STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	C 04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

(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=D	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 observation, record review, physician and staff interviews, the facility failed to notify the physician regarding pain for 1 of 3 sampled	F 157	Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes	5/6/16

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

Electronically Signed | 04/29/2016

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F 157	Continued From page 1 residents (Resident #1) reviewed for falls. Findings included: The undated Fall Protocol included steps to call a Code Green, to not move the resident until the Charge Nurse had made an assessment and to notify the physician if there was an injury or the resident complained of pain. Resident #1 had diagnoses that included dementia, abnormal involuntary movements, and muscle weakness. The most recent Minimum Data Set (MDS) dated 2/7/2016, revealed Resident #1 had short and long term memory problems and had severely impaired decision-making skills. The resident was also coded as requiring one-person assistance for ambulating in the room and in the hallways and indicated the resident's balance was not steady but that she was able to stabilize without human assistance. The MDS further indicated Resident #1 was frequently incontinent of bladder and had not had any falls in at least the last 3 months. The Care Plan [most recently updated on 2/19/16] for Resident #1 indicated the resident had an unsteady gait, lack of strength and was at risk for falls. Approaches included non-slip footwear, ambulation with staff supervision and hand-held physical assistance as necessary. The Care Plan also included a problem of incontinence and risk of urinary tract infections with approaches that included toileting assistance, and containment program every two hours and as needed. An incident report dated 4/5/2016 at 7:24 AM, and completed by Nurse #1 included, "Notified by CNA (Nursing Assistant #1) that resident fell at 0420 (4:20 AM), writer found resident sitting up on the bed C/O (complaining of) left knee pain. Resident had non-skid socks ON. Resident	F 157	this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Barbour Court Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. 1) The physician was notified of Resident #1 complaint of pain post fall on 4/5/16 by Nurse #2. New orders were received for Norco 5/325mg and to send resident to the ER on 4/5/16. 2) On 4/7/2016, 100% of Nurse□s notes and Risk Management Reports were reviewed for all residents to include resident #1 from 3/24/16-4/7/16 to ensure all documented acute changes in condition, to include pain post fall have documentation of MD notification by the Facility RN Nurse Consultants. All identified areas of concerns were addressed by the DON with MD	

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F 157	Continued From page 2 unable to follow commands to stretch her leg, writer tried to check for ROM (range of motion) resident was non-compliant, No swelling noted Skin intact." The report included, "Resident medicated for C/O pain, X-ray ordered results in." It also indicated the resident was maintained in bed with the bed in the lowest position and a bed alarm was in place. The vital signs included blood pressure 148/80, pulse 84, respirations 16 and temperature was 98.1 degrees. Record review revealed a Progress Note dated 4/5/2016 at 7:43 AM which included, "Resident fell in her room at 0420 (4:20 AM) while ambulating, per staff who was in the room with resident, resident fell on her left side. Resident was C/O left knee pain, Pain medication administered with positive outcome, X-ray done results in No acute bone pathology." The Progress note also indicated the Responsible Party (RP) had been notified and, "MD (Physician) consulted via consult book." The note was signed by Nurse #1. A Radiology report dated 4/5/2016, revealed an x-ray had been taken of Resident #1's left knee. It revealed no fracture of the left knee. Further review of Resident #1 ' s medical record revealed additional Progress Notes on 4/5/2016 were entered by the 7-3 shift, Nurse #2. The notes indicated the resident was given Tylenol at 10:30 AM for complaints of upper thigh and hip pain. Resident #1 was seen by the attending physician, who ordered Norco5/325mg for the pain, and the resident was sent out to the hospital after she was given the Norco at 1:30 PM. A Progress Note at 10:00 PM, on 4/5/2016 by Nurse #3, stated Resident #1 had been admitted to the hospital with a fracture to her left hip. Review of the hospital Radiology Report (dated 4/5/2016) revealed Resident #1 had sustained a	F 157	notification on 4/8/16. 3) 100% In-servicing to licensed nurses, to include Nurse #2, and Nurse # 3 was initiated on 4/8/2016 regarding physician notification for acute changes in condition to include pain post fall via phone, not the communication book by the Director of Nursing/RN Supervisor/QI Nurse/Resource Nurse. All newly hired employees will be in serviced regarding physician notification for acute changes in condition to include pain post fall via phone, not the communication book during the orientation process by Staff Facilitator, ADON or DON. 4) Nurses Notes and Risk Management Reports will be reviewed for all residents to include resident #1, 3 times per week X□s 4 weeks, then weekly X□s 4 weeks and then monthly X□s 1 month to ensure that the MD was notified timely of all acute changes in condition to include pain post fall using the QI Tool for Physician Notification by the RN Supervisor/ QI Nurse or MDS Nurse. Any concerns will be addressed immediately with reeducation of the license nurse and notification to the MD by RN Supervisor/ QI Nurse or MDS Nurse. The DON will review and initial the QI Tool for Physician Notification weekly for 8 weeks the monthly for 1 month for completion and to ensure all areas of concern were addressed. 5) The DON will forward the Results of the QI Tool for Physician Notification to the Executive QI committee monthly x 3 months to determine trends and/or issues that may need further interventions put in	

