurse evaluated the resident. NA #6 did not notice anything different about Resident #2's leg.

An interview was conducted with Nurse #2 on 3/26/25 at 8:15 AM. Nurse #2 stated she was an agency nurse that worked as needed at the facility. Nurse #2 was assigned to Resident #2 on 3/5/25 from 7:00 PM to 7:00 AM. Nurse #2 stated she did not recall anything about Resident #2. Nurse #2 stated she did not have much interaction with the residents other than administering medication and she did not recall if the NA reported that Resident #2 had pain.

Review of Resident #2's electronic health record revealed that on 3/5/25 there was no nursing progress note regarding an assessment of Resident #2 post fall, his pain level, or that NA #6 reported the resident was screaming or demonstrating increased pain during incontinence care.

A skilled nursing note dated 3/6/25 at 2:36 PM by Nurse #4 indicated Resident #2 was alert, oriented to person, place, time and situation and had no changes in condition in the past 24 hours. The note gave no indication of Resident #2's pain level, participation with therapy or assessment of his right leg.

An interview was conducted with NA #2 on 3/25/25 at 2:50 PM. NA #2 was assigned to Resident #2 on the 7:00 AM to 3:00 PM shift on 3/5/25 and 3/6/25. NA #2 indicated she did not recall much about Resident #2's care but she did recall he had a lot of pain in his leg. NA #2 stated

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she did not report Resident #2's pain to the floor nurse as she thought they already knew since he had been having pain for several days.

An interview was conducted with NA #5 on 3/26/25 at 8:50 AM. NA #5 indicated she worked on the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts. NA #5 stated she and NA #4 worked together on the rehabilitation unit where Resident #2 resided. NA #5 indicated that she provided care to Resident #2 on 3/3/25, 3/4/25 and 3/6/25 from 11:00 PM to 7:00 AM. NA #5 stated she recalled when Resident #2 fell on 3/3/25 and indicated that he was very agitated after the fall. NA #5 stated that Resident #2 required 2 person assistance with turning and reposition and incontinence care. NA #5 stated resident screamed and hollered during incontinence care and would become combative. NA #5 stated Resident #2's right leg had swelling in the thigh area, and he was having a lot of pain. NA #5 stated she and the other NA would try to be gentle and provide increased time with care. NA #5 stated it was difficult to get Resident #2 comfortable, but she did not report this to the nurse as she thought the nurses already knew. NA #5 could not recall if Resident #2's leg was externally rotated.

Review of Resident #2's electronic health record revealed that on 3/6/25 from 11:00 PM to 7:00 AM there was no nursing progress note regarding an assessment of Resident #2, his pain level or that he was screaming and agitated during incontinence care.

A Minimum Data Set (MDS) pain assessment completed by the MDS Nurse on 3/7/25 at 8:16 AM indicated Resident #2 had pain in the last 5

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days almost constantly and the pain affected his sleep, therapy and day to day activities frequently. Resident #2 rated his pain intensity as 10.

Resident #2's electronic health record revealed no nursing progress note by the MDS Nurse regarding resident's pain level of 10, notification of the medical provider or further assessment of the resident.

An interview was conducted with Nurse #3 on 3/25/25 at 1:14 PM. Nurse #3 was new to the facility and was assigned to Resident #2 on 3/7/25 from 7:00 AM to 7:00 PM. Nurse #3 stated on 3/7/25 Resident #2 did not want to get up out of bed or participate in therapy. Nurse #3 stated it was her first day assigned to Resident #2 and she did not know what his baseline was. Nurse #3 stated nothing was reported to her by the previous shift regarding resident's condition or increased pain. Nurse #3 acknowledged that she did not attempt to determine why Resident #2 did not want to get up or participate in therapy. During the shift on 3/7/25, Nurse #3 indicated eventually, Resident #2 was assisted up out of bed to the wheelchair and went to therapy. During the shift on 3/7/25, Nurse #3 stated she administered Resident #2's pain medication but did not complete a full assessment of the resident as she was busy with passing medications, her other duties, being new to the facility and still learning. Nurse #3 stated she did not recall anything about Resident #2's pain on 3/7/25, his right lower extremity, the pain level or factors that affected the pain.

An interview was conducted with Nurse #6 on 3/25/25 at 4:51 PM. Nurse #6 was an agency nurse assigned to Resident #2 on 3/6/25 and

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3/7/25 from 7:00 PM to 7:00 AM. Nurse #6 stated she did not know much about Resident #2 as she only was assigned to him a couple of times. Nurse #6 stated Resident #2 was confused and was combative with personal care. Nurse #2 stated that she assumed that was Resident #2's baseline as that was what she was told by other staff, but she could not recall which staff members told her this. Nurse #6 stated she thought that his behavior might be due to pain, so she thought she administered his PRN pain medication, and this seemed to help him. Nurse #6 stated she did not attempt to identify the source of the pain or complete an assessment of Resident #2 as she thought the pain medication seemed to help.

An interview was conducted with NA #3 on 3/25/25 at 5:15 PM. NA #3 indicated that she worked from 7:00 AM to 3:00 PM and was assigned to Resident #2 on 3/7/25. NA #3 indicated Resident #2 had a lot of pain in his hip and leg. Resident #2 did not want to move his leg and seemed scared to move it. NA #3 stated she informed the floor nurse of Resident #2's pain and stated the nurse knew that his leg was hurting.

Resident #2's electronic health record revealed no nursing progress note dated 3/7/25 by Nurse #3 regarding resident's pain level of 10, notification of the medical provider or assessment of the resident.

