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F 000	INITIAL COMMENTS A complaint investigation was conducted 9/16/19 and 9/17/19. 7 of the 8 complaint allegations were unsubstantiated.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, nurse practitioner (NP) and physician interviews the facility neglected to identify a positive x-ray result for a mildly displaced fracture of the right femoral neck which resulted in a 3-day delay in the resident receiving treatment for the fracture. This was evident for 1 of 3 residents reviewed for falls (Resident #6). The resident described his pain level as incapacitating in his right upper thigh to the physical therapist (PT) on 9/4/19 and experienced a decline in mobility due to pain. Resident #6 was transferred to the hospital on 9/07/19 for complaints of severe hip pain and was found to have a fractured hip which required	F 600	Past noncompliance: no plan of correction required.	10/15/19

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

Electronically Signed | 10/15/2019

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surgical repair.

Findings Included:

Resident #6 was admitted to the facility on 3/27/19 and diagnoses included history of falls, peripheral neuropathy, seizures, diabetes and dementia.

A quarterly minimum data set (MDS) dated 7/2/19 for Resident #6 revealed he had 2 or more falls, required staff assistance to stabilize balance, required extensive one -person assistance with bed mobility, transfers and toilet use and his cognition was intact.

A care plan with an onset date of 7/25/19 identified Resident #6 had pain. Interventions included to provide pain medication before pain became severe, Nurse to obtain pain management orders as necessary and nursing to monitor daily for pain.

A nursing note dated 9/1/19 at 6:40 am for Resident #6, written by Nurse #3, stated he was found on the floor at 5:45 am in a sitting position around the bathroom door. The resident had taken off his brief which was laying on his bed and was dry. The resident had voided on the floor while walking to the bathroom and consequently slid to the floor. He denied hitting his head and no injury sustained. He was assisted to his wheelchair and transferred to his bed for patient care. Floor mats were in place. The resident was resting without any complaints of pain voiced. Vital signs taken and within normal limits and his family would be notified of the incident later in the morning.

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A nursing note dated 9/1/19 at 6:15 pm for Resident #6 stated no complaints of pain or injuries noted from the fall. There were no additional nursing note entries until 9/4/19.

An interview on 9/17/19 at 3:18 pm with Nursing Assistant (NA) #2 revealed she worked with Resident #6 on second shift both before and after his fall on 9/1/19. She stated prior to his fall he could get up on his own and walk. She explained the resident wasn ' t supposed to walk on his own because he had fallen multiple times, but he was confused, and he would still do this. NA #2 stated after the fall on 9/1/19 the resident was in a lot of pain and he couldn ' t move around like he normally did. She added when she provided care, he was having pain which she reported to the nurse. NA #2 stated she was not sure if the nurse did anything about the pain.

A nursing note dated 9/1/19 at 7:34 am for Resident #6, written by Nurse #1, stated the resident ' s family was notified of the fall and were reassured that he was stable at that time. The staff would continue to monitor for any acute changes to his condition.

An incident report dated 9/1/19 at 5:45 am for Resident #6, completed by Nurse #3, revealed he was found on the floor in a sitting position. The resident stated he had used his walker to go to the bathroom. First aide provided included checking his range of motion (ROM) and vital signs which were normal. Pain scale was documented as a zero. A 24-hour follow-up identified mobility, mental status and vital signs were within normal limits. An intervention dated 9/1/19 to schedule toileting at 5:30 am. An intervention dated 9/2/19 for Speech Therapy

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(ST) screen and placed on caseload for cognition and safety. An intervention dated 9/3/19 for Physical Therapy (PT) to screen and on 9/4/19 placed on PT caseload.

