

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Smoky Hill Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 Johnstown Avenue Salina, KS 67401	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204</p> <p>The facility identified a census of 63 residents, with three residents reviewed for pain. Based on record review, observation, and interview, the facility failed to obtain the as needed (PRN) pain medicine prescribed to Resident (R) 1 after a total hip replacement. The facility further failed to follow R1's discharge orders regarding acetaminophen (pain medication) being given four times a day on a scheduled basis and instead put the order into R1's Electronic Medical Record as needed, requiring R1 to ask for the pain medication. On 02/11/25, R1 admitted to the facility for skilled care for rehabilitation after a total hip replacement. The orders from the surgical center documented R1 was to receive 5 milligrams (mg) of oxycodone (pain medication) as needed every six hours, acetaminophen 1000 mg every six hours scheduled, and an order to discontinue the Norco (pain medication) 5/325 mg. The facility failed to try to obtain the oxycodone 5 mg medication until the following day, Saturday, 02/12/25. The local pharmacy did not have any oxycodone. Instead of checking with twelve other pharmacies in town to see if they had oxycodone 5 mg, they had the medical director prescribe Norco 5/325 mg every six hours as needed. R1 told nursing staff multiple times over the weekend she was taking oxycodone 5 mg as needed and Norco 5/325 mg as needed at home before her hip replacement, and the Norco 5/325 mg did not help her pain. Staff did nothing to help alleviate R1's pain over the weekend after a Friday admission. This deficient practice placed R1 at risk for unalleviated pain, decreased ability to participate in rehabilitation, inability to sleep, and psychosocial impairment.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R1's EMR documented R1 had diagnoses of aftercare following a joint replacement surgery, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). <p>R1's Entry Tracking Record Minimum Data Set (MDS), dated [DATE], documented R1 admitted from a short-term hospital and was in the facility for a Medicare-covered stay.</p> <p>R1's Care Plan, dated 02/18/25, documented R1 had acute pain related to postoperative right hip discomfort. The care plan directed facility staff to administer pain medication per physician orders, anticipate R1's need for pain relief, and respond immediately to any complaint of pain, notify R1's physician if interventions were not successful, or if R1's current pain was a significant change from her past experience of pain. The care plan documented R1 required setup/supervision assistance for all activities of daily living (ADL).</p> <p>(continued on next page)</p>

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Smoky Hill Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 Johnstown Avenue Salina, KS 67401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Surgical Discharge Instruction, dated 02/14/25, documented R1 could walk as tolerated, use a walker as instructed for four to six weeks following surgery, and use a walker as long as R1 felt unsteady. R1 could use stairs as instructed by physical therapy. R1 was not to flex her right hip more than a right angle or ninety degrees for six weeks, avoid low chairs or sofas, and R1 could sit in a recliner or hard chair. R1 may need to use a high-rise toilet seat; R1 was not to cross her legs for six weeks after surgery. R1's discharge instructions documented R1 was to take acetaminophen 1000 mg by mouth every six hours scheduled, and the last time R1 took the medication was 02/14/25 at 10:00 AM, oxycodone 5 mg by mouth every six hours as needed for pain. The discharge instructions documented R1 was to discontinue Norco 5mg/325mg every four hours as needed for pain.</p> <p>R1's Medication Administration Record (MAR) for February 2025 documented Norco 5/325 mg, give one tablet every six hours as needed for pain with a start date of 02/14/25 and a discontinued date of 02/16/25. R1 received Norco 5/325 mg twice on 02/15/25 once at midnight and once at 08:32 PM. The MAR documented oxycodone 5 mg every four hours by mouth as needed for pain with a start date of 02/14/25. The oxycodone 5 mg was not given until 02/17/25 at 09:33 PM and again on 02/18/25 at 10:39 PM. The MAR documented acetaminophen 1000 mg by mouth every six hours as needed for pain with a start date of 02/14/25. The acetaminophen was given one time on 02/14/25 at 07:38 PM.</p> <p>The Health Status Note, dated 02/14/25 at 12:00 PM, documented R1 arrived at the facility at 11:00 AM from the surgical hospital after having a right hip replacement.</p> <p>The Social Service Note, dated 02/14/25 at 12:27 PM, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The note documented R1 did not have any signs of depression, and discharge planning had begun for R1 to go home with home health services.</p> <p>The Daily Skilled Note, dated 02/14/25 at 11:46 PM, documented R1 was alert and oriented, able to make needs known, had as needed Norco for pain control, and R1 was resting with her call light in reach.</p> <p>The Health Status Note, dated 02/15/25 at 12:16 AM, documented per Administrative Nurse D to continue Norco 5/325mg one tab every six hours as needed.</p> <p>The Daily Skilled Note, dated 02/15/25 at 09:55 AM, documented R1 was upset the way her pain was being handled because she did not feel Norco would hold her pain like the oxycodone did.