A skilled nursing note dated 3/8/25 at 6:19 PM by Nurse #1 indicated Resident #2 was oriented to person, was pleasant, anxious and combative or resistive to care and had no change in condition in the past 24 hours. The note gave no indication

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of Resident #2's pain level, participation with therapy or assessment of his right leg.

Resident #2's 5-day Minimum Data Set (MDS) dated 3/9/25 indicated the resident had moderate cognitive impairment and demonstrated rejection of care 1 to 3 days. Resident #2 had functional limitation in range of motion with impairment on 1 side of the lower extremity and required moderate assistance with bed mobility and transfers. Resident #2 had frequent incontinence of bowel and bladder, had a diagnosis of muscle weakness and unsteadiness. Resident #2 had almost constant pain that interfered with sleep, therapy and day-to-day activities. Resident #2 rated his pain a 10.

A skilled nursing progress note dated 3/9/25 by Nurse #1 indicated Resident #2 was oriented to person, was pleasant, anxious, combative or resistive to care and had no change in condition in the past 24 hours. The note gave no indication of Resident #2's pain level, participation with therapy or assessment of his right leg.

An interview was conducted with Nurse #1 on 3/26/25 at 3:30 PM. Nurse #1 stated she had a hard time recalling specific information about Resident #2, as the rehabilitation hall was her primary assignment and there was a high rate of turnover of residents. Nurse #1 recalled that Resident #2 had pain with movement, but she did not assess his leg. Resident #2 had difficulty expressing where the pain was, but Nurse #1 stated he would say repeatedly "Oh my leg" with any movement or activity. It was hard for him to describe where the pain was. She reported that with transfers, bed mobility, and incontinence care Resident #2 demonstrated non-verbal signs

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of intense pain which included grimacing or wincing. Nurse #1 stated she did not recall that therapy reported that Resident #2 had 10 out of 10 pain, was unable to stand or bear weight. Nurse #1 stated she did not inform the provider that Resident #2 had intense pain with movement as he had some dementia, and she assumed the provider knew.

A physician progress note dated 3/10/25 at 1:31 PM written by Physician #2 indicated the physician was asked to see Resident #2 as he was not participating in therapy, and he had a fall following admission to the facility. Per Resident #2's family member the resident was not himself, was not acting right and she (the family member) was concerned. Resident #2 was seen and examined with the resident complaining that his right groin was in a lot of pain down into this thigh. Resident #2 stated it hurt whenever anyone touched the area.

An interview was conducted with Physician #2 on 3/26/25 at 2:42 PM. Physician #2 indicated that he was asked to see Resident #2 on 3/10/25 due to the resident not participating in therapy and increased pain. Physician #2 indicated Resident #2 stated he had pain in his groin. Physician #2 stated he and 2 of the therapists assisted Resident #2 into bed. Physician #2 stated Resident #2 seemed worse from what staff reported since his fall. Physician #2 stated he was concerned that Resident #2 may have a fracture, and this needed to be addressed right away so he ordered for the resident to be sent to the hospital. Physician #2 stated that the resident's increased pain level and inability to bear weight should have been reported to the physician or NP to evaluate. Physician #2

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indicated it was possible that the fracture may not have had any outward signs, but increased pain and inability to bear weight was a sign that should have been reported for further evaluation. Physician #2 indicated that Resident #2 had mild dementia with some cognitive impairment. Physician #2 stated that a resident with dementia may demonstrate increased behaviors including agitation or combativeness because of pain. Physician #2 stated he did not recall if Resident #2's leg was shorter or externally rotated.

A nursing progress note dated 3/10/25 at 1:43 PM written by Nurse #3 indicated Resident #2 was sent to the emergency room for evaluation. Resident #2's family member stated that the resident complained of pain in his right hip area since he had an unwitnessed fall on 3/3/25. Resident #2's family member stated he had decreased mentation and the family member requested a urinalysis and Computed Tomography (CT) scan be completed. The physician assessed the resident and decided to send Resident #2 to the emergency room due to pain in the hip/groin area.

An interview was conducted with Nurse #3 on 3/25/25 at 1:14 PM. Nurse #3 stated she worked with Resident #2 during the 7:00 AM to 7:00 PM shift on 3/10/25. Nurse #3 stated that Resident #2's family member indicated that she wanted the resident evaluated so she informed the physician of the family member's request. Nurse #3 stated on 3/10/25, Resident #2 was in acute pain, could not get up out of bed and was unable to sit up. Nurse #3 stated Resident #2 was only able to tolerate lying flat in bed due to significant pain in the right hip and groin. Nurse #3 stated Resident #2's pain was excruciating. The physician gave

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the order to transfer Resident #2 to the hospital for evaluation.

The emergency department encounter note dated 3/10/25 indicated Resident #2 presented with groin pain since an unwitnessed fall at the facility on 3/3/25. The note indicated Resident #2 had right groin tenderness., right leg pain and deformity with external rotation of the right lower extremity. Resident #2's right leg was shorter than the left and was mildly edematous, a condition characterized by abnormal accumulation of fluid and can be caused by an injury. Two view x ray of the right femur result indicated a comminuted right intertrochanteric femur fracture. Resident #2 was admitted to the hospital on 3/10/25, underwent intermedullary nailing of the right femur (a procedure in which a metal rod is inserted into the long thigh bone to stabilize the fracture) and was discharged to a skilled nursing facility on 3/20/25. There was no indication of complications as a result of the surgery.

