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	345410	A. BUILDING _____ B. WING _____	C 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff, attending physician and physician ' s assistant, the facility delayed notifying the medical	F 157	1) Resident #22 was admitted for surgical repair on, 3-13-15 to hospital. The Director of Nursing directly in-serviced	5/21/15

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

Electronically Signed | 05/15/2015

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F 157	Continued From page 1 team when the ordered hip x-ray result was positive for a fractured left hip. The facility staff failed to notify the medical team when a delay in obtaining an appointment for an orthopedic consultation occurred. This was evident in 1 of 2 residents in the sample reviewed for physician notification. (Resident #22) Findings included: Resident #22 had cumulative diagnoses which included intellectual disability, encephalopathy, diabetes mellitus, history of right hip fracture and seizure disorder. Review of the admission Minimum Data Set assessment dated 2/8/15 revealed the resident has short and long term memory deficits. The resident required extensive assistance from staff for activities of daily living, mobility and wheelchair bound. Review of the care plan dated 2/18/15 revealed a problem with generalized muscle weakness with a risk for pain. The interventions included every shift assessment for pain using the scale of 1-10 (10 meaning severe pain) Review of the nurses progress notes dated 3/6/15 at (time unclear) revealed Resident #22 complained of left knee and hip pain. The physician assistant was contacted ordered an x-ray of the left hip and left knee. Review of the x-ray results revealed the report were faxed to the facility on 3/6/15 at 11:37 AM (Pacific Standard Time) which indicated a transverse subcaptial fracture of the left femoral neck and " the fracture is indeterminate in dating. "	F 157	Nurse #4 and nurse #6 and other supervising nurses on the importance of prompt notification of injuries to residents and their family members. The Director of Nursing will also in-service nurse #4 and nurse #6 and other supervising nurses on prompt physician notification. 1a) Individual in-services were held with Nurse #4 and Nurse #6 on 4/23/15. Shift supervisor and charge nurse in-services were held on 5/11/15 and 5/14/15. The Director of Nursing discussed physician notification and notification of change of resident's condition and importance of prompt action. Also discussed was information detailed in the policy regarding steps to take in regards to the aforementioned topics. 2) The Director of Nursing and/or her designee conducted chart reviews on resident #22 and all other resident□s to ensure all resident follow-up. 2a)100% of charts were reviewed. 1 issue was found and has since been resolved. A x-ray was performed on a resident on 4/21/15. The non-critical, non-emergent x-ray results were conveyed to medical provider on 4/23/15 at which time, an orthopedic evaluation was ordered. The orthopedic provider could not see until end of May so decision was made to contact another provider. The second provider was able to see resident on 4/29/15. The facility provider made the decision to send resident to the hospital on 4/27/15 for evaluation rather than wait until the 4/29/15 appointment. 3) A policy was developed and immediately implemented regarding	

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F 157	Continued From page 2 Interview on 04/23/2015 1:37 PM with the Director of Nurses (DON) revealed she called the radiology department who indicated the results of the hip x-rays were faxed at 2:37 pm (eastern Time) on 3/6/15. The DON also indicated that a follow-up phone call from the radiology department was done on 3/6/15 at 3:12 pm to Nurse #4 (house supervisor). Additionally, the resident had not experienced a fall. Nurse #4 was currently on leave was not available for interview. . Review of the Medication Record from 3/7/15 through 3/13/15 revealed Resident #22 had a pain assessment completed on each shift and no complained of left hip pain. The resident was administered Acetaminophen 650 mg by mouth but the indication was not documented Review of the medical record revealed the physician's assistant was notified on 3/10/15 by Nurse # 6 (house supervisor) of the 3/6/14 (4 days later) of the left hip x-ray result. An orthopedic consultation was ordered. This appointment date was not scheduled until 3/13/15 (3 days later from the order). Interview on 4/23/15 with Nurse #6 revealed she discovered the results of the right hip fracture while reviewing Resident #22 " s chart. Nurse #6 indicated it was the responsible of the house supervisors to contact the physician regarding x-ray results. Interview on 04/23/2015 2:20: PM with Nurse #5 (house supervisor who relieved Nurse #4 on 3/6/15) revealed she was not informed about the left hip x-ray results.	F 157	resident injuries, follow-up treatment, physician notification and subsequent need for changes in treatment. Updated procedures will detail nursing staff responsibility regarding, proper communication, including informing providers of potential delays in treatment or transfers. Also included in this policy will be information on transfers to more intensive care or acute services based on resident need and injury. 4) The Director of Nursing and/or her designee will conduct chart reviews monthly for the first three months, then at least quarterly, to assure follow-up treatment is appropriately being done. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance. 5) Quality Assurance meeting was held on 4/30/15. Physician notification expectations were discussed amongst Medical Director, Administrator, DON, ADON, Clinical Nurse Supervisor, Staff Development Coordinator, and Nursing Administrative Assistant. The Medical Director stated that her expectation is to be contacted by the nursing staff when resident has experienced a significant change or injury. Furthermore, the Medical Provider indicated that her expectation is that any delay treatment should be communicated to her or her staff for instructions on other treatment options. The outcome of this collaboration has been adopted into	