</p> <p>The Health Status Note, dated 02/15/25 at 01:27 PM, documented the facility nurse was told in report R1 had oxycodone 5 mg at a local pharmacy which needed picked up. Facility staff went to the local pharmacy and the pharmacy did not have a prescription for oxycodone as it had been discontinued due to being on a different pain medication. The note documented staff would continue to use Norco as needed. The note documented there was an order in R1's MAR for oxycodone that came from the hospital. R1 told the nurse she took both pain medications at home. The medical director sent over a prescription for Norco which was available in the facility in the Cubex (medication dispensing machine). R1 stated Norco does not work as well as the oxycodone. The note documented facility staff would continue to use as needed Norco until clarification was obtained on oxycodone versus Norco, but R1's pain was being taken care of.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Smoky Hill Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 Johnstown Avenue Salina, KS 67401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Daily Skilled Note, dated 02/15/25 at 07:33 PM, documented R1 was upset about her pain medication orders. R1 stated she was almost crying due to hurting so bad. Staff utilized as needed Norco at the time of assessment, and R1 was encouraged to ask for a pain pill at the onset of pain.</p> <p>The Daily Skilled Note, dated 02/16/25 at 08:53 AM, documented R1 was upset with the way her pain was being handled because she did not feel the Norco held her pain like oxycodone. The nurse had to educate R1 on asking for the pain medication as it was not scheduled. The night nurse reported R1 was in tears last night due to being in pain. R1 verbalized understanding.</p> <p>The Health Status Note, dated 02/16/25, documented the medical director reached out to facility staff about R1's pain medication. The medical director discontinued the as needed Norco and directed staff to just do as needed oxycodone. The medical director sent the prescription to Pharm Script for the oxycodone. R1 was told of the order.</p> <p>The Facility Medication Review Report, signed by the facility's medical director on 02/17/25, documented R1 had acetaminophen 1000 mg every six hours as needed for pain, Norco 5/325 mg every six hours as needed for pain, and oxycodone 5 mg every four hours as needed for pain.</p> <p>On 02/19/25 at 10:30 AM, observation revealed R1 sat in a hard-backed chair, legs at a ninety-degree angle, and reading a book. R1 had her call light and water within reach. R1's lights were off, the window shades were open, and the television was off.</p> <p>On 02/19/25 at 10:30 AM, R1 stated she was very upset with the facility for how her pain was managed the first three days at the facility. R1 stated she had Norco and oxycodone prescribed for her to take at home for pain, and Norco never worked to help alleviate her pain. R1 stated oxycodone helped her pain. R1 stated she tried repeatedly to tell the nurses Norco did not work for her, but they would not listen. R1 stated the first three nights she was in the facility, she was in tears every night and could not sleep due to the pain. R1 stated she did not understand how the staff expected her to participate in rehabilitation when her pain was not under control. R1 stated the only reason she was at the facility was for rehabilitation. R1 stated she just wanted to go home with home health and not be in the facility anymore.</p> <p>On 02/19/25 at 11:00 AM, Administrative Nurse D stated she was not aware R1's pain was not relieved over the weekend. Administrative Nurse D stated she knew there had been a problem getting the oxycodone from the local pharmacy as the pharmacy was out of oxycodone. Administrative Nurse D verified there were numerous other pharmacies in town, and staff did not reach out to any other pharmacy to get R1's oxycodone filled but instead had the medical director order Norco. Administrative Nurse D verified R1's acetaminophen 1000 mg every six hours had been ordered scheduled for R1 from the surgical hospital, and the facility staff had input the order in the MAR incorrectly. Administrative Nurse D stated she expected facility staff to help alleviate residents' pain and if residents' pain was not under control, to call and get different orders.</p> <p>On 02/19/25 at 11:30 AM, Administrative Staff A stated R1 admitted to the facility on a Friday, late in the afternoon. Administrative Staff A stated the facility got their medication from a pharmacy company out of another town a couple of hours away, and facility staff had reached out to one of the local pharmacies to obtain R1's medications otherwise, R1's medications would not have been delivered to the facility until 03:00 AM Sunday, 02/16/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Smoky Hill Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 Johnstown Avenue Salina, KS 67401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Actual harm Residents Affected - Few	<p>The facility's Pain - Clinical Protocol, revised April 2009, documented the physician and staff will identify individuals who have pain or who are at risk for pain. The nursing staff will assess each individual for pain upon admission, at the quarterly review, upon a change of condition, new or worsening of existing pain. The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain. The staff will discuss significant changes in the level of comfort with the attending physician, who will consider adjusting interventions accordingly. With input from the resident, the physician and staff will establish goals of pain treatment, for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, or sleep.