An interview on 9/17/19 at 2:03 pm with NA #1 revealed she provided care for Resident #6. She stated on 9/4/19 the resident told her he had fallen, and he thought his leg was broken. She explained when she tried to move him, or he tried to move himself he complained of pain. NA #1 added she felt like he was in a lot of pain, which was not normal for the resident. She stated she reported this to the nurse who told her they were going to get x-rays on him. NA#1 explained the resident could typically move himself around in bed, could sit up on his own, get out of bed on his own and could walk sometimes. She added she knew something was wrong because he couldn ' t move without being in pain.

A PT plan of care dated 9/4/19 for Resident #6 stated he was seen for evaluation and treatment due to a decline in function secondary to a recent fall. The resident complained of pain to his right lower extremity, had difficulty with transfers and bed mobility, was unable to walk and presented with weakness. The resident reported pain scale rating of incapacitating pain for right thigh area. Unable to assess muscle strength and to safely transfer due to pain in right lower extremity. An x-ray was requested.

A nursing note dated 9/4/19 at 8:40 am for Resident #6, written by Nurse #1, stated the resident had complaints of pain to right hip and knee. He had a fall on 9/1/19. Nurse Practitioner (NP) notified of change in condition and an x-ray of right hip and knee was ordered.

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The x-ray results for Resident #6 dated 9/4/19 revealed the right knee showed degenerative and postoperative changes with no acute fracture or dislocation. Results for the right hip revealed mildly displaced fracture of the right femoral neck with an associated mild Varus type deformity indeterminant in dating. The x-ray results were electronically signed by the physician of the x-ray company.

An interview on 9/17/19 at 11:35 am with a representative from the x-ray company that performed the x-ray dated 9/4/19 for Resident #6 revealed the results were faxed to the facility on 9/4/19 at 8:05 pm. She added there was confirmation that the fax was received.

A nursing note, written by Nurse #1, dated 9/5/19 at 10:20 am for Resident #6 stated results of the right hip and knee x-rays were negative and residents responsible party was notified.

A phone interview on 9/17/19 at 11:40 am with Nurse #1 revealed she was a nurse for Resident #6. She stated on 9/5/19 she was approached by the PT about x-ray results for the resident. She explained she was not aware the resident had fallen or had pending x-ray results because she had just returned to work. Nurse #1 stated she spoke to Unit Coordinator #2 who told her the x-ray results were back and they were negative. She stated later that morning another nurse manager asked her to notify Resident #6 ' s family that his x-rays were negative. She added she contacted the family and documented this in the nurse ' s notes. Nurse #1 stated she never saw the x-ray results. She explained on 9/5/19 and 9/6/19 Resident #6 did stay in bed, which

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was not usual for him and she did administer Tylenol for pain. She added on 9/7/19 she was assisting a NA with his care and she noticed he was in severe pain with movement. Nurse #1 stated she notified the on-call NP who instructed her to send him to the hospital.

An interview on 9/17/19 at 12:07 pm with Unit Coordinator #2 revealed she was aware of Resident #6 ' s fall on 9/1/19 and that he had an x-ray completed on 9/4/19. She stated the nurse who received the results of the x-ray were responsible for notifying the residents medical provider. She explained if the results were positive the on-call medical provider would have been called and if they were negative, they would be placed in the medical providers box. Unit Coordinator #2 stated she never saw the x-ray results for Resident #6. She added the Director of Nursing (DON) contacted her on 9/7/19 and asked her if she had seen the x-ray results and she said "no".

A PT note dated 9/5/19 for Resident #6, written by PT #1, stated per nursing the resident was negative for fractures to right lower extremity. The resident continued to complain of pain to his right thigh area. Applied bio-freeze and resident stated that made it feel better. Provided gentle ROM exercises to decrease tightness of bilateral lower extremities. Assisted the Nursing Assistant (NA) with bed mobility and instructed the NA with hand placement during hygiene due to residents increase pain during turning and when pressure applied to right thigh area.

A PT note, written by PT #2, dated 9/6/19 for Resident #6 stated the resident was in bed upon arrival and noted with increased fatigue. The

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resident was instructed in supine bilateral therapeutic exercise with active ROM to left lower extremity and passive ROM to right lower extremity secondary to pain.

