STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	C 03/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

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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 record review and staff interviews, the facility failed to notify the doctor when complaints of pain were made after a fall had occurred for 1	F 157	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	4/10/17

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

Electronically Signed | 04/10/2017

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F 157	Continued From page 1 of 3 sampled residents, Resident #1. An x-ray completed after the fall revealed the resident had sustained a right hip fracture. The findings include: Resident #1 was originally admitted to the facility on 11/29/16, with diagnoses including, Dementia, Alzheimer's Disease with late onset, Muscle Weakness, Difficulty Walking and Displaced fracture of base of neck of right femur, and subsequent encounter for closed fracture with routine healing. According to an Admission Minimum Data Set (MDS) dated 12/6/16, Resident #1 was moderately cognitively impaired. In the area of bed mobility and transfers, he required extensive assistance, two person physical assistance. In the area of dressing, eating and personal hygiene, Resident #1 required total assistance. Resident #1's care plan dated 12/12/16 addressed increased risk for falls related to deconditioning (loss of muscle tone or loss of function) with actual fall. The interventions included to monitor and document for pain x 72 hours post fall follow up and to report pain, bruising, change in mental status or agitation to the physician. During an interview on 3/19/17 at 3:05 AM, the Third Shift Nurse Supervisor revealed she was on another hall Christmas morning and she came back toward the nurse's station toward the medication cart. She revealed a Nursing Assistant told her Resident #1 was on the floor outside his door. She stated there was a lot going on at the time. The Third Shift Nurse Supervisor stated she assessed Resident #1 and he did not exhibit any signs of pain. She recalled the resident was alert and there was no grimacing.	F 157	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 157 A corrective action for affected resident: For resident # 1, on 12/28/2016 when the resident was assessed by the hall nurse to have pain in the right hip and leg, the resident was medicated with PRN pain medication and the on-call MD was notified. The MD gave an order on 12/28/2016 to complete a pelvis and right hip x-ray. X-ray results were received back on 12/29/2016 positive for an acute impacted sub capital fracture of the right femur neck. The MD was notified of fracture on 12/29/16. The resident was sent to the hospital ER on 12/29/2016 and admitted. On 12/30/16, MD was notified that the investigation into the injury revealed an unreported fall. All current residents experiencing pain have the potential to be affected by the alleged deficient practice. Beginning on 04/07/2017 all current residents were assessed for indications of pain or injury by the hall nurses under the direction of the Director of Nursing. These were completed on 4/10/17. The pain assessment included interviewing all	

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F 157	Continued From page 2 She stated she did not see anything to keep from moving him. The Third Shift Nurse Supervisor revealed she brought Resident #1 to the front of the nursing station in a special chair to watch him more closely. She stated she forgot to write up everything that morning, to report the fall to the next shift, and to contact the family and doctor. She revealed she went home at the end of her shift and forgot about it. The Third Shift Nurse Supervisor continued by stating Resident #1 complained of pain two or three days later and she found out later there was a possibility of a small fracture. The Third Shift Nurse Supervisor recalled prior to Resident #1's fall, she gave him medication when he became agitated. She stated when she came back to work Monday (12/26/16) or Tuesday (12/27/16) night after the fall, he started complaining of pain. The Third Shift Nurse Supervisor did not explain why she did not call the doctor when Resident #1 started complaining of pain on 12/26/16 or 12/27/16 after the resident had fallen. In reference to reporting the fall to the doctor, the Third Shift Nurse Supervisor stated if there were no injuries after a fall, she would fax the doctor and if there was an injury she would get an order to send the resident out to the emergency room. She stated she did not fax the doctor the night of Resident #1's fall because it slipped her mind. The Third Shift Nurse Supervisor said a lot was going on, such as a lot of people needing care at one time. During an interview on 3/19/17 at 2:47 PM, Staff Nurse #1 revealed she worked on first shift with Resident #1 every day during the week and he denied pain, prior to 12/28/16. She stated the Nursing Assistant was doing her rounds on 12/28/16 and told her Resident #1 was complaining of pain. She stated Resident #1 did	F 157	current interviewable patients to ask if they are currently experiencing pain. If they are in pain then an assessment was completed that included the location of the pain, severity of the pain, characteristics of the pain, range of motion for extremity pain and whether or not it is chronic or acute. For cognitively impaired residents, the PAIN AD pain scale was completed. This pain scale numerically ranks pain signs and symptoms such as breathing, negative vocalizations, facial expressions, body language, and consolability to determine a 1-10 pain scale for the patient. If pain was identified, then an assessment was completed that included the location of the pain, severity of the pain, characteristics of the pain, range of motion for extremity pain and whether or not it is chronic (based on history) or acute. For chronic pain, as needed pain medications were administered by the nurse. A follow up 30-45 minutes after administration was completed to ensure pain was resolved. If not resolved then additional pain medications were administered according to orders or if additional pain medications were not ordered by the physician, they were contacted immediately for additional pain management orders. For acute pain, the Director of Nursing was notified and as needed pain medications were administered (if ordered). If the patient did not have an order for pain medications the MD was contacted immediately to get pain medication and other pain related orders.	