An interview was conducted with Physician #1 on 3/26/25 at 2:00 PM. Physician #1 indicated that she was not aware of Resident #2 sustaining a fall on 3/3/25 or having external rotation or shortening of his leg. Physician #1 stated if she had been informed that Resident #2 had a fall on 3/3/25 she would have evaluated the resident regarding the fall and possible injury. Physician #1 stated Resident #2 complained of pain, and she attributed this to his recent right total knee replacement. During Resident #2's stay, neither the nursing staff nor the therapists reported increased pain level or inability to stand or bear weight. Physician #1 stated if the nursing staff or therapists had reported that Resident #2 had a

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pain level of 10 out of 10, inability to stand or bear weight, she would have ordered x rays and evaluated the resident further. Physician #1 stated that she expected that the nursing staff or therapists would have reported the changes and there seemed to be a lack of communication. Physician #1 stated she was not aware that Resident #2 was diagnosed with an intertrochanteric femur fracture when he was sent to the hospital for evaluation on 3/10/25.

An interview was conducted with Unit Manager #2 on 3/26/25 at 3:00 PM. Unit Manager #2 stated she was not aware of Resident #2 having increased pain, not participating in therapy or inability to bear weight. Unit Manager #2 stated she did not assess the resident at any time or consult with the provider regarding the resident's pain or external rotation or shortening of his leg. Unit Manager #2 stated that the floor nurses were expected to report changes in the residents to her and she reported changes to the NP or Physician.

An interview was conducted with the Director of Nursing on 3/25/25 at 3:40 PM. The DON stated that Resident # 2 had pain during his stay in the facility and the staff assumed it was his knee and did not evaluate to determine where the pain was. The DON indicated she was aware that Resident #2 was not participating well with therapy, but the staff assumed it was just the resident and his behavior and did not attribute it to the pain or a change in condition such as an injury or fracture. The DON's expectation was that the nursing staff monitored the residents for pain, assessed the residents and reported increased pain and changes to the physician for evaluation.

An interview was conducted with the

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F 684	Continued From page 19 Administrator on 3/26/25 at 1:45 PM. The Administrator stated Resident #2 was a complicated case and the facility may have missed something. The Administrator indicated that communication could have been better between the nursing staff, therapy staff and the provider. The Administrator stated that Resident #2 should have had a complete assessment and changes including external rotation and shortening of the leg, increased pain and changes in weight bearing should have been reported to the NP or physician for evaluation.	F 684		
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. This REQUIREMENT is not met as evidenced by: Based on record review and staff, resident, family, Nurse Practitioner and Physician interviews, the facility failed to provide thorough and ongoing pain assessments that included identifying the source of the pain and to evaluate a resident's pain regimen when the prescribed medication was not effectively managing the resident's pain. The resident was discharged from the hospital on 3/3/25 after being admitted for pain control following a total knee replacement. The initial pain assessment on admission to the facility indicated a pain rating of 5 (on a 0 to 10 scale with 10 being the worst pain imaginable). The resident experienced a fall on 3/3/25 in the evening. The following day (3/4/25),	F 697	Resident #2 no longer resides in the facility The Director of Nursing or designee interviewed all cognitively intact residents on 3/27/2025 as it relates to pain management or increase in acute pain and assessed all cognitively impaired residents on 3/27/2025 for signs of pain and reviewed the medical record for increased documentation of pain or increase in pain medication requirements. (What are the findings?) On 3/27/2025 the Director of Nursing or	4/16/25

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F 697	Continued From page 20 Resident #2 experienced increased pain with a pain level ranging from 6 to 10 through 3/10/25. On 3/10/25 the resident was evaluated at the hospital and was identified with a comminuted right intertrochanteric femur fracture (most common type of hip fracture which the long bone of the thigh breaks into multiple pieces caused by a fall and is characterized by severe pain in the hip, inability to bear weight on the affected leg, and shortening and external rotation of the leg). The resident underwent intermedullary nailing of the right femur (a procedure in which a metal rod is inserted into the long thigh bone to stabilize the fracture) with no complications as a result of the surgery. The deficient practice was observed for 1 of 1 resident reviewed for pain management (Resident #2). Findings included: A review of Resident #2's hospital discharge summary dated 3/3/25 indicated the resident was diagnosed with weakness. The history of the present illness indicated Resident #2 had a total knee replacement one week prior to hospitalization and was unable to make progress at home. The resident was admitted for pain control on 2/28/25. The hospital course indicated the resident was stable upon discharge and the resident's pain was improved. Resident #2 made slow progress with physical therapy at the hospital and was discharged to the skilled nursing facility to continue with therapy. Resident #2 was admitted on 3/3/25 with diagnoses which included: aftercare following knee replacement surgery, muscle weakness, unsteadiness on feet and a history of dementia.	F 697	designee educated all staff on the pain management policy with emphasis on identifying the source of the pain and reported increased pain to the provider. To ensure ongoing compliance the Director of Nursing or designee will interview 5 cognitively intact residents weekly for 12 weeks to ensure there are no reports of uncontrolled pain or increases in acute pain that have been unaddressed by the facility. The Director of Nursing or designee will also assess and review the electronic medical record for 5 cognitively impaired residents weekly for 12 weeks to ensure all signs of pain or increase pain medication needs are being reported to the provider and addressed appropriately by the staff. The audits will be reviewed in the quality assurance performance improvement meeting monthly for 3 months. The QA committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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Resident #2's electronic health record indicated a physician order dated 3/3/25 for hydrocodone-acetaminophen 5-325 milligram 2 tablets every 6 hours as needed (PRN) for moderate to severe pain not to exceed 8 tablets in 24 hours. A physician order dated 3/3/25 indicated Resident #2 was also ordered tramadol 50 milligrams every 6 hours PRN for moderate to severe pain not to exceed 200 milligrams in 24 hours.