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F 157	Continued From page 3	F 157		

minimally displaced left femoral neck fracture.
An investigation was conducted by the facility which included written statements from several staff members who worked on 4/5/2016.
A statement from Nursing Assistant (NA) #1 on 4/6/2016, indicated she was the staff member who had been in the room when Resident #1 had fallen. It indicated she had entered the resident's room to take her to the bathroom. The statement also included, "Once she was standing I took her by the hand and took her with me to the closet to get her (an incontinent brief) to put on her once she was in the bathroom on the toilet." The NA's statement said she let go of the resident's hand to get the incontinent brief and when, "I turned back around she (the resident) had started walking back towards her bed she turned too quick and fell on her side. I couldn't catch her in time to stop her fall." The statement also said, "I got her up walked her back to the bed. She was complaining about her leg." The statement indicated the resident was walked back to the bed and then the nurse was called to the room.
NA #1 was interviewed on 4/11/2016 at 4:18 PM. NA#1 stated she was supposed to take the resident to the bathroom every 2 hours. NA # 1 said, "I woke her up and got her to sit on the side of the bed to make sure she was awake before she stood up." NA#1 reiterated that she had taken the resident to the closet and let go of the resident's hand to get an incontinent brief from the closet. The NA said she turned around to find the resident had started to walk away and when the NA said the resident's name, the resident turned, lost her balance and fell to the floor onto her left side. NA#1 said, "We are supposed to allow the nurse to check (the resident). I wasn't thinking about that. I just was thinking she was on the floor. So I picked her up off the floor and

place and to determine that need for further and/or frequency of monitoring.

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walked her back to the bed. She wasn't walking so good."
Nurse #1's statement was taken by the facility on 4/8/2016. The statement included, "Upon entering the resident's room I found [the] resident sitting on the bed." In the statement Nurse #1 said she asked NA #1 why a code green had not been called but the NA did not respond. "Secondly I asked her how the resident got from the floor to the bed, (NA #1) stated that the resident ambulated back to the bed without assistance." The statement indicated the nurse had examined the resident "from head to toe" and the resident was able to move her upper extremities and her right leg but was not able to move the left leg. The nurse instructed the nursing assistants to not move the resident from the bed until further notice. The statement said Nurse #1 called the supervisor (11-7 shift Resource Nurse), informed her Resident #1 had fallen and had complained of left knee pain. The statement indicated the supervisor had asked why a code green had not been called and "I explained that the aide had moved the resident from the floor to the bed and the resident had ambulated back to the bed and was c/o left knee pain." It also said, "I asked the supervisor whether I need to call the on-call MD for left knee x-ray. Supervisor stated no and that we are covered with initiating the standing order." The statement said Nurse #1 had initiated the standing orders, given the resident Tylenol for pain, and called for an x-ray. The RP was notified, the x-ray was done and the results were put in the physician's book and, "a consult form was filled to MD to (follow-up) and evaluate."
Nurse #1 was interviewed on 4/12/2016 at 12:26 PM. Nurse #1 said she entered Resident #1's room and found her sitting on the side of the bed. NA #1 explained how the resident had fallen and