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F 157	Continued From page 3 Review of the nurses notes revealed on 3/13/15 at 8:55 am Resident #22 was transported to the orthopedic appointment. By 3/13/15 at 1:30 PM, Resident #22 was transported to the hospital from the facility and admitted for a surgical repair of the fracture left hip. Interview on 4/23/15 at 9:45 am with the attending physician revealed she would have expected staff to contact her when the results were faxed and a delay in contacting a medical provider was not acceptable. The attending physician indicated she would have considered CT scan or transferred the resident to the emergency room. Further interview with the physician revealed that once the staff could not obtain an orthopedic consult the medical providers should have been notified for an option transfer the resident to the emergency room. Interview on 04/23/2015 10:29 AM with the physician assistant revealed Resident #22 had a long standing living arrangement in the assisted living and was transferred to the skilled center for additional care I was not aware that they could not have gotten an appointment for 3 days. The physician ' s assistant indicated she would have wanted to know about the delay of the orthopedic appointment and the results of the x-ray. Interview on 4/23/15 at 4:15 pm with the administrator and DON was done. The DON indicated that she knew Resident #22 when he resided in the assisted living facility and the resident was admitted to the skilled nursing facility due to his decline and pain. The administrator indicated Resident #22 refused to go to the hospital from the orthopedic office and	F 157	practice at the facility and detailed in two separate facility policies titled, "Notification of Change in Resident's Condition" and "Outside Appointments".	

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F 157	Continued From page 4 returned to the facility. However, the manager from the assisted living facility (who was familiar with Resident #22) arrived at the facility and encouraged Resident #22 to have the surgical repair of the hip. Both the administrator and DON indicated their expectations were that the physician be made aware immediately of the x-ray result and the delay of obtaining an orthopedic appointment.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to provide assistance with toileting during a meal, resulting in an undignified dining experience for 1 of 1 resident (Resident #127) in the sample. The incident caused the resident to have feelings of worthlessness and caused pain while having to wait to void. Findings included: Record review indicated the resident was admitted to the facility on 02/16/15 with diagnoses of: Urinary Tract Infection, Rheumatoid Arthritis, Chronic Pain, and Genera Muscle Weakness. The 14 day Minimum Data Set (MDS) Assessment with an assessment reference date of 03/02/15 was reviewed. The MDS was coded	F 241	1) On 4-23-15, the Director of Nursing re-educated CNAs about maintaining resident dignity and respect pertaining to resident toileting during meal times. This was also discussed during in-services held on 5-11-15 and 5-14-15. 2)The Director of Nursing and Staff Development Coordinator conducted in-services with all nursing staff on the importance of resident dignity and respect, specifically in the manner of toileting residents during meal times. 2a) An in-service was held on 4/27/15 by Administrator and DON to clarify expectations regarding toileting during a meal. The expectations were clearly communicated with staff about steps for ensuring an individual resident's dignity	5/21/15