A nursing progress note dated 3/3/25 at 5:40 PM written by Nurse #1 indicated that Resident #2 was admitted for aftercare following a right total knee replacement. Resident #2 was alert and oriented to person, place and event with some confusion. Resident #2 transferred with stand and pivot assistance with one person assistance with orders for weight bearing as tolerated. Resident #2 was noted as continent of bowel and bladder and had been using a urinal and bedpan prior to admission. Resident #2 wore glasses and had a hearing aid which he left at home.

A pain assessment dated 3/3/25 at 6:11 PM by Nurse #1 indicated a pain interview was conducted and indicated that Resident #2 had pain in the past 5 days, the pain affected his sleep, participation with therapy and day to day activities. Resident #2 rated his pain intensity as a 5 (out of 10).

A nursing progress note completed by Nurse #4 dated 3/3/25 at 11:54 PM indicated Resident #2 had a fall in the room. The resident was alert and oriented. The right knee, which was recently replaced, had a dressing in place and showed old bruises and slight swelling. Resident #2 reported no new injuries or increased pain. The note

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indicated every 4 hour neurological checks were initiated and the on-call provider was contacted.

A focused head to toe observation dated 3/3/25 at 11:45 PM completed by Nurse #4 indicated an observation was made of Resident #2 as a follow up to a fall. The observation indicated that Resident #2 was alert to person, place, time and situation with strong bilateral hand grasps. Foot press strength, a test in which the resident is asked to push against resistance as part of a neurological evaluation, was not assessed due to right knee surgery. The observation noted impaired range of motion of Resident #2's right knee and leg with the lower extremities equal in length.

A fall event report dated 3/3/25 at 11:58 PM completed by Nurse #4 indicated Resident #2 had an unwitnessed fall with no injuries. Resident #2 was found in his room on the floor. The report indicated Resident #2 did not complain of or exhibit pain related to the fall. The report indicated the nurse was unable to complete range of motion of his right lower extremity and a rotation deformity or shortening of Resident #2's right lower extremity was observed (an abnormal finding often associated with a femur fracture). This was different than the 11:45 PM observation completed by Nurse #4 which indicated Resident #2's lower extremities were equal in length.

An interview was conducted with Nurse #4 on 3/25/25 at 3:00 PM. Nurse #4 stated she worked night shift the night that Resident #2 had an unwitnessed fall (3/3/25) in which he slipped out of bed when he was using the urinal. Nurse #4 indicated she assessed the resident, and he did not have any injury, so he was transferred back to

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the bed using a mechanical lift. Nurse #4 indicated that throughout the night, Resident #2 complained of spasms in his back and he could not get comfortable. Nurse #4 stated she did not recall if she administered pain medication that night, but she thought that she and the staff repositioned the resident frequently to try to get him comfortable.

Resident #2's electronic Medication Administration Record (eMAR) for 3/4/25 at 9:23 AM revealed resident received PRN hydrocodone-acetaminophen for a pain level of 9. The eMAR indicated the medication was effective. The pain level recorded after the medication was administered was a 9.

Resident #2's occupational therapy evaluation and plan of treatment by the Occupational Therapist (OT) dated 3/4/25 indicated based on behavior exhibited, the resident demonstrated a pain level of 10 out of 10. The evaluation indicated nursing was aware of Resident #2's pain and was providing medication as prescribed. Resident #2 participated in the evaluation as able.

Resident #2's physical therapy evaluation and plan of care dated 3/4/25 indicated the resident verbalized a pain level of 10 out of 10 with constant and sharp pain to the right knee and shin which limited mobility, standing and ambulation. Resident #2 reported a 10 out of 10 pain level at rest and with movement and was unable to bear weight on the right lower extremity during transfers.

An interview was conducted with the Physical Therapist (PT) on 3/26/25 at 10:26 AM. PT stated that he was aware that Resident #2 had a fall on

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3/3/25 after admission. PT stated Resident #2 had a lot of pain and difficulty with weight shifting. PT stated Resident #2 had cognitive impairment and it was difficult to discern if resident's pain was out of proportion or as intense as it seemed or if it was more behavioral. PT indicated Resident #2 not bearing weight was not necessarily an indication of a problem. PT stated Resident #2's therapy had to be modified due to his pain level and his inability to bear weight. PT stated from what he was told, Resident #2 did not progress at home with home health therapy so he assumed the resident probably would not do well here. PT indicated Resident #2's right leg was externally rotated, but he assumed this could have been caused by staying in bed a lot. PT stated he did not report Resident #2's increased pain level or inability to bear weight to the nursing staff or the medical provider since he assumed it was related to his dementia.

An interview was conducted with the Physical Therapy Assistant on 3/26/25 at 10:40 AM. PTA stated that she worked with Resident #2 for therapy during his stay and his right leg was very painful. PTA indicated Resident #2 could not tolerate standing due to pain and was not able to bear weight on the right leg. PTA stated Resident #2 was difficult to work with, but she assumed this was because he was not motivated. PTA stated she did not report Resident's pain level or inability to bear weight to the therapist or the nursing staff.

A physician progress note dated 3/4/25 at 7:58 PM by Physician #1 documented Resident #2 indicated he had 8 out of 10 right leg pain. Resident #2 was to continue with pain management with the pain medications that were

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prescribed from the hospital.