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when asked by Nurse #1 how the resident had gotten back to the bed, the NA had said the resident was able to ambulate from the floor to the bed. Nurse #1 said, "I didn't get into details about how she got off the floor. My concern was how she was able to ambulate back to her bed." Nurse #1 said she checked the resident's face, head and ROM and that the resident complained of knee pain. When asked, Nurse #1 said the exam had taken place while the resident sat on the side of the bed, and the nurse had not asked the resident to lie down on the bed to assess for asymmetry, nor had she looked for any bruising or redness on the leg. Nurse #1 said she gave the resident some medication for the pain and ordered an x-ray to her left knee, and a set of vital signs were obtained. When asked if the physician had been notified or an order obtained for the x-ray from the on-call physician, Nurse #1 indicated her method of notification was to write it in the physician's communication book. She stated she had not called the attending physician or the on-call physician.

The 11-7 Resource Nurse on 4/5/2016 was interviewed on 4/12/2016 at 8:30 AM. She indicated, as Resource Nurse on night shift it was her role to assist the other nurses as necessary and that she also had a unit of residents herself. She stated that when a resident fell, the Protocol was to call a Code Green so staff would respond immediately and assess for injury to see if the resident should be moved. The Fall Protocol also included notifying the physician as necessary. When asked if she had gone to assess the resident or ask if the physician had been notified, the Resource Nurse stated, "I asked if she (Nurse#1) needed help and she said she had it covered." The Resource Nurse said she herself had not called the physician.

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F 157	Continued From page 6 Resident #1 was observed in bed on 4/12/2016 at 10:00 AM, while being examined by her attending physician, the Medical Director. She did not complain of pain and appeared comfortable. The Medical Director was interviewed on 4/12/2016 at 10:07 AM. He stated, "If there is no injury with a fall then we have a protocol but if there is a suspected injury or pain I would expect to be notified." During an interview on 4/12/2016 at 5:58 PM, the Administrator and DON indicated it was their expectation that a resident who had fallen would be assessed while still on the floor and if there was pain or suspected injury the physician should be notified. They both indicated for Resident #1, the on-call physician should have been contacted on 4/5/2016, immediately after the nurse's assessment.	F 157		
F 309 SS=D	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 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, physician and staff interviews, the facility failed to conduct an assessment at the time of a fall to determine if it was safe for the resident to ambulate, and failed to implement the facility Fall Protocol regarding assessment and pain for 1 of 3 residents	F 309	1) The Physician assessed resident #1 post fall on 4/5/16 with new orders for Norco 5/325 mg and to send resident to the ER. 2) 100% of Nurse□s notes and Risk Management Reports were reviewed from	5/6/16

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F 309	Continued From page 7 (Resident #1) reviewed for falls. Findings included: The undated Fall Protocol included steps to call a Code Green, to not move the resident until the Charge Nurse had made an assessment and to notify the physician if there was an injury or the resident complained of pain. Resident #1 had diagnoses that included dementia, abnormal involuntary movements, and muscle weakness. The most recent Minimum Data Set (MDS) dated 2/7/2016, revealed Resident #1 had short and long term memory problems and had severely impaired decision-making skills. The resident was also coded as requiring one-person assistance for ambulating in the room and in the hallways and indicated the resident's balance was not steady but that she was able to stabilize without human assistance. The MDS further indicated Resident #1 was frequently incontinent of bladder and had not had any falls in at least the last 3 months. The Care Plan [most recently updated on 2/19/16] for Resident #1 indicated the resident had an unsteady gait, lack of strength and was at risk for falls. Approaches included non-slip footwear, ambulation with staff supervision and hand-held physical assistance as necessary. The Care Plan also include a problem of incontinence and risk of urinary tract infections with approaches that included toileting assistance, and containment program every two hours and as needed. An incident report dated 4/5/2016 at 7:24 AM, and completed by Nurse #1 included, "Notified by CNA (Nursing Assistant #1) that resident fell at 0420 (4:20 AM), writer found resident sitting up on the bed C/O (complaining of) left knee pain. Resident had non-skid socks ON. Resident	F 309	3/24/16-4/7/16 to identify all residents who had a fall to include Resident #1 to ensure that an assessment was conducted at the time of the fall and the fall protocol regarding assessment and pain was followed. This audit was completed by the Facility Consultants, on 4/7/2016. All identified areas of concerns were addressed by the DON by assessing the resident to assure no acute changes to include pain were observed by 4/16/16. 3) 100% In-servicing was initiated on 4/8/2016 with all licensed nurses by the Director of Nursing/RN Supervisor/Resource Nurse/QI Nurse regarding the fall protocol to include conducting a full head to toe assessment at the time of a fall to include full ROM, pain, observing for bruising, redness, swelling, asymmetry, notifying the MD via phone of any findings from the assessment not the communication book, not moving or ambulating the resident if sign and symptoms of a fracture to include pain are observed during the assessment, and calling code green for falls (code used to notify staff of a resident fall in the facility). All CNAs were in serviced regarding calling code green for falls, not to move or ambulate a resident post fall until the license nurse has performed a full head to toe assessment to ensure the resident is able to safely ambulate, and notification to the nurse for any resident complaints of pain to include post fall. All newly hired license nurses will be educated regarding conducting a full head to toe assessment at the time of a fall to include full ROM, pain, observing	