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F 241	Continued From page 5 to indicate the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was alert and oriented times three .The resident required extensive assistance for toilet use and personal hygiene with one person assist, and was occasionally incontinent of urine and always continent of bowel. The Care Plan dated 03/04/15 read: Occasional episodes of urinary incontinence related to loss of bladder muscle tone. Goal: Promote increased continence through nursing assessment, intervention and evaluation times 90 days 06/04/15. The approaches included: encourage resident to call for assistance with toileting /bed pan. Utilizes disposable incontinent products to manage accidents. At risk of urinary tract infections. Review of the physician ' s orders for 04/14/15 revealed the physician ordered urinalysis and culture and sensitivity laboratory studies for Dysuria (painful or difficult urination). The results of the Urinalysis was positive for proteus bacteria, which indicated the resident had a urinary tract infection. An antibiotic was ordered to be given twice per day. During observations of the breakfast meal service on 04/21/15 at 8:38 AM resident # 127 was observed ringing her call bell, and calling out to staff that she needed to be changed. The breakfast meal tray was observed opened and situated on the resident ' s over bed table. Continued observations and interview with resident # 127 on 04/21/15 from 8:38 AM - 9:15 AM revealed the following: The resident stated	F 241	and respect is maintained. Staff instructed to toilet residents based on need regardless of time of day, including during meals. 2b) Nursing staff in-service held on 5/11/15 and 5/14/15 to discuss several topics including toileting during meal times. Staff instructed to assist resident's with their bowel and bladder needs, and without regard to the resident's continence level, no matter when the need arises and especially during meal times. 3) Incontinence rounds will be conducted monthly to assure residents are being toileted timely and accordingly to facility policy. Specifically, residents will be offered the opportunity to be toileted and therefore free of bodily fluids during meal times. Staff will assist residents immediately when an incontinence episode has occurred or upon request from a resident. Staff will remove meal trays out of the room and/or cover the tray and heat the food back up if necessary. 4) Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance. 5) Resident interviews conducted by Social Work staff on 4/24/15 and 4/27/15. Residents with a BIMS score of 15 and requiring extensive assistance for toilet use and personal hygiene, and who are occasionally incontinent of urine or bowel were interviewed on their experiences with toileting during meal times. There are 11 residents who meet the	

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F 241	Continued From page 6 she had two incontinent episodes during the breakfast meal service. The resident was in tears and stated she had been "begging " the staff to change her. The resident stated after repeated requests to be changed, the staff told her to go in her incontinent brief, and told her to wait until the breakfast meal was over to be changed. The resident reported, "I was wet before I got my breakfast, and when I ate my breakfast. I am wet now." The resident also stated, " I have a Urinary Tract Infection, and it just backs up in me, because I wait so long to go. It hurts when I have to hold it so long. I have to ask the nursing assistants when it is okay for me to (void). When I ring my bell the Nursing Assistant comes and turns off my light, but does not help me, even though I am telling them I can't hold it anymore." The resident was crying as she reported the situation. A second observation was conducted on 04/22/15 at 8:20 AM - 9:20 AM. The resident reported, "I am waiting to (void). I asked the NA #1 if it was okay to (void) now, and she said I needed to wait until after the breakfast trays were passed. Observation revealed the resident pushed the call light at 8:25 AM for assistance. NA #1 was observed going into the room, turned the call light off, and was out of the resident's room in three minutes (8:28 AM), but did not offer assistance. The resident pushed the call light on again at 8:30 AM, and NA #1 told the resident she could not change her, until the roommate finished eating her breakfast. The resident reported she told NA #1, "That could take her (referring to the roommate) an hour to finish eating). " The resident also stated to NA #1, "That's just not right, that I have to wait so long to be changed. Just ask the state lady about that." NA #1 was	F 241	aforementioned criteria and each responded to the interview questions. 7 residents reported no problems with toileting during meal times. 2 residents reported a longer wait to be toileted during meal times and are attended to once meal trays are off the hall. 1 resident reports trying to "hold" bowel and bladder during meal times out of respect for other residents but sometimes has accidents. This resident also reports that if a bowel and bladder accident occurs, she has to wait to be changed until after meal times. 1 resident reports that it's her preference not to be toileted during meal times regardless of need. As previously mentioned, in-servicing and continual education of staff has been conducted to prevent this from happening in the future.	

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observed in the hallway and not in a resident's room feeding a resident at 8:35 AM, when the resident activated the call light again. NA #1 was observed answering the call light at 8:39 AM. NA #1 jerked the privacy curtain around the roommate, and then changed the resident.

An additional interview was conducted with the resident on 04/22/15 at 9:00 AM. When asked how it made the resident feel, when NA #1 jerked the privacy curtain around the resident. The resident stated, "It makes me feel like a nothing. Like I don't matter to them (referring to the staff). It also hurts. I ' m in pain when I have to wait to go to the bathroom."

A staff interview was conducted on 04/22/15 at 9:30 AM with NA #1 regarding the facility procedures for changing residents during meal service. NA #1 stated, "If we are feeding a resident, we cannot stop to change another resident or give them the bed pan. We try to encourage the residents to wait until the meal is over to be changed or given the bed pan. The residents are supposed to be checked and changed every two hours."