An interview was conducted with Nursing Assistant (NA) #1 on 3/25/25 at 2:30 PM. NA #1 stated she was assigned to Resident #2 on 3/3/25 from 3:00 PM to 7:00 PM, on 3/4/25 from 7:00 AM to 7:00 PM and 3/8/25 from 7:00 AM to 7:00 PM. NA #1 stated Resident #2 was pleasant and cooperative when he was admitted on 3/3/25 and did not complain of pain. NA #1 stated when she came in on 3/4/25 she was told by the previous NA that the resident had a fall. Later that day when she was providing care for him, Resident #2 yelled out in pain when she turned or rolled him in bed. NA #1 stated Resident #2 complained of pain in the right leg and described the pain as a pulling or a burning pain. NA #1 stated it took 2 people to provide care for Resident #2 due to the pain he had in his right leg. NA #1 indicated Resident #2 was only able to tolerate sitting up in a wheelchair for a short time due to the pain. NA #1 stated she observed swelling in Resident #2's right thigh about a day or 2 after he was admitted, and she reported this to the floor nurse who she thought was Nurse #4. NA #1 stated Resident #2 would get aggravated during care due to the pain in his groin area and upper leg. Resident #2 stayed in bed when he was not receiving therapy due to the pain and the inability to sit comfortably in a wheelchair. NA #1 indicated she would try to position the resident in bed with pillows for comfort.

A Nurse Practitioner progress note dated 3/5/25 at 6:50 AM indicated in part that she evaluated Resident #2 due to the resident screaming and giving the Nursing Assistant and Nurse difficulty with care. Resident #2 was agitated and incontinent. The note indicated Resident #2 was

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to continue with the prescribed pain medication and stated that the resident's mild dementia was affecting his ability to comply with therapy and was impacting his recovery.

An interview was conducted with the Nurse Practitioner (NP) on 3/26/25 at 10:00 AM. The NP stated she went into Resident #2's room early on the morning of 3/5/25 when she heard him hollering and screaming during care. The NP stated Resident #2 was calm after the incontinence care was provided. The NP stated she was not aware that Resident #2 was having pain at an intensity of 10 out of 10 and that he was not able to bear weight on his right leg. The NP stated if she had been made aware of Resident #2's pain intensity of 10 and inability to bear weight she would have evaluated the resident further as these are signs of a serious condition such as a fracture.

Resident #2's eMAR indicated PRN hydrocodone-acetaminophen was administered on 3/5/25 at 8:02 AM for a pain level of 6. The eMAR indicated the medication was effective. The pain level after the medication was administered was a 6.

Resident #2's eMAR indicated PRN hydrocodone-acetaminophen was administered on 3/5/25 at 2:13 PM for a pain level of 6. The eMAR indicated the medication was effective. The pain level after the medication was administered was a 6.

A care plan for falls was created on 3/5/25 and revealed Resident #2 was at risk for falls related to pain. The interventions dated 3/5/25 included to administer medications as ordered, assist with

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mobility as needed, and ensure the resident was wearing non-skid footwear when out of bed.

A skilled nursing note dated 3/5/25 at 7:49 PM by Nurse #1 indicated Resident #2 was pleasant, cooperative, anxious, and combative or resistive to care with no changes in condition in the past 24 hours. The note gave no indication of Resident #2's pain level, participation with therapy or assessment of his right leg.

An interview was conducted with NA #6 on 3/26/25 at 8:40 AM. NA #6 indicated that she worked from 3:00 PM to 11:00 PM and was assigned to Resident #2 on 3/5/25. NA #6 stated that when she attempted to provide incontinence care, Resident #2 began screaming. NA #6 stated she did not know what was wrong but could tell Resident #2 was in a lot of pain. NA #6 stated she asked another NA to assist her and they were able to provide incontinence care to Resident #2 by providing increased time and support with moving him. NA #6 indicated she informed the assigned nurse that Resident #2 was having severe pain during care. NA #6 stated she did not know if the nurse evaluated the resident.

An interview was conducted with Nurse #2 on 3/26/25 at 8:15 AM. Nurse #2 stated she was an agency nurse that worked as needed at the facility. Nurse #2 was assigned to Resident #2 on 3/5/25 from 7:00 PM to 7:00 AM. Nurse #2 stated she did not recall anything about Resident #2. Nurse #2 stated she did not have much interaction with the residents other than administering medication and she did not recall if a NA reported that Resident #2 had pain.

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A skilled nursing note dated 3/6/25 at 2:36 PM by Nurse #4 indicated Resident #2 was alert, oriented to person, place, time and situation and had no changes in condition in the past 24 hours. The note gave no indication of Resident #2's pain level, participation with therapy or assessment of his right leg.

An interview was conducted with Nurse #4 on 3/25/25 at 3:00 PM. Nurse #4 stated she was assigned to Resident #2 a couple of days after his 3/3/25 fall and he was unable to participate with therapy. Nurse #4 indicated she did not recall the NAs reporting any swelling in Resident #2's thigh or pain in his groin or hip area. Nurse #4 stated when she observed that Resident #2 had pain, she administered as needed pain medication, and it seemed to be effective for a short time but he required it frequently to try to manage his pain. Nurse #4 stated she did not report Resident #2's pain or inability to participate in therapy to the physician but she probably should have.

An interview was conducted with NA #2 on 3/25/25 at 2:50 PM. NA #2 was assigned to Resident #2 on the 7:00 AM to 3:00 PM shift on 3/5/25 and 3/6/25. NA #2 indicated she did not recall much about Resident #2's care but she did recall he had a lot of pain in his leg. NA #2 stated she did not report Resident #2's pain to the floor nurse as she thought they already knew since he had been having pain for several days.

Resident #2's eMAR indicated PRN hydrocodone-acetaminophen was administered on 3/6/25 at 9:03 PM for a pain level of 6. The eMAR indicated the medication was effective. The pain level after the medication was

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administered was a 6.

