STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215365	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hagerstown	14014 Marsh Pike Hagerstown, MD 21742

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40927 Based on observation, record review, and interview it was determined that facility staff failed to treat their residents with dignity. This was evident for 1 (#31) of 17 residents reviewed for abuse. The findings include: On 12/31/24, at 12:12 PM R31's (resident #31) call light was observed to be on. R31 was lying in bed slightly turned away from the doorway. Geriatric nursing assistant (GNA) #7 was observed going into the room, without knocking, and stated to the resident that she needed him/her to be patient because they [staff] were in the middle of passing lunch trays. GNA #7 failed to ask the resident what s/he needed, turned the call light off, and walked out of the room. The GNA came out of the room and continued to pass lunch trays. A medical record review for R31 on 1/2/25, at 3:21 PM revealed a minimum data set (MDS) with the assessment reference date of 10/29/24. Staff documented that the resident had no cognitive impairment and was able to make their needs known. Further review revealed the resident was dependent on a ventilator and was unable to get out of bed without staff assistance. During an interview with GNA #7 on 1/3/25 at 11:49 AM she was asked what was expected of staff when answering a resident's call light. She responded that she should knock and asked the resident what they needed. She reported that during lunch she will respond to call lights if the room was close by and asked the resident what they needed. She reported staff were taught to leave the call light on until they were able to meet the resident's need. The surveyor reviewed the observation, made on 12/31/24, with GNA #7 and she admitted that she should have asked the resident what s/he needed and left the call light on. She stated she was rushing to get the food trays passed versus paying attention to the resident's needs. An interview with the Director of Nursing (DON) on 1/3/25 at 1:30 PM revealed her expectation of staff while answering call lights was to knock and asked what the resident needed. She stated that staff should not turn off the call light prior to meeting the resident's need because of the possibility when they leave the room they could be distracted and forget to go back to the room. The surveyor reviewed the observation with the DON and she agreed GNA #7 had not treated R31 with dignity and respect during this observation. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings were reviewed with the Nursing Home Administrator (NHA) with the DON present on 1/9/25 at 11:55 AM.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40927 Based on record review and interview it was determined that facility staff failed to ensure that all allegations of abuse were reported to the state agency within the required 2-hour timeframe. This was evident for 2 (#31 and #29) of 17 residents reviewed for abuse. The findings include: 1) On 1/6/25 at 1:27 PM a review of a copy of the facility's investigation file for the facility reported incident #MD00207032 revealed the initial report. According to the initial report form, on 6/24/24, at 9:53 PM R31 (resident #31) reported to geriatric nursing assistant (GNA) #9 an allegation of abuse. The resident reported that GNA #7 stated to him/her, she was going to get him/her back and called the resident a curse word. However, a review of the email confirmation for the initial report revealed that this report was sent to the state agency on 6/25/24, at 11:52 AM, which was over 24 hours later. Further review of the investigation file revealed a statement from GNA #9, that read she immediately reported the allegation of abuse to licensed practical nurse (LPN) #13. The statement did not include the response from LPN #13 but further noted that GNA #9 called Unit Manager (UM) #6 and left a message to call back regarding an incident. The GNA wrote she reported back to LPN #13, with Registered Nurse (RN) #14 present, and was told to write a statement and leave it under UM #6's office door. A statement from the Director of Nursing (DON) read that she was informed of the allegation of abuse on 6/25/24 by UM #6. The DON reported she checked UM #6's phone and confirmed there was no missed call or message on 6/24/24, as stated in GNA #9's statement. During an interview with UM #6 on 1/8/25, at 10:49 AM she confirmed she was not made aware of the allegation of abuse until the following morning [6/25/24] when she found the statement under her office door. The concerns were reviewed with the DON and the Nursing Home Administrator (NHA) on 1/8/25 at 3:04 PM. The DON reported that the expectations were the GNA reports the allegation of abuse to the nurse who then reports it to the nurse on call. She reported this should be done immediately following the allegation of abuse. 