A staff interview was conducted with NA #2 on 04/22/15 at 9:35 AM. When asked what care resident # 127 required, NA# 2 indicated, "The resident has to be given the bedpan. When asked if the resident wore incontinent briefs, NA #2 stated, the resident wore incontinent briefs, and had an incontinent pad on the mattress. When asked what is done if the resident has incontinent episodes during a meal, NA #2 stated, "We change the incontinent briefs and the pads."

An interview was conducted with the resident on

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04/22/15 at 2:55 PM. When asked if the resident had been checked for wetness since the lunch meal, the resident stated, "They never check me unless I call repeatedly on my bell." When asked if the resident was dry, the resident agreed, "Yes I am dry."

An interview with the resident on 04/23/15 at 8:15 AM indicated the resident continued to have concerns with staff not offering the resident the bedpan or checking at least every 2 hours for the need to be toileted/changed. When asked how long it had been since a staff member checked on her, the resident stated, " They never come in and check on me. I have to ask, beg, and ring my bell repeatedly. The last time I was changed was at 5:00 AM this morning. I am holding it now. "

Interview with the attending physician on 04/23/15 at 10:10 AM. When asked about the physician ' s expectations related to the resident repeatedly asking staff when she (the resident) can void, the physician stated, "Obviously she should not have to ask to void, and not have to wait until after the meal to be changed."

A staff Interview was conducted on 04/23/14 at 10:40 AM with NA #3 (who worked the 7AM - 3PM shift). When asked what the normal procedure was for changing the resident's incontinent brief during a meal, NA #3 stated, "Usually, if she has already started eating, and she tells us she is wet, we tell her we will change her when she finishes eating. If she has not started eating, we will take the tray out, change her, and then bring the tray back in the room after we have changed her." When asked when NA #3 last change the resident or offer the bedpan, NA #3 stated, " NA #4 should have offered to change

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the resident or offer the bedpan before she went on her lunch break. NA #3 indicated she had not changed or offered to change the resident on the shift since 7:00 AM.

Interview with the resident on 04/23/15 at 12:20 PM revealed the resident continued to state she had to have repeated requests for assistance, before staff would change her. The resident stated," the staff never offer me the bedpan. I have to beg and wait to get them to change me." When asked if it was her choice to wear an incontinent brief, the resident stated, " No. I don ' t want to get the bed wet, and with them (referring to the nursing assistants) not coming when I need to be changed, I wear the brief in case I have an accident. "

A staff interview with NA # 4 was conducted on 04/23/15 at 12:30 PM. NA #4 who arrived on the shift at 6:45 AM, did not check the resident's brief until 9:30 AM for wetness. When asked what is done if the resident has an incontinent episode while eating. NA #4 revealed, "After the resident finishes eating, we will change her. If we have not set up the tray yet, and the resident has an incontinent episode, then we will remove the tray out of the room, do incontinent care, and then return the tray to the resident."

A staff interview was conducted on 04/23/15 at 2:20 PM with Nurse #1. When asked the reason the resident wore an incontinent brief, the nurse stated, she was unaware about the reason, and stated, "The resident came in the facility with one. We offered her the bed pan. I don't know that she is totally continent."

The Director of Nurses (DON) was interviewed on

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F 241	Continued From page 10 04/23/15 at 3:40 PM about the expectations of the staff. The DON indicated, " A resident who has had an incontinent episode during meals or feeding, should not have to wait until after the meal is over to be changed. The expectation is, if the meal tray is in the room, during an incontinent episode, the meal tray should be removed, the resident changed, and the meal tray brought back in after the resident was changed. It was a concern three weeks ago, that some staff had the interpretation that if the trays were on the hall, a resident could not be taken to the bathroom or changed. So to clarify the expectation, we did an in-service/monthly staff meeting on April 13 and April 16 of 2015 with all the nursing department, and we instructed the staff that residents could be taken to the bathroom during meal times, and also when the tray was in the room, covered. If a resident was in the process of eating the staff was told to change the resident if they were wet, so the resident would not eat their meal while wet. They were instructed to put the meal tray back on the cart, during the change. The title of the in-service/monthly staff meeting was: Trays on the Hall and Taking Residents to the Bathroom. " The DON indicated the staff had not followed what was covered in the recent in- service. The Administrator was interviewed on 04/23/15 at 4:00 PM regarding the expectations of the staff. The Administrator indicated, "Our expectation is that we don't want any resident sitting in their urine or bowel movement while they are eating their meal. The expectation is no matter what, the resident should be changed if they are wet or soiled."	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250		5/21/15

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CENTRAL CONTINUING CARE	**1287 NEWSOME STREET MOUNT AIRY, NC 27030**