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F 309	Continued From page 8 unable to follow commands to stretch her leg, writer tried to check for ROM (range of motion) resident was non-compliant, No swelling noted Skin intact." The report included, "Resident medicated for C/O pain, X-ray ordered results in." It also indicated the resident was maintained in bed with the bed in the lowest position and a bed alarm was in place. The vital signs included blood pressure 148/80, pulse 84, respirations 16 and temperature was 98.1 degrees. Record review revealed a Progress Note dated 4/5/2016 at 7:43 AM, which included, "Resident fell in her room at 0420 (4:20 AM) while ambulating, per staff who was in the room with resident, resident fell on her left side. Resident was C/O left knee pain, Pain medication administered with positive outcome, X-ray done results in No acute bone pathology." The Progress note also indicated the Responsible Party (RP) had been notified and, " MD (Physician) consulted via consult book." The note was signed by Nurse #1. A Radiology report dated 4/5/2016, revealed an x-ray had been taken of Resident #1's left knee. It revealed no fracture of the left knee. Later Progress Notes on 4/5/2016 were entered by the 7-3 shift, Nurse #2. The notes indicated the RP had arrived at the facility at 7:50 AM, and the resident was given Tylenol at 10:30 AM for complaints of upper thigh and hip pain. Because of the pain, Nurse #2 documented that she had suggested to the RP twice during the morning that Resident #1 be sent to the hospital for further evaluation. Resident #1 was seen by the attending physician, who ordered Norco5/325mg for the pain, and the resident was sent out to the hospital after she was given the Norco at 1:30 PM. A Progress Note at 10:00 PM, on 4/5/2016 by	F 309	for bruising, redness, swelling, asymmetry, notifying the MD via phone of findings from the assessment not the communication book, not moving or ambulating the resident if sign and symptoms of fracture to include pain are observed during the assessment, and calling code green for falls in the orientation process by Staff Facilitator, DON or ADON. All newly hired CNAs will be in serviced regarding calling code green for falls, not to move or ambulate a resident post fall until the license nurse has performed a full head to toe assessment to ensure the resident is able to safely ambulate, and notification to the nurse for any resident complaints of pain to include post fall during orientation by Staff Facilitator, ADON, DON. 4) Nurses Notes and Risk Management Reports will be reviewed for all residents to include resident #1, 3 times per week X□s 4 weeks, then weekly X□s 4 weeks and then monthly X□s 1 month to identify all residents who had a fall to include Resident #1 to ensure that an assessment was conducted at the time of the fall and the fall protocol regarding assessment and pain was followed using the QI Tool for Falls by the QI Nurse or MDS Nurse. Any identified areas of concerns will be addressed immediately with an assessment of the resident and reeducation of the staff member by the QI Nurse or MDS nurse. The DON will review and initial the QI Tool for Fall Protocol weekly for 8 weeks the monthly for 1 month for completion and to ensure all	