2) On 1/3/25 at 10:29 AM a review of the facility's investigation file for the facility reported incident #MD00210375 revealed the initial report. According to the initial report R29 reported to the Social Worker (SW) #15 on 9/19/24, at 10:12 AM that s/he was missing a wallet with $80.00 in it. However, according to the email confirmation, it was not reported to the state agency until 9/19/24 at 4:52 PM. On 1/9/25, at 11:55 AM reviewed the finding with the Nursing Home Administrator (NHA) and Director of Nursing (DON) who confirmed that it was reported late. The rational provided by the NHA was he found it difficult to send the initial report to the state agency within the required timeframe because of the number of questions that were on the initial report form.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40927 Based on record review and staff interview it was determined that the facility failed to conduct a thorough investigation of an allegation of abuse and to ensure that an employee had access to vulnerable residents until it was determined they abused the resident or not. This was evident for 1 (#31) of 17 residents reviewed for abuse. The findings include: On 12/31/24 at 2:25 PM a review of the facility's policy titled, Abuse, Neglect, Exploitation that was implemented on 3/14/23 was conducted. The policy stated in #6 titled as, Protection that the alleged perpetrator was to be removed from the resident care areas. Then under the section titled, Procedures for Response and Reporting Allegations of Abuse/Neglect/Exploitation it read under #2b the administrator was to initiate and conduct a thorough investigation and obtain statements related to the incident from the victim, individuals reporting incident, alleged perpetrator, and any witnesses. #2c. read the administrator was to remove the accused employee from the facility and place them on administrative leave pending completion of the investigation. A review of the facility's investigation file for the facility reported incident #MD00207032 on 1/6/25 at 1:27 PM revealed an initial report form that read Resident #31 had reported an allegation of abuse on 6/24/24, at 9:53 PM to GNA #9. The GNA wrote a statement dated 6/24/24, that read she was told by Resident #31 that GNA #9 came in his/her room on dayshift and told the resident she was going to get him/her back and called them a curse word. GNA #9 further reported that she told LPN #13 immediately so she could notify the nurse on call. Then she wrote she tried to call Unit Manager (UM) #6 [the nurse on call] and left a message to call back regarding an incident. The GNA wrote she reported back to LPN #13, with Registered Nurse (RN) #14 present, and was told to write a statement and leave it under UM #6's office door. Further review of the file revealed no statements or interviews were conducted with LPN #13 and RN #14 to determine the delay in reporting the allegation of abuse. A statement from HR stated that GNA #7 was suspended pending the investigation. The final investigation report form indicated that the final investigation was sent to the state agency on 6/28/24. On 1/8/25 at 12:09 PM a review of GNA #7's time punches for 6/24/24 - 6/28/24 revealed she punched in on 6/25/24 and left early that day. However, she worked on 6/26/24 and 6/27/28, which meant she was not suspended pending the investigation. An interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 1/8/25 at 3:04 PM revealed the DON's expectation was that the once the GNA reported the allegation of abuse then LPN #13 or RN #14 should have notified the on-call nurse. She stated that staff know that if they cannot reach the on-call nurse then they can call her directly. When asked if they interviewed or obtained statements from LPN #13 or RN #14, they reported they thought they had. The NHA stated he would check to see if they had additional information. When asked why the nurses had not reported the abuse immediately, the DON and NHA were unable to provide a rationale. Reviewed GNA #7's time punches and asked why she had been working with residents before they had completed their investigation regarding the allegation of abuse. The DON stated she thought the GNA had been suspended and wanted to check with human resources. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 11:55 AM reviewed the findings with the DON and NHA they offered no additional evidence regarding the interviews with the nurses to determine the reason for the delayed reporting or the fact that the GNA had continued to work before the investigation was completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52125 Based on record review, staff interview, and review of facility policy Care Plans, Comprehensive Person-Centered , the facility failed to implement a care plan for 1 resident (R#1) of 8 residents reviewed. Findings include: Review of policy titled Care Plans, Comprehensive Person-Centered last reviewed 5/26/2023 revealed Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 8. The comprehensive, person-centered care plan will: g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems. R#1 was admitted to facility 8/17/2023 with diagnoses including but not limited to Charcot's Joint Right Ankle/Foot, type 2 diabetes mellitus, venous thrombosis and embolism, hereditary motor and sensory neuropathy, tachycardia, chronic kidney disease stage 3, and pressure ulcer stage 3. Review of Minimum Data Set, dated dated dated [DATE] revealed R#1 had a stage 3 pressure ulcer on admission. Review of R#1's care plan initiated on 8/17/2023 revealed R#1 has potential for impairment to skin integrity related to fragile skin, immobility and incontinence. This person-centered care plan did not address resident's actual impaired skin integrity. During an interview on 1/3/1025 at 11:35 a.m., the Director of Nursing stated her expectation is for the care plan to be accurate and updated with changes in condition including wounds with appropriate interventions in place.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52125 Based on record review, staff interviews, and review of facility policy Pressure Injury Prevention and Management, the facility failed to provide wound care to one resident (R#1) of 5 residents reviewed for pressure ulcers. This resulted in R#1's stage 3 pressure ulcer to worsen resulting in hospitalization . Findings include: Review of facility policy titled Pressure Injury Prevention and Management last reviewed 5/26/2023 revealed, This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. R#1 was admitted to the facility on [DATE] with diagnoses including but not limited to pressure ulcer stage 3, Charcot's Joint Right Ankle/Foot, type 2 diabetes mellitus, venous thrombosis and embolism, hereditary motor and sensory neuropathy, and chronic kidney disease stage 3. Review of R#1's Wound Assessment Report, dated 8/17/2023, noted R#1 to have Stage 3 pressure ulcer on the sacrum and revealed an order from the Nurse Practitioner (NP) for Dressing Change Frequency: Daily, and PRN(as needed) Clean Wound With: Cleanse with soap and water, pat dry; Primary Treatment: Zinc Oxide Paste Other Dressings: Bordered gauze. At the time of the wound assessment, the wound measured 1.1 centimeters (cm) length (L) x .7 cm width (W) x .20 cm depth (D). Review of Minimum Data Set (MDS) dated [DATE] revealed R#1 had a stage 3 pressure ulcer on admission. Review of Treatment Assessment Record dated August 2023 revealed the treatment orders from 8/17/23 were not placed on the Medication Administration Record (MAR) until 8/28/2023, eleven days after admission and the initial wound assessment by the NP. Review of R#1's Wound Assessment Report for 8/21/2023 revealed the pressure ulcer increased in size. At the time of the wound assessment, the wound measured 1.4 cm L x .7 cm W x .20 cm D. Review of R#1's Wound Assessment Report for 8/28/2023 revealed the pressure ulcer increased in size again. At the time of the wound assessment, the wound measured 1.6 cm L x .8cm W x .20 cm D. Additionally, as well as two new pressure ulcers were found to be unstageable. One unstageable pressure ulcer was on the left buttocks and measured 7.80 cm L x 5.0 cm W x .10 cm D. The other unstageable pressure ulcer was on the right buttocks and measured 6.50 cm L x 7.0 cm W x .10 cm D. Continued review revealed, R#1 had a change in condition on 8/28/2023 related to the presence of the wounds and was sent to the hospital for evaluation. R#1 was admitted to the hospital with diagnoses of pressure ulcers with sepsis and cellulitis to the site. Since R#1 was admitted to the hospital on 8/28/2023, he never received the daily wound care treatment that was ordered by the NP, except when done on 8/17/2023, 8/21/2023, and 8/28/23 when completed by the wound care team. R#1 was at the facility for 12 days and missed nine wound care treatments and developed two additional pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/30/2024 at 11:53 a.m., R#1's family member revealed R#1 was admitted to the hospital on 8/28/2023 with a diagnosis of sepsis related to his/her wound. R#1's family member further revealed R#1 was hospitalized from 8/28/2023 to 9/2/2023 and did not return to the facility afterward. R#1's family member stated the facility did not communicate with the family about the severity of the wounds. An interview on 1/3/2025 at 10:45 a.m. Licensed Practical Nurse (LPN) #5 revealed she was responsible to make wound rounds with the Nurse Practitioner in August 2023. LPN#5 stated she does not recall this resident. After reviewing the medical record, stated she did not make rounds on that particular day with the wound care NP because she did not work on Thursdays at that time. LPN #5 stated the Unit Manager or Director of Nursing (DON) would have made rounds with the NP that day. LPN #5 