(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 250	Continued From page 11 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to schedule a follow-up cardiology appointment as ordered. This was evident in 1 of 1 resident who required a follow-up cardiology appointment. (Resident #115) Findings included: Resident #115 had numerous diagnoses which included paroxysmal atrial fibrillation and cerebral vascular accident. Review of the medical record revealed Resident #115 was seen by the cardiologist on 12/10/14. Review of the report of consultation revealed the cardiologist recommendation to increase Sotalol (a drug used to treat irregular heartbeats) from 80 milligrams (mg) to 160 mg twice a day, an EKG in one week (after the 12/10/14 visit) and a follow-up cardiology appointment in one month. Review of the medical record revealed an EKG was done on 12/19/14 and was faxed to the cardiologist. Further review of the medical record revealed no follow-up appointment to be seen by the cardiologist until 2/27/15 (1 month later then ordered). Review of the consultation form from the follow-up appointment on 2/27/15 revealed	F 250	1) Resident #115 attended cardiology appointment on 2-27-15. The Director of Nursing in-serviced Nurse #6 on the importance of follow-up appointments and scheduling appointments. 2) The Director of Nursing and/or her designee conducted chart reviews to assure all follow-up appointments. 2a) Chart reviews were completed on 100% of resident charts. No other appointments were missed. 3) A policy was implemented on proper appointment scheduling, including steps to ensure both routine and follow-up appointments are scheduled and attended to. When notified of an appointment by either the MD office, progress note, or family request, nursing staff will acknowledge need by documenting receipt of request. Request will then be given to the Unit Clerk. The Unit Clerk will either schedule appointment on follow-up with office to verify appointment time. Unit Clerk will then record appointment on calendar, notify resident and/or family as well as nursing staff and document receipt of these actions. Any changes to appointments by facility, provider transportation, or family will be	

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F 250	Continued From page 12 Sotalol dose was decreased to 80 mg every 12 hours. Review of the grievance /complaint investigation form dated 3/2/15 revealed the scheduling of the follow-up cardiology appointment was overlooked by the staff. Interview on 04/22/2015 2:35 PM with the social worker revealed when residents return from an appointment the consult form is given to the nurse. The nurse in turn would provide to the unit clerk to make the arrangement. Interview on 04/22/2015 2:43:57 PM with unit clerk revealed Nurse #6 would have received the information from the consultation then forward to me to make the appointment. The unit clerk could not recall if she received the consultation form to make the follow-up appointment. Interview on 04/22/2015 3:27 PM with Nurse #6 revealed she did not follow-up on the scheduled appointment, faxed the EKG results to the cardiologist and thought the cardiologist office would have made the scheduled appointment. Interview on 04/22/2015 3:10 PM with the Director of Nurses revealed her expectation was for her staff to make the physician appointment. .	F 250	documented in resident record. Any questionable delays will be addressed by the nursing supervisor or staff nurse and communicated to provider and then to resident and/or family if necessary. 3a) 1a) Individual in-services were held with Nurse #4 and Nurse #6 on 4/23/15. Shift supervisor and charge nurse in-services were held on 5/11/15 and 5/14/15. The Director of Nursing discussed physician notification and notification of change of resident's condition and importance of prompt action for both instances. Appointment scheduling information was communicated with staff on the policy titled, "Outside Appointments'. 4) The Director of Nursing and/or her designee will do monthly chart audit for the first three months, then at least quarterly, to assure follow-ups are carried through. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		5/21/15

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F 309	Continued From page 13 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff, attending physician and physician ' s assistant, the facility delayed treatment of the repair of a fractured left hip. This was evident in 1 of 1 resident in the sample with a delay in the treatment for a fractured left hip. (Resident #22) Findings included: Resident #22 had cumulative diagnoses which included intellectual disability, encephalopathy, diabetes mellitus, history of right hip fracture and seizure disorder. Review of the admission Minimum Data Set assessment dated 2/8/15 revealed the resident has short and long term memory deficits. The resident required extensive assistance from staff for activities of daily living, mobility and wheelchair bound. Review of the care plan dated 2/18/15 revealed a problem with generalized muscle weakness with a risk for pain. The interventions included every shift assessment for pain using the scale of 1-10 (10 meaning severe pain) Review of the nurses progress notes dated 3/6/15 at (time unclear) revealed Resident #22 complained of left knee and hip pain. The physician assistant was contacted ordered an x-ray of the left hip and left knee.	F 309	1) Resident #22 was admitted for surgical repair on, 3-13-15 to hospital, where treatment was administered. The Director of Nursing directly in-serviced Nurse #4 and Nurse #6 and other supervising nurses on the importance of having no delay in resident treatment. 1a) Individual in-services were held with Nurse #4 and Nurse #6 on 4/23/15. Shift supervisor and charge nurse in-services were held on 5/11/15 and 5/14/15. Director of Nursing discussed physician notification and notification of change of resident's condition and importance of prompt action. Also discussed was information detailed in policy regarding steps to take. Appointment scheduling was also discussed at this in-service. 2) The Director of Nursing and/or her designee conducted chart reviews on resident #22 and all other resident□s to ensure all resident follow-up. 2a) The Director of Nursing and/or her designee conducted chart reviews on resident #22 and all other residents to ensure there has been no delay in any resident treatment. 3) As stated in Tag F-157, a policy was implemented to ensure the facility maintains the highest well-being for residents, by the way of physician notification, proper appointment	