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F 309	Continued From page 9 Nurse #3, stated Resident #1 had been admitted to the hospital with a fracture to her left hip. Review of the hospital Radiology Report (dated 4/5/2016) revealed Resident #1 had sustained a minimally displaced left femoral neck fracture. An investigation was conducted by the facility which included written statements from several staff members who worked on 4/5/2016. A statement from Nursing Assistant (NA) #1 on 4/6/2016, indicated she was the staff member who had been in the room when Resident #1 had fallen. It indicated she had entered the resident's room to take her to the bathroom. The NA had the resident sit on the side of the bed, "making sure she was woke up and that she had on her non-skid socks." The statement also included, "Once she was standing I took her by the hand and took her with me to the closet to get her (an incontinent brief) to put on her once she was in the bathroom on the toilet." The NA's statement said she let go of the resident's hand to get the incontinent brief and when "I turned back around she (the resident) had started walking back towards her bed she turned too quick and fell on her side. I couldn ' t catch her in time to stop her fall." The statement also said, "I got her up walked her back to the bed. She was complaining about her leg." The statement indicated the resident was walked back to the bed and then the nurse was called to the room. NA #1 was interviewed on 4/11/2016 at 4:18 PM. NA#1 stated she was supposed to take the resident to the bathroom every 2 hours. NA # 1 said, "I woke her up and got her to sit on the side of the bed to make sure she was awake before she stood up." NA#1 reiterated that she had taken the resident to the closet and let go of the resident's hand to get an incontinent brief from the closet. The NA said she turned around to find	F 309	areas of concern were addressed. 5) The DON will forward the Results of the QI Tool for Fall Protocol to the Executive QI committee monthly x 3 months to determine trends and/or issues that may need further interventions put in place and to determine that need for further and/or frequency of monitoring.	

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the resident had started to walk away and when the NA said the resident's name, the resident turned, lost her balance and fell to the floor onto her left side. NA#1 said, "We are supposed to allow the nurse to check (the resident). I wasn't thinking about that. I just was thinking she was on the floor. So I picked her up off the floor and walked her back to the bed. She wasn't walking so good."

Nurse #1's statement was taken by the facility on 4/8/2016. The statement included, "Upon entering the resident's room I found [the] resident sitting on the bed." In the statement Nurse #1 said she asked NA #1 why a code green had not been called but the NA did not respond. "Secondly I asked her how the resident got from the floor to the bed, (NA #1) stated that the resident ambulated back to the bed without assistance." The statement indicated the nurse had examined the resident "from head to toe" and the resident was able to move her upper extremities and her right leg but was not able to move the left leg. The nurse instructed the nursing assistants to not move the resident from the bed until further notice. The statement said Nurse #1 called the supervisor (11-7 shift Resource Nurse), informed her Resident #1 had fallen and had complained of left knee pain. The statement indicated the supervisor had asked why a code green had not been called and "I explained that the aide had moved the resident from the floor to the bed and the resident had ambulated back to the bed and was c/o left knee pain." It also said, "I asked the supervisor whether I need to call the on-call MD for left knee x-ray. Supervisor stated no and that we are covered with initiating the standing order." The statement said Nurse #1 had initiated the standing orders, given the resident Tylenol for pain, and called for an x-ray. The RP was notified,

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the x-ray was done and the results were put in the physician's book and "a consult form was filled to MD to (follow-up) and evaluate."
Nurse #1 was interviewed on 4/12/2016 at 12:26 PM. Nurse #1 said she entered Resident #1's room and found her sitting on the side of the bed. NA #1 explained how the resident had fallen and when asked by Nurse #1 how the resident had gotten back to the bed, the NA had said the resident was able to ambulate from the floor to the bed. Nurse #1 said, "I didn't get into details about how she got off the floor. My concern was how she was able to ambulate back to her bed." Nurse #1 said she checked the resident's face, head and ROM and that the resident complained of knee pain. When asked, Nurse #1 said the exam had taken place while the resident sat on the side of the bed, and the nurse had not asked the resident to lie down on the bed to assess for asymmetry, nor had she looked for any bruising or redness on the leg. Nurse #1 said she gave the resident some medication for the pain and ordered an x-ray to her left knee, and a set of vital signs were obtained. When asked if the physician had been notified or an order obtained for the x-ray from the on-call physician, Nurse #1 indicated her method of notification was to write it in the physician's communication book. Nurse #1 indicated she had not called for a verbal order for the x-ray but had called the supervisor right after the incident happened and, "She advised me that we could use the standing order to give her something for pain and to order the x-rays." Nurse #1 indicated the Physician's Standing Orders were kept in the front of the Medication Administration book and on the computer. Nurse #1 said she had reviewed the Standing Order sheet for Tylenol but had not looked for the standing order for an x-ray.

