STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 04/04/23 through 04/05/23. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Five complaints were investigated during the survey. One complaint was non-compliant with related deficiency. One complaint was non-compliant with related deficiency, Past Non-compliance. Three complaints were compliant with the regulations. The census in this 180 certified bed facility was 164 at the time of the survey. The survey sample consisted of 4 current resident reviews and 2 closed record reviews.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or	F 552		

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

Electronically Signed

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 1	F 552		

treatment options and to choose the alternative or option he or she prefers.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, family interview, and staff interviews, facility staff failed allow the resident to choose the treatment options he or she prefers as evidenced by reports that a staff member informed the resident that going to the hospital emergency department would result in loss of nursing home placement for 1 of 6 residents in the survey sample (Resident #4).

Resident #4 was admitted to the facility with diagnoses that included cerebral infarction, hemiplegia/hemiparesis following cerebral infarction, diabetes mellitus, and hypertension. On the Minimum Data Set assessment with assessment reference date 11/28/22, the resident scored 13/15 on the Brief Interview for Mental Status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The assessment indicated that the resident had reported occasional pain with pain severity as high as 10/10 with 10 being the highest possible score.

During an interview on 4/4/23, the resident reported that there had been two nights, 12/6/22 and 12/7/22 when the resident was in pain and did not receive treatment that reduced the pain to an acceptable level. The resident became tearful when recounting the events of the two nights. The resident reported asking the nurse to go to the hospital emergency department to seek treatment. The resident stated the room mate witnessed the interaction and the resident's daughter was on the phone at the time. The surveyor spoke with the resident's room mate on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 552	Continued From page 2 4/4/23 and the room mate confirmed witnessing the resident crying with pain for the 2 nights in question and that the resident had asked to be sent to the emergency department for treatment of pain. The room mate stated the nurse told the resident that pain was not an emergency and the resident would lose the nursing home bed if the resident left to go to the hospital. On 4/5/23 the surveyor interviewed the resident's daughter, who reported being on the phone with the resident through the interaction with the nurse who told the resident that the resident could not go to the hospital for treatment and return to the facility. The surveyor interviewed the resident's nurse (LPN #5) by phone on 4/5/23. The nurse stated the resident did complain of pain the nights in question and was given something (per Medica Administration Record, at 4:30 AM, and 5:36 AM on 12/7/22, the second night). The nurse did not remember the resident asking to go to the hospital. The surveyor received similar reports from two residents and 1 family member and the employee involved did not remember the reported incident. The preponderance of evidence suggests the resident was told that going to the hospital for treatment would result in loss of nursing home placement. The administrator and director of nursing were made aware of the concern during a summary conference on 4/4 and 4/5/23.	F 552		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v)	F 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 3 §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and family interviews, facility staff failed to allow the resident to receive visitors at times of choosing as evidenced by limiting visitation to specific hours not dependent on clinical or safety concerns for 1 of 6 residents in the survey sample (Resident #4).	F 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 4	F 563		

Resident #4 was admitted to the facility with diagnoses that included cerebral infarction, hemiplegia/hemiparesis following cerebral infarction, diabetes mellitus, and hypertension. On the Minimum Data Set assessment with assessment reference date 11/28/22, the resident scored 13/15 on the Brief Interview for Mental Status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The assessment indicated that the resident had reported occasional pain with pain severity as high as 10/10 with 10 being the highest possible score.

The surveyor interviewed the resident's sister by phone on 4/5/23 about concerns expressed by the resident. The resident's sister stated that she had only been allowed to visit during the day. Staff informed her that she had to leave before 8 PM and could not return until after 8 AM. She and other family members had asked to go sit with the resident on some nights when the resident was having problems and had been told that it was outside visiting hours and to wait. The sister also stated that her husband had tried to drop off clean clothing for the resident on his way to work one day. He arrived at around 7:45 AM and knocked on the door. A staff member looked at him, he held up the clothes basket, and the staff member shook her head and walked away.

The surveyor reported the conversation to the administrator and director of nursing on 4/5/23. The administrator stated that facility doors are locked for safety between 8 PM and 8 AM. She stated that locked doors and unmanned front desk did not equal banning visitors.

The surveyor determined that staff statements

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 5 that visitation was not allowed, and the report that staff did not open the door to accept the clean laundry indicated that visitation was disallowed. The administrator and director of nursing were made aware of the concern during a summary conference on 4/4 and 4/5/23.	F 563		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to ensure the resident received adequate supervision to prevent accidents for 1 of 5 residents in the survey sample (Resident #1). This is past noncompliance. Resident #1 was admitted to the facility with diagnoses including Alzheimer's dementia, dementia with agitation, severe malnutrition, dysphagia, congestive heart failure, hearing loss, hypertension, and arthritis. On the Minimum data set assessment with assessment reference date 2/20/23, the resident scored 1/15 on the brief interview fro mental status (indicating significant cognitive impairment) and was assessed as exhibiting physical and verbal behaviors 1-3 of the prior 7 days, significant interference with	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

care, putting others at risk, and disrupting the care environment. The resident was discharged to the hospital for a procedure and readmitted on 3/9/23.