stated the Unit Manager would have been responsible to transcribe orders and ensure they were put into the MAR. LPN #5 further stated the Charge Nurse was responsible for doing daily treatments. LPN #5 confirmed R#1 did not have treatment orders transcribed from the NP in MAR until 8/28/23. During an interview on 1/3/2025 at 11:35 a.m., the DON stated LPN #5 was the full-time treatment nurse during the time frame of 8/17/2023 - 8/28/2023. The DON confirmed the wound care NP made note of the orders in the documentation. The DON stated the treatment nurse should have transcribed those orders in the Electronic Health Record (EHR) so that treatments could be completed daily by the charge nurses. The DON confirmed there were no orders in place for eleven days. The DON stated her expectation is when a wound is found, whether on admission or after, the MD is notified for orders to be received and implemented. The DON stated the family should be notified and updated of all changes in condition including wounds and the care plan should be updated.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40927 Based on record review and staff interview it was determined that the facility failed to 1.) ensure that residents were free of accidents and 2) ensure that interventions were initiated after a fall to prevent recurrence. This was evident for 1 (#31) of 17 residents reviewed for abuse and 1 (#12) of 6 residents reviewed for falls. The deficient practice resulted in actual harm to resident # 31. The findings include: Care plan - is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) A medical record review on 1/6/25, at 9:45 AM for Resident #31 revealed that on 12/7/20, facility staff initiated a care plan for self-care deficit related to the resident ' s impaired mobility and disease process. Interventions added on 4/29/21, read the resident required 2 staff for assistance while bathing and to turn and reposition in bed. A review of the Kardex (which was a tool that geriatric nursing assistants should use to determine the level of care and assistance a resident required) revealed that for bed mobility it noted the resident required 2 staff members to assist with turning and repositioning and while bathing. Further review revealed a change in condition evaluation dated 10/23/24 at 10:53 AM that documented the resident had a fall on that day. According to the report, after the fall the resident complained of musculoskeletal pain in the coccyx (tailbone) and right foot and x-rays were ordered. In the summary section it was noted that Resident #31 reported s/he was too close to the edge of the bed and rolled out. On 1/6/25 at 8:40 AM a review of a copy of the facility ' s investigation file revealed in the initial report that Resident #31 had accused GNA #8 of pushing him/her out of bed on 10/23/24. The report read that the resident reported this allegation on 10/30/24, to a visitor, who subsequently informed the facility. According to GNA #8 ' s statement dated 10/30/24, she was bathing the resident while the resident was rolled towards the opposite side of the bed. The GNA turned to rinse her rag and still had a hand on the resident ' s hip. The GNA wrote that the air mattress fluctuated and the resident rolled out of bed onto the floor. A statement written by the Director of Nursing (DON) regarding an interview with the Resident ' s roommate revealed that s/he heard GNA #8 state to Resident #31 to stop moving around because the resident was too close to the edge of the bed and she [the GNA] was not able to reposition him/her without assistance. According to the statement, the roommate reported the curtain was closed, so s/he had not witnessed the resident ' s fall, but right after that statement s/he heard a noise that sounded like the resident fell to the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility ' s incident report revealed Resident #31 had a skin tear on the left elbow and complained of pain in the coccyx (tailbone) area and the right foot. In the section titled, Other Info it was documented the resident had been rolled on their side, too close to the edge of the bed and was noted to have an air mattress. The resident required 2 staff for assistance and the fall was avoidable. A review of the x-ray reports revealed that on 10/23/24, the resident had a series of x-rays to include; the left wrist, left humerus (upper arm bone), sacrum and coccyx, right foot, and left shoulder. The right foot impression read the resident had a suspected, non-displaced hairline fracture along the base of the 2 and 3 toes. The left shoulder impression read that they found no definite fracture, but if symptoms continued a follow up x-ray was clinically warranted. A review of the care plans revealed a care plan for a right foot fracture had been added on 10/23/24. The facility included, in the investigation file, an educational power point for using a coding system to identify a