</p> <p>The facility failed to obtain the as needed pain medicine R1 was prescribed after a total hip replacement. The facility further failed to follow R1's dismissal orders regarding acetaminophen (pain medication) being given four times a day on a scheduled basis and instead put the order into R1's EMR for as needed, requiring R1 to ask for the pain medication without her knowledge. This deficient practice placed R1 at risk for unalleviated pain, decreased ability to participate in rehabilitation, inability to sleep, and psychosocial impairment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Smoky Hill Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 Johnstown Avenue Salina, KS 67401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204</p> <p>The facility identified a census of 63 residents, with three residents reviewed for pain. Based on record review, observation, and interview, the facility failed to obtain the as-needed (PRN) pain medicine prescribed to Resident (R) 1 after a total hip replacement. The facility further failed to follow R1's discharge orders regarding acetaminophen (pain medication) being given four times a day on a scheduled basis and instead put the order into R1's Electronic Medical Record (EMR) as needed, requiring R1 to ask for the pain medication. These significant medication errors placed R1 at risk for unalleviated pain, decreased ability to participate in rehabilitation, inability to sleep, and psychosocial impairment.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R1's EMR documented R1 had diagnoses of aftercare following a joint replacement surgery, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). <p>R1's Entry Tracking Record Minimum Data Set (MDS) dated [DATE], documented R1 admitted from a short-term hospital and was in the facility for a Medicare-covered stay.</p> <p>R1's Care Plan, dated 02/18/25, documented R1 had acute pain related to postoperative right hip discomfort. The care plan directed facility staff to administer pain medication per physician orders, anticipate R1's need for pain relief, respond immediately to any complaint of pain, notify R1's physician if interventions were not successful, or if R1's current pain was a significant change from her past experience of pain. The care plan documented R1 required setup/supervision assistance for all activities of daily living (ADL).</p> <p>The Surgical Discharge Instruction, dated 02/14/25, documented R1 could walk as tolerated, use a walker as instructed for four to six weeks following surgery, and use a walker as long as R1 felt unsteady. R1 could use stairs as instructed by physical therapy. R1 was not to flex her right hip more than a right angle or ninety degrees for six weeks, avoid low chairs or sofas, and R1 could sit in a recliner or hard chair. R1 may need to use a high-rise toilet seat; R1 was not to cross her legs for six weeks after surgery. R1's discharge instructions documented R1 was to take acetaminophen 1000 mg by mouth every six hours scheduled, and the last time R1 took the medication was 02/14/25 at 10:00 AM, oxycodone 5 mg by mouth every six hours as needed for pain. The discharge instructions documented R1 was to discontinue Norco 5 mg/325 mg every four hours as needed for pain.</p> <p>R1's Medication Administration Record (MAR) for February 2025 documented Norco 5/325 mg, give one tablet every six hours as needed for pain with a start date of 02/14/25 and a discontinued date of 02/16/25. R1 received Norco 5/325 mg twice on 02/15/25 once at midnight and once at 08:32 PM. The MAR documented oxycodone 5 mg every four hours by mouth as needed for pain with a start date of 02/14/25. The oxycodone 5 mg was not given until 02/17/25 at 09:33 PM and again on 02/18/25 at 10:39 PM. The MAR documented acetaminophen 1000 mg by mouth every six hours as needed for pain with a start date of 02/14/25. The acetaminophen was given one time on 02/14/25 at 07:38 PM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Smoky Hill Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 Johnstown Avenue Salina, KS 67401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Health Status Note, dated 02/14/25 at 12:00 PM, documented R1 arrived at the facility at 11:00 AM from the surgical hospital after having a right hip replacement.</p> <p>The Social Service Note, dated 02/14/25 at 12:27 PM, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The note documented R1 did not have any signs of depression, and discharge planning had begun for R1 to go home with home health services.</p> <p>The Daily Skilled Note, dated 02/14/25 at 11:46 PM, documented R1 was alert and oriented, able to make needs known, had as-needed Norco for pain control, and R1 was resting with her call light in reach.</p> <p>The Health Status Note, dated 02/15/25 at 12:16 AM, documented per Administrative Nurse D to continue Norco 5/325mg one tab every six hours as needed.</p> <p>The Daily Skilled Note, dated 02/15/25 at 09:55 AM, documented R1 was upset with the way her pain was being handled because she did not feel Norco would hold her pain like the oxycodone did.