A facility reported incident indicated the resident had an unwitnessed fall with head injury requiring hospitalization on 3/12/23.

A nursing Fall note dated 3/12/23 Patient went outside in wheelchair and fell. Patient has laceration on right side of eye/head. Contributing factors were "wander guard not in place", wheelchair lock. New interventions were: wander guard, geri chair (a recliner).

Clinical record review revealed an administrative order for Left ankle Check Wander Prevention patient band every shift every to start 2/15/2023 and discontinued 3/9/2023.

The surveyor interviewed LPN#4 on 4/5/23 at 11:20 AM. LPN#2 stated that the first time the resident sought exit after returning from the hospital on 3/9/23. On 3/12/23 the resident became aggressive and would not let staff touch him. The resident was moving around the nursing unit in a wheelchair. The receptionist at the front door yelled for help from a nurse. The nursing supervisor and another nurse went outside to bring the resident back inside. The supervisor and nurse witnessed the resident stand and fall to his knees, then face down. When they brought the resident back inside, he was bleeding from his forehead and swinging at staff as they tried to clean his wounds. The resident's color changed and was still bleeding, so staff called 911 to send him to the hospital. The resident had not returned to the facility by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 end of the survey on 4/5/23. The surveyor interviewed the director of nursing (DON) on 4/5/23 at 11 AM. The DON stated the resident's wander guard was not replaced on admission because the resident was not having any of the behaviors that caused the wander guard to be placed on him. The surveyor asked for the assessment that resulted in not replacing the wander prevention device on the resident's return from the hospital on 3/9. No wander assessment had been completed on readmission. The DON stated that the facility recognized there was an issue and initiated a QA(quality assurance) investigation and plan of correction. The plan, except for staff education, had been completed on 3/31/23. The QA team determined that a wander assessment on readmission could have resulted in replacement of the wander prevention device prevented the resident from exiting through the front door and falling outside. Nursing staff reviewed all admissions and readmissions from 3/13 through 3/31/23 and ensured each had a wander assessment within 24 hours of admission and appropriate interventions were put in place. An inservice education program addressing elopement and conducting elopement assessment on admission. All licensed nurses received training by 4/3/23. The DON and/or designee will review all admissions to ensure wander assessments are completed within 24 hours. Results will be reported to the QA committee monthly until the QA committee determines the problem no longer exists, at which time wander assessment on admission will become part of the random audit process.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 Surveyors reviewed residents admitted within 30 days of the survey and all had wander assessments conducted on admission and appropriate interventions in place. During a summary meeting on 4/5/23, the administrator and director of nursing were notified that the issue was to be considered past non-compliance with a correction plan completed.	F 689		
F 697 SS=D	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 resident interview, family interview, and staff interviews, facility staff failed ensure pain management was provided to the resident for 1 of 6 residents in the survey sample (Resident #4). Resident #4 was admitted to the facility with diagnoses that included cerebral infarction, hemiplegia/hemiparesis following cerebral infarction, diabetes mellitus, and hypertension. On the Minimum Data Set assessment with assessment reference date 11/28/22, the resident scored 13/15 on the Brief Interview for Mental Status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The assessment indicated that the resident had reported occasional pain with pain severity as high as 10/10 with 10 being the highest possible	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 9 score. During an interview on 4/4/23, the resident reported that there had been two nights, 12/6 and 12/7/2013 when the resident was in pain and did not receive treatment that reduced the pain to an acceptable level. The resident became tearful when recounting the events of the two nights. The resident reported asking the nurse to go to the hospital emergency department to seek treatment. The resident stated the room mate witnessed the interaction and the resident's daughter was on the phone at the time. The surveyor spoke with the resident's room mate on 4/4/23 and the room mate confirmed witnessing the resident crying with pain for the 2 nights in question. The room mate confirmed that the resident had cried and been awake all night with pain. On 4/5/23 the surveyor interviewed the resident's daughter, who reported being on the phone with the resident on those 2 nights and heard the resident asking for pain management. Clinical record review revealed two medications were available as needed for pain: 1- an order for acetaminophen 325 milligrams give 2 tablets by mouth every 6 hours as needed for pain started 11/23/22 and discontinued 12/8/22. The medication administration record (MAR) indicated the resident received the medication one time on 12/7/22 at 5:36 AM for pain at a level 8/10. 2- an order for baclofen tablet 5 milligrams give 1 tablet every 8 hours as needed for muscle pain/spasms started 11/23/22 and discontinued 12/8/22 was administered on 12/7/23 at 4:30 AM. The surveyor interviewed the resident's nurse (LPN #5) by phone on 4/5/23. The nurse stated	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495293	A. BUILDING _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE HEALTH & REHABILITATION CENTER	705 CLEARVIEW DRIVE VINTON, VA 24179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 10 the resident did complain of pain the nights in question and was given something (per MAR, at 4:30 AM and 5:36 AM the second night). The nurse did not offer a reason for not administering available medications on the night of 12/6 or earlier in the night on 12/7/22. The administrator and director of nursing were made aware of the concern with pain management during a summary conference on 4/4 and 4/5/23.	F 697		