resident ' s level of care and assistance by looking at their name tag on the door. During an interview with GNA #8 on 1/7/25, at 10:56 AM, via a phone call, she reported that on 10/23/24, she was assigned Resident #31 for the first time. She admitted that she failed to review the resident ' s Kardex before providing care. She reported that while she was giving the resident a bed bath, she recognized the resident was too close to the edge of the bed but failed to intervene. Then stated while she had the resident rolled away from her the resident slipped out of bed. She reported the bed had been at her waist level at the time of the fall. An interview on 1/8/25 at 10:54 AM with Unit Manager #6 revealed it had not been the first time GNA #8 had worked with Resident #31. She stated that most bed bound residents in the facility were required to have the assistance of 2 staff for care to protect the resident and the staff. She reported she provided education to the GNA on 10/23/24, after the fall. The DON was interviewed on 1/8/25 at 3:18 PM regarding how staff were made aware of the needs and level of assistance each resident required. She stated that the GNAs were aware that they need to review the Kardex for each resident assigned to them, so they can provide safe care. 41274 2.) Review of the policy and procedure titled, Fall Prevention Program, last revised 9/5/2023, revealed it was the policy of the facility to assess each resident for the risk of falls and provide care and services in accordance with individual level of risk to minimize the likelihood of falls. Each resident's risk factors, and environmental hazards were to be evaluated during development of resident ' s comprehensive plan of care. Interventions in the plan of care were to be monitored for effectiveness and revised as needed. When residents experienced a fall, the facility was to assess the resident prior to moving them, complete a post fall assessment and incident report, obtain witness statements in case of injury, document all assessments/ actions and review the resident ' s care plan and update as indicated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #12 was admitted to the facility with diagnoses which included dementia without behavioral disturbance, lack of coordination, abnormalities of gait and mobility and adult failure to thrive. The Minimum Data Set (MDS, an assessment tool) dated 5/20/2022 documented the resident was assessed with a Brief Interview for Mental Status (BIMS) score of 3/15 which was indicative of severe cognitive impairment. The resident required extensive assistance to complete activities of daily living (ADLs) and was documented to have had two or more falls since their last assessment on 3/8/2022. An Unwitnessed Fall Event Note dated 6/24/2022 documented Resident #12 was observed lying on the floor in their bathroom with the right side of their head resting against the wall. The resident was assessed for injury and was observed with a red mark on the right side of their forehead with a bump measuring one centimeter. The resident was unable to recall what they were doing. The resident was documented to be confused and had impaired memory and balance. The facility did not document any actions taken or new interventions implemented to prevent recurrence. An Unwitnessed Fall Event Note dated 6/28/2022, documented the unit nurse heard a noise from the hallway and went to search where the noise had come from. Resident #12 was found lying supine on the floor with the back of their head resting on their roommate ' s bed frame. Resident #12 was assessed and noted to be bleeding from a laceration on the back of their head. The resident was documented to have been found with a change in vital signs. Both paramedics and family were called and arrived at the facility shortly after. On 12/31/2024, review of Resident #12 ' s Care Plan, initiated 3/9/2020, revealed fall interventions were last updated on 7/19/2021 and no new interventions were implemented in 2022 after the Resident #12 experienced falls. During an interview on 12/31/25 at 12:50 PM, Licensed Practical Nurse (LPN) #3 stated that if a resident had a fall, they would immediately alert the nurse supervisor, and the resident would be assessed for injuries. They stated the facility would investigate the fall to determine what factors may have contributed to the fall and determine appropriate new interventions to prevent recurrence. During an interview on 1/8/2025 at 2:48 PM, the DON stated when a resident had a fall, the interdisciplinary (IDT) team should evaluate what occurred during the fall to identify contributing factors and evaluate what interventions should be implemented to prevent recurrence; new interventions should then be included in the resident ' s care plan. They stated the facility should have looked at what occurred during Resident #12 ' s fall and implemented interventions. They stated fall interventions could be implemented by different departments including therapy, nursing and activities staff and may include more frequent checks on the resident or adding activities that assisted with gait and balance. They stated therapy staff should assess residents after they had a fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215365	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hagerstown	14014 Marsh Pike Hagerstown, MD 21742