An interview was conducted with NA #5 on 3/26/25 at 8:50 AM. NA #5 indicated she worked on the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts. NA #5 stated she and NA #4 worked together on the rehabilitation unit where Resident #2 resided. NA #5 indicated that she provided care to Resident #2 on 3/3/25, 3/4/25 and 3/6/25 from 11:00 PM to 7:00 AM. NA #5 stated she recalled when Resident #2 fell on 3/3/25 and indicated that he was very agitated after the fall. NA #5 stated that Resident #2 required 2 person assistance with turning and reposition and incontinence care. NA #5 stated resident screamed and hollered during incontinence care and would become combative. NA #5 stated it seemed like Resident #2 was having a lot of pain so she and the other NA would try to be gentle and provide increased time with care. NA #5 stated it was difficult to get Resident #2 comfortable, but she did not report this to the nurse as she thought the nurses already knew.

A Minimum Data Set (MDS) pain assessment completed by the MDS Nurse on 3/7/25 at 8:16 AM indicated Resident #2 had pain in the last 5 days almost constantly and the pain affected his sleep, therapy and day to day activities frequently. Resident #2 rated his pain intensity as 10.

Resident #2's electronic health record revealed no nursing progress note by the MDS Nurse regarding resident's pain level of 10 or notification of the medical provider.

Resident #2's eMAR indicated PRN hydrocodone-acetaminophen was administered

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on 3/7/25 by Nurse #3 at 2:13 PM for a pain level of 7. The eMAR indicated the medication was effective. The pain level after the medication was administered was a 2.

An interview was conducted with Nurse #3 on 3/25/25 at 1:14 PM. Nurse #3 was new to the facility and was assigned to Resident #2 on 3/7/25 from 7:00 AM to 7:00 PM. Nurse #3 stated on 3/7/25 Resident #2 did not want to get up out of bed or participate in therapy. Nurse #3 stated this was her first day assigned to Resident #2 and did not know what his baseline was. Nurse #3 stated nothing was reported to her by the previous shift regarding resident's condition or increased pain. During the shift on 3/7/25, Nurse #3 indicated eventually, Resident #2 was assisted up out of bed to the wheelchair and went to therapy. During the shift on 3/7/25, Nurse #3 stated she administered Resident #2's pain medication but did not complete a full assessment of the resident as she was busy with passing medications and other duties. Nurse #3 indicated she was new to the facility and was still learning. Nurse #3 stated she did not recall anything about Resident #2's pain on 3/7/25 regarding the area, the pain level or factors that affected the pain.

An interview was conducted with NA #3 on 3/25/25 at 5:15 PM. NA #3 indicated that she worked from 7:00 AM to 3:00 PM and was assigned to Resident #2 on 3/7/25. NA #3 indicated Resident #2 had a lot of pain in his hip and leg. Resident #2 did not want to move his leg and seemed scared to move it. NA #3 stated she informed the floor nurse of Resident #2's pain and stated the nurse knew that his leg was hurting.

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Resident #2's eMAR indicated PRN hydrocodone-acetaminophen was administered on 3/7/25 by Nurse #3 at 5:03 PM for a pain level of 10. The eMAR indicated the medication was effective. The pain level after the medication was administered was a 0.

Resident #2's electronic health record revealed no nursing progress note dated 3/7/25 by Nurse #3 regarding resident's pain level of 10 or notification of the medical provider.

An interview was conducted with Nurse #6 on 3/25/25 at 4:51 PM. Nurse #6 was an agency nurse assigned to Resident #2 on 3/6/25 and 3/7/25 from 7:00 PM to 7:00 AM. Nurse #6 stated she did not know much about Resident #2 as she only was assigned to him a couple of times. Nurse #6 stated Resident #2 was confused and was combative at times with personal care. Nurse #2 stated that she assumed that was Resident #2's baseline as that was what she was told by other staff, but she could not recall which staff members told her this. Nurse #6 stated she thought that his behavior might be due to pain so she thought she administered his PRN pain medication, and this seemed to help him. Nurse #6 stated she did not attempt to identify the source of the pain. Nurse #6 stated that since the pain medication seemed to help, she did not assess Resident #2 any further.

Review of the eMAR revealed that PRN hydrocodone-acetaminophen was not recorded as administered by Nurse #6 on 3/6/25 or 3/7/25 from 7:00 PM to 7:00 AM.

A skilled nursing note dated 3/8/25 at 6:19 PM by

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Nurse #1 indicated Resident #2 was oriented to person, was pleasant, anxious and combative or resistive to care and had no change in condition in the past 24 hours. The note gave no indication of Resident #2's pain level, participation with therapy or assessment of his right leg.

Resident #2's eMAR indicated PRN tramadol was administered on 3/8/25 by Nurse #1 at 6:23 PM. No pain level was recorded prior to or following administration of the medication. The eMAR indicated the medication was effective.

Resident #2's 5-day Minimum Data Set (MDS) dated 3/9/25 indicated the resident had moderate cognitive impairment and demonstrated rejection of care 1 to 3 days. Resident #2 had functional limitation in range of motion with impairment on 1 side of the lower extremity and required moderate assistance with bed mobility and transfers. Resident #2 had frequent incontinence of bowel and bladder, had a diagnosis of muscle weakness and unsteadiness. Resident #2 had almost constant pain that interfered with sleep, therapy and day-to-day activities. Resident #2 rated his pain a 10.