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The 11-7 Resource Nurse on 4/5/2016 was interviewed on 4/12/2016 at 8:30 AM. She indicated, as Resource Nurse on night shift it was her role to assist the other nurses as necessary and that she also had a unit of residents herself. She stated that when a resident fell, the Protocol was to call a Code Green so staff would respond immediately and assess for injury to see if the resident should be moved. The Fall Protocol also included notifying the Responsible Party and the physician. The Resource Nurse stated Nurse #1 had called her a little after 5AM to tell her Resident #1 had fallen. "I asked why a Code Green had not been called and she said they were already getting her up." When asked if she had gone to assess the resident or ask if the physician had been notified, the Resource Nurse stated she had not gone to assess the resident and had not asked Nurse #1 if the physician had been called. The Resource Nurse said, "I asked if she needed help and she said she had it covered." The Resource Nurse said Nurse #1 had not told her it was the NA who had ambulated the resident. The Resource Nurse also said, "She didn't say nothing about standing orders for the x-ray. We don't have a standing order for x-ray."
The Director of Nursing (DON) was interviewed on 4/12/2016 at 9:07 AM. She indicated she had been made aware of the fall when she arrived in the morning about 8:00 AM but had not examined the resident. The DON said, "I do remember that we offered to send the resident out a couple of times" and indicated the RP wanted to wait and wanted the resident to have lunch. When asked, the DON said staff had not followed the Fall Protocol.
Resident #1 was observed in bed on 4/12/2016 at 10:00 AM, while being examined by her attending physician, the Medical Director. She did not

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F 309	Continued From page 13 complain of pain and appeared comfortable. The Medical Director was interviewed on 4/12/2016 at 10:07 AM. He stated that if there was a fall with suspected injury or pain, he would expect to be notified and said, "I expect the supervisor to have examined and assessed the resident, and have a set of vitals also, so that I can make a determination." The Medical Director said, "We need to make sure the nurses get there to do a thorough assessment." During an interview on 4/12/2016 at 5:58 PM, the Administrator and DON indicated it was their expectation that when a resident had a fall, a code green would be called and an assessment would be done while the resident was still on the floor.	F 309		
F 510 SS=D	483.75(k)(2)(i) RADIOLOGY/DIAGNOSTIC SVCS ONLY WHEN ORDERED The facility must provide or obtain radiology and other diagnostic services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, record review, physician and staff interviews, the facility failed to obtain an order from the physician for diagnostic services for 1 of 4 residents (Resident #1) reviewed for physician orders. Findings included: Resident #1 had diagnoses that included dementia, abnormal involuntary movements, and muscle weakness. The most recent Minimum Data Set (MDS) dated 2/7/2016, revealed Resident #1 had short and long term memory	F 510	1) The Physician assessed resident #1 post fall on 4/5/16 with new orders for Norco 5/325 mg and to send resident to the ER. 2) 100% audit of all resident□s to include resident #1, diagnostic tests, to include x-rays, from 3/24/16 to 4/7/16, was completed by the Facility Consultant on 4/8/16 to ensure an order was obtained from the physician prior to obtaining the diagnostic test. All identified areas of concerns were addressed with MD	5/6/16