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F 157	Continued From page 3 not talk much and each time she picked up his right side he grabbed her hand as if he was hurting. She stated she turned him over and he guarded his right side. She revealed his family was in the room with him when he indicated he was hurting. Staff Nurse #1 revealed she gave Resident #1 Tylenol for pain and called the doctor on call at 4:29 PM. She revealed she did not know Resident #1 had fallen. She stated she looked for information regarding a fall and she did not see anything about him having a fall. During an interview on 3/20/17 at 2:13 PM, the Director of Nursing (DON) revealed an investigation probably was not done when the fall happened because the Third Shift Nurse Supervisor went home. The DON revealed the Third Shift Nurse Supervisor was careless in not calling Resident #1's family and not doing an incident report. The DON revealed she could not find a nurse's note written on 12/25/16 regarding the fall and she did not see an incident report or a fax to the doctor or a phone call to the family. She emphasized for a fall with an injury, the procedure was to call the DON, Administrator, family and doctor and for a fall without injury, make notifications and put something in place to prevent the fall from happening again such as putting a mattress beside the bed or bringing the resident up to the nurse's station. The DON revealed on 12/28/17 an X-ray was done and on 12/29/16 it was determined Resident #1 had a fracture. Resident #1 had surgery, due to the fracture for right hip repair on 12/30/16. The DON revealed after it was discovered through interviews that Resident #1 had a fall and fracture, she revealed the doctor and Resident #1's family were notified on 12/30/16 at 10:25 AM. During an interview on 3/21/17 at 12:00 PM, the	F 157	Once pain medications were administered a follow up 30-45 minutes after administration was completed to ensure that the pain was resolved. If not resolved, the MD was notified immediately for additional orders and interventions. If the acute pain involved an extremity, the MD was immediately notified of the findings. Systemic changes made were: In-service education began on 04/07/2017 by the Staff Development Coordinator for all RNs, LPNs, Med Aides, and NA□s FT, PT, and PRN. The in-service topics included: assessment and notification of the physician of new or unresolved pain. The Director of Nursing will ensure that any employee who has not received this training by 04/10/2017 will not be allowed to work until the training is completed. (See Education Attachment) The RN on call is the Director of Nursing if the staffing on-call is a LPN. The facility specific in-service was sent to Hospice Providers and Agency Staff whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training by 04/10/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 157	Continued From page 4 Administrator stated on the day Resident #1 was X-rayed and it was determined he had a fracture on 12/29/16, they started interviewing staff. She revealed once they started interviewing staff they found out Resident #1 had fallen. She revealed the Third Shift Nurse Supervisor did not call her to let her know when Resident #1 had fallen. During an interview on 3/21/17 at 1:03PM, the Administrator stated it was her expectation that when a resident had a fall incident, the nurse must immediately notify the resident's family and doctor.	F 157	all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing, Staff Development Coordinator, or designee will monitor this issue using the Clinical Quality Assurance Survey Tool Incident Review and MD Notification Tool (see attachment). The monitoring will include observing five resident□s for indicators of pain after a fall, pain management, and timely MD notification. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514		4/10/17

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F 514	Continued From page 5 systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document an assessment of a fall and also failed to document resident's complaints of pain and medication given for pain relief after a fall had occurred, for 1 of 3 sampled residents, Resident #1. An x-ray completed after the fall revealed the resident had sustained a right hip fracture. The findings included: Resident #1 was originally admitted to the facility on 11/29/16, with diagnoses including, Dementia, Alzheimer's Disease with late onset, Muscle Weakness, Difficulty Walking and Displaced fracture of base of neck of right femur, and subsequent encounter for closed fracture with routine healing. During an interview on 3/19/17 at 3:05 AM, the Third Shift Nurse Supervisor revealed she was on another hall Christmas morning and she came back toward the nurse's station toward the medication cart. She revealed a Nursing Assistant told her Resident #1 was on the floor outside his door. The Third Shift Nurse Supervisor stated she assessed Resident #1 and he did not exhibit any signs of pain. She recalled	F 514	F 514 A corrective action for affected resident: For resident # 1, on 12/28/2016 when the resident was assessed by the hall nurse to have pain in the right hip and leg, the resident was medicated with PRN pain medication and the on-call MD was notified. The MD gave an order on 12/28/2016 to complete a pelvis and right hip x-ray. X-ray results were received back on 12/29/2016 positive for an acute impacted sub capital fracture of the right femur neck. The MD was notified of fracture and orders on 12/29/16. The resident was sent to the hospital ER on 12/29/2016 and admitted. On 12/30/16, the MD was notified that the investigation into the origin of injury revealed an unreported fall. All current residents who have had a fall have the potential to be affected by the alleged deficient practice. Beginning on 04/07/2017 all current residents were interviewed or assessed based on their cognitive status, for a falls	