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 40927 Based on observation, record review, and staff interview it was determined that facility staff failed to provide pain management in accordance with standards of professional practice. This was evident for 1 (#31) of 1 resident reviewed for pain management. The findings include: An observation on 12/31/24 at 12:12 PM revealed that the resident had his/her call light on and geriatric nursing assistant (GNA) #7 was observed going into R31's (resident #31) room and stated she was going to need the resident to be patient because they [staff] were in the middle of passing lunch trays. GNA #7 proceeded to turn off the resident's call light and left the room. She failed to ask the resident the reason they had turned on their call light. On 12/31/24 at 12:15 PM GNA #7 was observed going back into R31's room and asked the resident what they needed. The resident could not be heard, but the GNA was overheard stating the resident was having pain in their g-tube (gastric feeding tube) and that she would let their nurse know. An interview with R31 on 12/31/24 at 12:17 PM confirmed s/he was having pain in the g-tube area. Subsequently, in the hallway 12/31/24 at 12:17 PM GNA #7 was overheard telling the resident's assigned nurse licensed practical nurse (LPN) #12 that R31 was complaining about their g-tube hurting but she thought maybe the resident wanted the dressing changed. LPN #12 was heard stating that she told R31 she would change the dressing after lunch. The LPN failed to go to R31's room to ask him/her about their pain and provide care. LPN #12 was observed on 12/31/24 at 12:25 PM at her medication cart preparing a cup of medications. However, she carried the cup of medications around while tending to other residents until 12:43 PM when she was observed taking the same cup of medications into R31's room. On 12/31/24 at 12:43 PM LPN #12 entered R31's room and sat the cup of medications on his/her bedside table. She asked the resident about their pain and attempted to release any air from the g-tube and palpated the abdomen. The nurse stated the resident was bloated as per his/her baseline. The nurse failed to check placement of the g-tube and to check the residual in the stomach. She failed to ask the pain level on a scale of 1-10 to determine the level of pain so she can later measure the effectiveness of treatment. After assessing and changing the dressing of the g-tube, the nurse stated to the resident that she brought in his/her pain medication and indicated the cup of medications she brought in. A standard of practice for nurses would be to assess the resident's pain and then determine if the resident had an order to treat the pain. On 1/2/25 at 3:21 PM medical record review for R31 revealed in the physician's orders that the resident had an order to receive routine Tylenol at 2:00 PM and an order for tramadol every 12 hours as needed for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent review of R31's medical record on 1/2/25 at 3:45 PM revealed that LPN #12 signed the routine Tylenol order and at 1:30 PM, 45 minutes after the observation the nurse signed off that tramadol was given. On 1/3/25 at 1:22 PM the surveyor attempted to call LPN #12 by phone for an interview and left a message to call back. However, LPN #12 failed to call back. An interview with the Director of Nursing (DON) on 1/3/25 at 1:30 PM revealed she expected staff to answer call lights during mealtimes and to at least ask the resident what they needed to determine the urgency. She reported that if a GNA reported to a nurse that the resident was having pain she would expect the nurse to go in and assess the pain and then determine the need for medication. The observation was reviewed with the DON who stated it was unacceptable for staff to make a resident wait 20 minutes before going in to assess for pain. She stated that she would have expected the LPN to ask the pain level on a scale of 1-10, to check the placement of the g-tube, and to check for residual contents in the stomach. She stated that the nurse should not have pulled the medications prior to conducting her assessment of the resident. The DON was made aware that LPN #12 was called, and a message was left for her to call the surveyor. She stated she would ask the LPN to call the surveyor. However, LPN #12 had not returned the surveyor's phone call for an interview. On 1/9/25 at 11:25 AM the concerns were reviewed with the Nursing Home Administrator.