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F 510	Continued From page 14 problems and had severely impaired decision-making skills. The resident was also coded as requiring one-person assistance for ambulating in the room and in the hallways and indicated the resident's balance was not steady but that she was able to stabilize without human assistance. The MDS further indicated Resident #1 was frequently incontinent of bladder and had not had any falls in at least the last 3 months. The Care Plan [most recently updated on 2/19/16] for Resident #1 indicated the resident had an unsteady gait, lack of strength and was at risk for falls. Approaches included non-slip footwear, ambulation with staff supervision and hand-held physical assistance as necessary. The Care Plan also include a problem of incontinence and risk of urinary tract infections with approaches that included toileting assistance, and containment program every two hours and as needed. An incident report dated 4/5/2016 at 7:24 AM, and completed by Nurse #1 included, "Notified by CNA (Nursing Assistant #1) that resident fell at 0420 (4:20 AM), writer found resident sitting up on the bed C/O (complaining of) left knee pain. Resident had non-skid socks ON. Resident unable to follow commands to stretch her leg, writer tried to check for ROM (range of motion) resident was non-compliant, No swelling noted Skin intact." The report included, "Resident medicated for C/O pain, X-ray ordered results in." It also indicated the resident was maintained in bed with the bed in the lowest position and a bed alarm was in place. The vital signs included blood pressure 148/80, pulse 84, respirations 16 and temperature was 98.1 degrees. Record review revealed a Progress Note dated 4/5/2016 at 7:43 AM, which included, "Resident fell in her room at 0420 (4:20 AM) while	F 510	notification of the diagnostic test by the DON on 4/8/16. 3) 100% in servicing was initiated with all licensed nurses on 4/8/16 regarding standing orders, and ensuring that a physician order is in place prior to obtaining any diagnostic tests to include x-rays by the DON/RN Supervisor/QI nurse/Resource nurse. All newly hired license nurses will be educated regarding standing orders, and ensuring that a physician order is in place prior to obtaining any diagnostic tests to include x-rays in the orientation process by Staff Facilitator, ADON or DON. 4) Physicians orders and diagnostic testing manifest will be reviewed for all residents to include resident #1 using the QI Tool for monitoring diagnostic test, 3 times per week X□s 4 weeks, then weekly x 4 weeks and then monthly X□s 1 month to ensure a physician order was in place prior to obtaining the diagnostic test by the QI Nurse or MDS Nurse. Any concerns will be addressed immediately with MD notification and reeducation of the license nurse regarding obtaining a diagnostic test without a physician order by the QI Nurse or MDS Nurse. The DON will review and initial the QI Tool for monitoring diagnostic test weekly for 8 weeks the monthly for 1 month for completion and to ensure all areas of concern were addressed. 5) The DON will forward the Results of the QI Tool for monitoring diagnostic test to the Executive QI committee monthly x 3 months to determine trends and/or issues	

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F 510	Continued From page 15 ambulating, per staff who was in the room with resident, resident fell on her left side. Resident was C/O left knee pain, Pain medication administered with positive outcome, X-ray done results in No acute bone pathology." The Progress note also indicated the Responsible Party (RP) had been notified and, "MD (Physician) consulted via consult book." The note was signed by Nurse #1. A Radiology report dated 4/5/2016, revealed an x-ray had been taken of Resident #1's left knee. It revealed no fracture of the left knee. Later Progress Notes on 4/5/2016 were entered by the 7-3 shift, Nurse #2. The notes indicated the RP had arrived at the facility at 7:50 AM, and the resident was given Tylenol at 10:30 AM for complaints of upper thigh and hip pain. Resident #1 was seen by the attending physician, who ordered Norco5/325mg for the pain, and the resident was sent out to the hospital after she was given the Norco at 1:30 PM. A Progress Note at 10:00 PM, on 4/5/2016 by Nurse #3, stated Resident #1 had been admitted to the hospital with a fracture to her left hip. Review of the hospital Radiology Report (dated 4/5/2016) revealed Resident #1 had sustained a minimally displaced left femoral neck fracture. An investigation was conducted by the facility which included written statements from several staff members who worked on 4/5/2016. A statement from Nursing Assistant (NA) #1 on 4/6/2016, indicated she was the staff member who had been in the room when Resident #1 had fallen. It indicated she had entered the resident's room to take her to the bathroom. The NA had the resident sit on the side of the bed, "making sure she was woke up and that she had on her non-skid socks." The statement also included, "Once she was standing I took her by the hand	F 510	that may need further interventions put in place and to determine that need for further and/or frequency of monitoring.	

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and took her with me to the closet to get her (an incontinent brief) to put on her once she was in the bathroom on the toilet." The NA's statement said she let go of the resident's hand to get the incontinent brief and when "I turned back around she (the resident) had started walking back towards her bed she turned too quick and fell on her side. I couldn't catch her in time to stop her fall." The statement also said, "I got her up walked her back to the bed. She was complaining about her leg." The statement indicated the resident was walked back to the bed and then the nurse was called to the room.