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F 514	Continued From page 6 the resident was alert and there was no grimacing. She stated she did not see anything to keep from moving him. She stated she forgot to write up everything that morning, to report the fall to the next shift, and to contact the family and doctor. She revealed she went home at the end of her shift and forgot about it. The Third Shift Nurse Supervisor continued by stating Resident #1 complained of pain two or three days later and she found out later there was a possibility of a small fracture. The Third Shift Nurse Supervisor recalled prior to Resident #1's fall, she gave him medication when he became agitated. She stated when she came back to work Monday (12/26/16) or Tuesday (12/27/16) night after the fall, he started complaining of pain. During an interview on 3/19/17 at 2:47 PM, Staff Nurse #1 revealed she worked on first shift with Resident #1 every day during the week and he denied pain, prior to 12/28/16. She stated the Nursing Assistant was doing her rounds on 12/28/16 and told her Resident #1 was complaining of pain. She stated Resident #1 did not talk much and each time she picked up his right side he grabbed her hand as if he was hurting. She stated she turned him over and he guarded his right side. She revealed his family was in the room with him when he indicated he was hurting. Staff Nurse #1 revealed she gave Resident #1 Tylenol for pain and called the doctor on call at 4:29 PM. She revealed she did not know Resident #1 had fallen. She stated she looked for information regarding a fall and she did not see anything about him having a fall. During an interview on 3/20/17 at 2:13 PM, the Director of Nursing (DON) revealed an investigation probably was not done when the fall happened because the Third Shift Nurse Supervisor went home. The DON revealed the	F 514	history or indicators that a fall may have occurred. The Social Worker interviewed all alert and oriented residents for any falls that may have occurred over the past 30 days. If falls were reported by the resident, it was then compared to the resident□s medical records to ensure a falls assessment was completed along with MD and responsible party notifications. For cognitively impaired residents, the hall nurses under the direction of the Director of Nursing completed a head to toe assessment for injuries of unknown origin. If injuries were noted, an investigation as initiated. In addition to this, various nursing staff across all three shifts were interviewed to identify any unreported falls over the past 30 days. This was accomplished by printing a list of falls for the last 30 days. The Director of Nursing reviewed the list of falls with staff for identification of any possible unreported falls that they may be aware of. If any falls were identified as unreported, the resident was immediately assessed for injury, the MD and responsible party notified, and an incident report completed. This process was completed on 04/10/2017. Systemic changes made were: In-service education began on 04/07/2017 by the Staff Development Coordinator for all RNs, LPNs, Med Aides, and NA□s FT, PT, and PRN. The in-service topics included: Incident reporting and required notifications, completion of an incident report, falls assessment, ongoing	

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F 514	Continued From page 7 Third Shift Nurse Supervisor was careless in not calling Resident #1's family and not doing an incident report. The DON revealed she could not find a nurse's note written on 12/25/16 regarding the fall and she did not see an incident report or a fax to the doctor or a phone call to the family. She emphasized for a fall with an injury, the procedure was to call the DON, Administrator, family and doctor and for a fall without injury, make notifications and put something in place to prevent the fall from happening again such as putting a mattress beside the bed or bringing the resident up to the nurse's station. The DON revealed on 12/28/17 an X-ray was done and on 12/29/16 it was determined Resident #1 had a fracture. Resident #1 had surgery, due to the fracture for right hip repair on 12/30/16. The DON revealed after it was discovered through interviews that Resident #1 had a fall and fracture, she revealed the doctor and Resident #1's family were notified on 12/30/16 at 10:25 AM. During another interview on 3/21/17 at 1:03 PM, the Administrator revealed her expectation would be for the Nurse to complete fall report and notify them through the fall reporting system.	F 514	monitoring, pain assessment and documentation of interventions including administering PRN medications. The Director of Nursing will ensure that any employee who has not received this training by 04/10/2017 will not be allowed to work until the training is completed. (See Education attachment). The facility specific in-service was sent to Hospice Providers and Agency Staff whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training by 04/10/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing, Staff Development Coordinator, or designee will monitor this issue using the Clinical Quality Assurance Survey Tool Incident Review and MD Notification Tool (see attachment). The monitoring will include observing five resident□s for falls assessment, indicators of pain after a fall, pain management, documentation of PRN pain medications and timely MD	

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F 514	Continued From page 8	F 514	notification. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	