Resident #2's eMAR indicated PRN tramadol was administered on 3/9/25 by Nurse #1 at 9:12 AM with no pain level recorded prior to or following administration of the medication. The eMAR indicated the medication was slightly effective.

A skilled nursing dated 3/9/25 by Nurse #1 indicated Resident #2 was oriented to person, was pleasant, anxious, combative or resistive to care and had no change in condition in the past 24 hours. The note gave no indication of Resident #2's pain level, participation with therapy

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or assessment of his right leg.

An interview was conducted with Nurse #1 on 3/26/25 at 3:30 PM. Nurse #1 stated she had a hard time recalling specific information about Resident #2, as the rehabilitation hall was her primary assignment and there was a high rate of turnover of residents. Nurse #1 recalled that Resident #2 had pain with movement. Resident #2 had difficulty expressing where the pain was, but Nurse #1 stated he would say repeatedly "Oh my leg" with any movement or activity. It was hard for him to describe where the pain was. She reported that with transfers, bed mobility, incontinence care Resident #2 demonstrated non-verbal signs of intense pain. Nurse #1 stated she did not recall that therapy reported that Resident #2 had 10 out of 10 pain, was unable to stand or bear weight. Nurse #1 stated she did not inform the provider that Resident #2 had intense pain with movement as he had some dementia and she assumed the provider knew.

An interview was conducted with NA #4 on 3/25/25 at 5:00 PM. NA #4 indicated that she worked from 7:00 PM to 7:00 AM and was assigned to Resident #2 on 3/3/25, 3/7/25, 3/8/25 and 3/9/25. NA stated when Resident #2 fell on 3/3/25 he had pain and required 2-person assistance to get him up and provide his care. Prior to the fall, NA #4 stated Resident #2 seemed fine and did not have pain. NA #4 indicated she observed that his right thigh area had swelling on the nights she was assigned to Resident #2 after the fall and he complained of hip pain. NA #4 stated she checked on Resident #2 often, tried to talk to him to calm him down and reassure him. NA #4 stated that she thought Resident #2 was restless due to pain. NA #4

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stated she reported his pain to the floor nurse each time she worked but she did not know if the nurse administered pain medication or assessed the resident.

An interview was conducted with Nurse #5 on 3/25/25 at 2:00 PM. Nurse #5 was an agency nurse assigned to Resident #2 on 3/4/25, 3/8/25 and 3/9/25 from 7:00 PM to 7:00 AM. Nurse #5 stated she did not know that Resident #2 had a fall on 3/3/25 and that information regarding falls was normally communicated verbally during shift report. Nurse #5 stated she found out after Resident #2 was transferred to the hospital that he had fallen. Nurse #5 stated Resident #2 had a lot of pain and it required 2 people to provide care for him. Nurse #5 stated she assumed that his complaints of pain were more of a behavior or were related to his dementia and did not require medication or further evaluation. Nurse #5 indicated she only administered pain medication to Resident #2 once because she assumed his complaint of pain was a behavior and he was just being difficult. Nurse #5 stated Resident #2 yelled at her one of the nights when she went into the room, so she did not attempt to complete an assessment. Nurse #5 indicated that if she had assessed Resident #2 and observed swelling in his upper thigh or hip area she would have notified the provider. Nurse #5 stated she probably should have assessed Resident #2 and evaluated his pain.

Resident #2's eMAR indicated PRN hydrocodone-acetaminophen was administered on 3/10/25 by Nurse #3 at 6:42 AM for a pain level of 8. The eMAR indicated the medication was effective with a pain level of 3 after the medication was administered.

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A physician progress note dated 3/10/25 at 1:31 PM written by Physician #2 indicated the physician was asked to see Resident #2 as he was not participating in therapy, and he had a fall following admission to the facility. Per Resident #2's family member the resident was not himself, was not acting right and she (the family member) was concerned. Resident #2 was seen and examined with the resident complaining that his right groin was in a lot of pain down into this thigh. Resident #2 stated it hurt whenever anyone touched the area.

An interview was conducted with Physician #2 on 3/26/25 at 2:42 PM. Physician #2 indicated that he was asked to see Resident #2 on 3/10/25 due to the resident not participating in therapy and increased pain. Physician #2 indicated Resident #2 stated he had pain in his groin. Physician #2 stated he and two of the therapists assisted Resident #2 into bed. Physician #2 stated Resident #2 seemed worse from what staff reported since his fall. Physician #2 stated he was concerned that Resident #2 may have a fracture, and this needed to be addressed right away so he ordered for the resident to be sent to the hospital. Physician #2 stated that the resident's increased pain level and inability to bear weight should have been reported to the physician or NP to evaluate. Physician #2 indicated it was possible that the fracture may not have had any outward signs, but increased pain was a sign. Physician #2 indicated that Resident #2 had mild dementia with some impaired cognition, but his pain level should have been addressed.

A nursing progress note dated 3/10/25 at 1:43 PM

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written by Nurse #3 indicated Resident #2 was sent to the emergency room for evaluation. Resident's family member stated that Resident #2 complained of pain in his right hip area since he had an unwitnessed fall on 3/3/25. Resident #2's family member stated he had decreased mentation and the family member requested a urinalysis and Computed Tomography (CT) scan be completed. The physician assessed the resident and decided to send Resident #2 to the emergency room due to pain in the hip/groin area.