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F 309	Continued From page 14 Review of the x-ray results revealed the report were faxed to the facility on 3/6/15 at 11:37 AM (Pacific Standard Time) which indicated a transverse subcaptial fracture of the left femoral neck and " the fracture is indeterminate in dating. " Interview on 04/23/2015 1:37 PM with the Director of Nurses (DON) revealed she called the radiology department who indicated the results of the hip x-rays were faxed at 2:37 pm (eastern Time) on 3/6/15. The DON also indicated that a follow-up phone call from the radiology department was done on 3/6/15 at 3:12 pm to Nurse #4 (house supervisor). Additionally, the resident had not experienced a fall. Nurse #4 was currently on leave was not available for interview. . Review of the Medication Record from 3/7/15 through 3/13/15 revealed Resident #22 had a pain assessment completed on each shift and no complained of left hip pain. The resident was administered Acetaminophen 650 mg by mouth but the indication was not documented Review of the medical record revealed the physician's assistant was notified on 3/10/15 by Nurse # 6 (house supervisor) of the 3/6/14 (4 days later) of the left hip x-ray result. An orthopedic consultation was ordered. This appointment date was not scheduled until 3/13/15 (3 days later from the order). Review of the nurses notes revealed on 3/13/15 at 8:55 am Resident #22 was transported to the orthopedic appointment. By 3/13/15 at 1:30 PM, Resident #22 was transported to the hospital from the facility and admitted for a surgical repair of	F 309	scheduling, and continual education and in-servicing with nursing staff. 4) The Director of Nursing and/or her designee conducted chart reviews monthly for the first three months, then at least quarterly, to ensure there is no delay in treatment, and policies are followed. Procedures will be assessed and reviewed at QA meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance. 5) Quality Assurance meeting was held on 4/30/15. Physician notification expectations were discussed amongst Medical Director, Administrator, DON, ADON, Clinical Nurse Supervisor, Staff Development Coordinator, and Nursing Administrative Assistant. The Medical Director stated that her expectation is to be contacted by the nursing staff when resident has experienced a significant change or injury. Furthermore, the Medical Provider indicated that her expectation is that any delay treatment should be communicated to her for instructions on other treatment options. The outcome of this collaboration has been adopted into practice at the facility and detailed in two separate facility policies titled, "Notification of Change in Resident's Condition" and "Outside Appointments". 6) Improved communication will be achieved via verbal shift reporting and use of a communication board for supervisors. The 24 report is also utilized at present and has been revised to maximize use.	

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F 309	Continued From page 15 the fracture left hip. Interview on 4/23/15 at 9:45 am with the attending physician revealed she would have expected staff to contact her when the results were faxed and a delay in contacting a medical provider was not acceptable. The attending physician indicated she would have considered CT scan or transferred the resident to the emergency room. Interview on 04/23/2015 10:29 AM with the physician assistant revealed Resident #22 had a long standing living arrangement in the assisted living and was transferred to the skilled center for additional care I was not aware that they could not have gotten an appointment for 3 days. The physician ' s assistant indicated she would have wanted to know about the delay of the orthopedic appointment and the results of the x-ray. Interview on 4/23/15 at 4:15 pm with the administrator and DON was done. Both the administrator and DON indicated their expectations were that the physician be made aware immediately of the x-ray result and the delay of obtaining an orthopedic appointment so that treatment could be rendered.	F 309	Nursing staff have been educated on documenting as well as reporting to oncoming shifts. This education took place on 5/11/15 and 5/14/ and is ongoing.	