</p> <p>The Health Status Note, dated 02/15/25 at 01:27 PM, documented the facility nurse was told in report R1 had oxycodone 5 mg at a local pharmacy, which needed to be picked up. Facility staff went to the local pharmacy and the pharmacy did not have a prescription for oxycodone as it had been discontinued due to being on a different pain medication. The note documented staff continued to use Norco as needed. The note documented there was an order in R1's MAR for oxycodone that came from the hospital. R1 told the nurse she took both pain medications at home. The medical director sent over a prescription for Norco which was available in the facility in the Cubex (medication dispensing machine). R1 stated Norco did not work as well as the oxycodone. The note documented facility staff would continue to use as-needed Norco until clarification was obtained on oxycodone versus Norco, but R1's pain was being taken care of.</p> <p>The Daily Skilled Note, dated 02/15/25 at 07:33 PM, documented R1 was upset about her pain medication orders. R1 stated she was almost crying due to hurting so bad. Staff utilized as-needed Norco at the time of assessment, and R1 was encouraged to ask for a pain pill at the onset of pain.</p> <p>The Daily Skilled Note, dated 02/16/25 at 08:53 AM, documented R1 was upset with the way her pain was being handled because she did not feel the Norco held her pain like oxycodone. The nurse had to educate R1 on asking for the pain medication as it was not scheduled. The night nurse reported R1 was in tears the prior night due to being in pain. R1 verbalized understanding.</p> <p>The Health Status Note, dated 02/16/25, documented the medical director reached out to facility staff about R1's pain medication. The medical director discontinued the as-needed Norco and directed staff to just do as needed oxycodone. The medical director sent the prescription to Pharm Script for the oxycodone. R1 was told of the order.</p> <p>The Facility Medication Review Report, signed by the facility's medical director on 02/17/25, documented R1 had acetaminophen 1000 mg every six hours as needed for pain, Norco 5/325 mg every six hours as needed for pain, and oxycodone 5 mg every four hours as needed for pain.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Smoky Hill Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 Johnstown Avenue Salina, KS 67401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/19/25 at 10:30 AM, observation revealed R1 sat in a hard-backed chair, legs at a ninety-degree angle, and reading a book. R1 had her call light and water within reach. R1's lights were off, the window shades were open, and the television was off.</p> <p>On 02/19/25 at 10:30 AM, R1 stated she was very upset with the facility for how her pain was managed the first three days at the facility. R1 stated she had Norco and oxycodone prescribed for her to take at home for pain, and Norco never worked to help alleviate her pain. R1 stated oxycodone helped her pain. R1 stated she tried repeatedly to tell the nurses Norco did not work for her, but they would not listen. R1 stated the first three nights she was in the facility; she was in tears every night and could not sleep due to the pain. R1 stated she did not understand how the staff expected her to participate in rehabilitation when her pain was not under control. R1 stated the only reason she was at the facility was for rehabilitation. R1 stated she just wanted to go home with home health and not be in the facility anymore.</p> <p>On 02/19/25 at 11:00 AM, Administrative Nurse D stated she was not aware R1's pain was not relieved over the weekend. Administrative Nurse D stated she knew there had been a problem getting the oxycodone from the local pharmacy as the pharmacy was out of oxycodone. Administrative Nurse D verified there were numerous other pharmacies in town, and staff did not reach out to any other pharmacy to get R1's oxycodone filled but instead had the medical director order Norco. Administrative Nurse D verified that R1's acetaminophen of 1000 mg every six hours had been ordered to be scheduled for R1 from the surgical hospital, and the facility staff had input the order in the MAR incorrectly. Administrative Nurse D stated she expected facility staff to help alleviate residents' pain and if residents' pain was not under control, to call and get different orders.</p> <p>On 02/19/25 at 11:30 AM, Administrative Staff A stated R1 was admitted to the facility on a Friday, late in the afternoon. Administrative Staff A stated the facility got their medication from a pharmacy company out of another town, a couple of hours away, and facility staff had reached out to one of the local pharmacies to obtain R1's medications otherwise, R1's medications would not have been delivered to the facility until 03:00 AM Sunday, 02/16/25.</p> <p>The facility's Medication Monitoring and Management Policy, dated 10/01/2007, documented in order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. When selecting medication and non-pharmacological intervention, members of the interdisciplinary team participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition.</p> <p>The facility failed to obtain the as-needed pain medicine R1 was prescribed after a total hip replacement. The facility further failed to follow R1's dismissal orders regarding acetaminophen (pain medication) being given four times a day on a scheduled basis and instead put the order into R1's EMR for as-needed, requiring R1 to ask for the pain medication without her knowledge. This deficient practice placed R1 at risk for unalleviated pain, decreased ability to participate in rehabilitation, inability to sleep, and psychosocial impairment.</p>		