NA #1 was interviewed on 4/11/2016 at 4:18 PM. NA#1 said, "We are supposed to allow the nurse to check (the resident). I wasn't thinking about that. I just was thinking she was on the floor. So I picked her up off the floor and walked her back to the bed. She wasn't walking so good."

Nurse #1's statement was taken by the facility on 4/8/2016. The statement included, "Upon entering the resident's room I found [the] resident sitting on the bed." In the statement Nurse #1 said she asked NA #1 why a code green had not been called but the NA did not respond. "Secondly I asked her how the resident got from the floor to the bed, (NA #1) stated that the resident ambulated back to the bed without assistance." The statement indicated the nurse had examined the resident "from head to toe" and the resident was able to move her upper extremities and her right leg but was not able to move the left leg. The nurse instructed the nursing assistants to not move the resident from the bed until further notice. The statement said Nurse #1 called the supervisor (11-7 shift Resource Nurse), informed her Resident #1 had fallen and had complained of left knee pain. The statement included, "I explained that the aide had moved the resident

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from the floor to the bed and the resident had ambulated back to the bed and was c/o left knee pain." It also said, "I asked the supervisor whether I need to call the on-call MD for left knee x-ray. Supervisor stated no and that we are covered with initiating the standing order." The statement said Nurse #1 had initiated the standing orders, given the resident Tylenol for pain, and called for an x-ray. The RP was notified, the x-ray was done and the results were put in the physician's book and "a consult form was filled to MD to (follow-up) and evaluate."

Nurse #1 was interviewed on 4/12/2016 at 12:26 PM. Nurse #1 said she entered Resident #1's room and found her sitting on the side of the bed. NA #1 explained how the resident had fallen and when asked by Nurse #1 how the resident had gotten back to the bed, the NA had said the resident was able to ambulate from the floor to the bed. Nurse #1 said, "I didn't get into details about how she got off the floor. My concern was how she was able to ambulate back to her bed." Nurse #1 said she checked the resident's face, head and ROM and that the resident complained of knee pain. When asked, Nurse #1 said the exam had taken place while the resident sat on the side of the bed, and the nurse had not asked the resident to lie down on the bed to assess for asymmetry, nor had she looked for any bruising or redness on the leg. Nurse #1 said she gave the resident some medication for the pain and ordered an x-ray to her left knee, and a set of vital signs were obtained. When asked if the physician had been notified or an order obtained for the x-ray from the on-call physician, Nurse #1 indicated her method of notification was to write it in the physician's communication book. Nurse #1 indicated she had not called for a verbal order for the x-ray but had called the supervisor right after

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the incident happened and, "She advised me that we could use the standing order to give her something for pain and to order the x-rays." Nurse #1 indicated the Physician's Standing Orders were kept in the front of the Medication Administration book and on the computer. Nurse #1 said she had reviewed the Standing Order sheet for Tylenol but had not looked for the standing order for an x-ray.

The 11-7 Resource Nurse on 4/5/2016 was interviewed on 4/12/2016 at 8:30 AM. She indicated, as Resource Nurse on night shift it was her role to assist the other nurses as necessary and that she also had a unit of residents herself. She stated that when a resident fell, the Protocol was to call a Code Green so staff would respond immediately and assess for injury to see if the resident should be moved. The Fall Protocol also included notifying the Responsible Party and the physician. The Resource Nurse stated Nurse #1 had called her a little after 5AM to tell her Resident #1 had fallen. The Resource Nurse said Nurse #1 had not told her it was the NA who had ambulated the resident. The Resource Nurse also said, "She didn't say nothing about standing orders for the x-ray. We don't have a standing order for x-ray."

Resident #1 was observed in bed on 4/12/2016 at 10:00 AM, while being examined by her attending physician, the Medical Director. She did not complain of pain and appeared comfortable.

The Medical Director was interviewed on 4/12/2016 at 10:07 AM. He stated that if there was a fall with suspected injury or pain, he would expect to be notified and said, "I expect the supervisor to have examined and assessed the resident, and have a set of vitals also, so that I can make a determination." The Medical Director said, "There is no circumstance where the nurse

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F 510	Continued From page 19 should be ordering tests or x-rays." During an interview on 4/12/2016 at 5:58 PM, the Administrator and DON indicated it was their expectation that if the nurse felt an x-ray was indicated, she should obtain the order from the physician.	F 510		