An interview was conducted with Nurse #3 on 3/25/25 at 1:14 PM. Nurse #3 stated she worked with Resident #2 during the 7:00 AM to 7:00 PM shift on 3/10/25. Nurse #3 stated that Resident #2's family member indicated that she wanted the resident evaluated so she informed the physician of the family member's request. Nurse #3 stated on 3/10/25, Resident #2 was in acute pain, could not get up out of bed and was unable to sit up. Nurse #3 stated Resident #2 was only able to tolerate lying flat in bed due to significant hip and groin pain. Nurse #3 stated Resident #2's pain was excruciating. Nurse #3 stated when the family member came in and expressed concerns, she informed the physician of Resident #2's severe groin and hip pain. The physician gave the order to transfer Resident #2 to the hospital for evaluation. Nurse #3 stated she looked at Resident #2's legs and did not observe a rotation of resident's leg or a leg length difference.

The emergency department encounter note dated 3/10/25 indicated Resident #2 presented with groin pain since an unwitnessed fall at the facility on 3/3/25. The note indicated Resident #2 had right groin tenderness, right leg pain and

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deformity with external rotation of the right lower extremity. Resident #2's right leg was shorter than the left and was mildly edematous, a condition characterized by swelling due to abnormal accumulation of fluid in the body's tissues. A two view x-ray of the right femur result indicated a comminuted right intertrochanteric femur fracture. Resident #2 was admitted to the hospital on 3/10/25, underwent intermedullary nailing of the right femur (a procedure in which a metal rod is inserted into the long thigh bone to stabilize the fracture) and was discharged to a skilled nursing facility on 3/20/25. There was no indication of complications as a result of the surgery.

During a phone interview on 3/25/25 at 9:45 AM with Resident #2's family member she reported Resident #2 experienced pain at the facility that was not addressed. She indicated the pain medication provided to the resident was not effective to manage the pain. She revealed that Resident #2's decreased participation with therapy and inability to bear weight on the affected leg due to pain should have been evaluated sooner.

An interview was conducted with Unit Manager #2 on 3/26/25 at 3:00 PM. Unit Manager #2 stated she was not aware of Resident #2 having increased pain, not participating in therapy or inability to bear weight. Unit Manager #2 stated she did not assess the resident at any time or consult with the provider regarding the resident's pain.

An interview was conducted with the MDS Coordinator on 3/26/25 at 4:15 PM. The MDS Coordinator stated the MDS Pain Assessment

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was to be attempted with each resident, even if the resident had a diagnosis of dementia. The MDS Coordinator stated the resident was interviewed or a picture scale was used to identify the resident's pain. The MDS Coordinator recalled that the staff struggled to manage Resident #2's pain. When a resident reported a high level of pain, frequent pain or pain that interfered with therapy or daily activities, the MDS Nurse should review the resident's medical record and inform the Unit Manager and medical provider of the results of the interview. The MDS Coordinator indicated that the MDS Nurse was new to the position, but she should have informed the Unit Manager or the medical provider of the results of Resident #2's pain assessment.

An interview was conducted with Physician #1 on 3/26/25 at 2:00 PM. Physician #1 indicated that she was not aware of Resident #2 sustaining a fall on 3/3/25. Physician #1 stated she would have expected the floor nurse to notify her of the fall. She indicated the on-call provider was notified of the fall but typically the floor nurse also informed her (Physician #1) of changes such as recent falls when she was making her rounds. Physician #1 stated if she had been informed that Resident #2 had a fall on 3/3/25 she would have evaluated the resident regarding the fall and possible injury. Physician #1 stated Resident #2 complained of pain and she attributed this to his recent right total knee replacement. During Resident #2's stay, neither the nursing staff nor the therapists reported increased pain level or inability to stand or bear weight. Physician #1 stated if the nursing staff or therapists had reported that Resident #2 had a pain level of 10 out of 10, inability to stand or bear weight, she would have ordered x rays and evaluated the

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resident further. Physician #1 stated that she expected that the nursing staff or therapists would have reported the changes and there seemed to be a lack of communication. Physician #1 stated she was not aware that Resident #2 was diagnosed with an intertrochanteric femur fracture when he was sent to the hospital for evaluation on 3/10/25.

An interview was conducted with the Director of Nursing on 3/25/25 at 3:40 PM. The DON stated that Resident # 2 had pain during his stay in the facility and the staff assumed it was his knee and did not evaluate to determine where the pain was. The DON indicated she was aware that Resident #2 was not participating well with therapy, but the staff assumed it was just the resident and his behavior and did not attribute it to the pain or a change in condition. The DON's expectation was that the nursing staff monitored the residents for pain and reported increased pain and changes to the physician for pain management if indicated.

A follow-up interview was conducted with the DON on 3/26/25 at 2:15 PM. The DON indicated she reviewed Resident #2's record after he was discharged to the hospital, and she thought his pain was being managed. The DON stated she was not aware that the Physical Therapy evaluation on 3/4/25 indicated that Resident #2 had a pain level of 10 out of 10 and that the resident was unable to stand and bear weight. The DON stated she expected that a pain level of 10 out of 10 would be reported to the physician or Nurse Practitioner to evaluate. The DON stated she was not aware of the MDS pain assessment on 3/7/25 that indicated Resident #2 had a pain intensity of 10 out of 10 almost constantly that affected his sleep, therapy and day-to-day

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activities. The DON stated that the physician or NP should have been made aware of Resident #2's pain on the MDS pain assessment. The DON indicated that the facility initiated a plan of correction to address falls that occur after admission to ensure that preadmission assessments are completed, residents at high risk for falls are identified and safety interventions are implemented upon the resident's arrival to the facility.

An interview was conducted with the Administrator on 3/26/25 at 1:45 PM. The Administrator stated Resident #2 was a complicated case and the facility may have missed something. The Administrator indicated that communication could have been better between the nursing staff, therapy staff and the provider and that increased pain levels should be reported.