A phone interview on 9/17/19 at 2:20 pm with the PT #1 revealed she had evaluated Resident #6 on 9/4/19 after he sustained a fall on 9/1/19. She stated the resident was in bed during the evaluation. She explained normally the resident could sit up on his own and would "pop right up", but during the evaluation he was not able to sit on the edge of the bed and he had facial grimacing upon movement. The PT added the resident complained of pain and she felt like something was wrong because that was not normal for the resident. She explained she notified the resident ' s nurse and recommended an x-ray of his right leg. She stated on 9/5/19 she inquired about the results of the x-ray and Nurse #1 told her it was negative. She added she also read a nurses note that stated the x-ray was negative. The PT explained Resident #6 did receive therapy on 9/5/19 and 9/6/19 that included ROM and bed mobility exercise. She added he received bio-freeze on 9/5/19 and ice packs on 9/6/19 to the right leg during his therapy which seemed to help the pain.

The September 2019 medication administration record for Resident #6 revealed an order for Tylenol 500 milligrams (mg) times 2 tabs every 8 hours as needed for pain with a start date of 6/18/19. The record identified from 9/1/19 through 9/7/19 the resident received 1000 mg of Tylenol twice on 9/6/19 (no times identified) related to pain in right hip and leg. The record did not identify any other pain medications ordered or administered from 9/1/19 through 9/7/19. A pain

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scale with a start date of 6/18/19 identified a pain level of "6" on 9/1/19 on the night shift, a "4 "on the day and night shift on 9/6/19 and a "4" on the day shift for 9/7/19. The numeric pain scale identified "0" as no pain, "1 to 3" as mild pain, "4 to 6" as moderate pain and "7 to 10" as severe pain.

A nursing note, written by Nurse #1, on 9/7/19 at 2:27 pm for Resident #6 stated the resident complained of severe right hip pain with movement. The on-call NP was notified, and a new order obtained to send the resident out to the emergency room for further evaluation.

The hospital record dated 9/7/19 for Resident #6 revealed the patient had sustained a fall a week ago at the nursing home and the initial x-ray at the nursing home were negative. The patient continued to have right hip pain but was able to ambulate and due to increased hip pain a second x-ray was done on 9/7/19 which showed mildly displaced right femoral neck fracture with mild medial angulation. The patient had right hip hemiarthroplasty (a surgical procedure that involved replacing half of the hip joint) done on 9/8/19.

During an interview with the NP for Resident #6 on 9/17/19 at 11:10 am she stated she was usually in the facility on Tuesdays and Thursdays. She stated Resident #6 had a fall on Sunday, 9/1/19 and she did not work on weekends, so the on-call provider would have been notified of the fall. The NP explained she was notified on 9/4/19 by a facility nurse that Resident #6 was complaining of pain in his right lower extremity and she ordered an x-ray. She explained if the results of the x-ray were faxed in after 5:00 PM,

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the on-call provider would have been notified of the results. The NP stated when she came into the building on 9/5/19 she was not given any x-ray results. She added she had checked her box that was located on the unit but there were no x-ray results present for Resident #6. The NP stated she did not examine Resident #6 on 9/5/19 but stated she did see him on the unit in his wheel chair self-propelling. She stated Resident #6 did not have any grimacing and there were no symptoms that stood out that would alert her to do a full evaluation and assessment on him. When asked if the initials on the x-ray results dated 9/4/19 were hers, she stated they were, but she had noted the results a couple of days ago, and that she didn ' t usually date lab or x-ray results when she read them. The NP stated she did not see the x-ray result prior to the resident leaving to go to the hospital on 9/7/19. When asked to read Resident #6 ' s x-ray result from 9/4/19 she stated if she had seen and read the x-ray results, she would have determined the resident had a fracture to his right lower extremity and sent him to the hospital for an evaluation. When asked if the resident was cognitively intact, she stated that due to his comorbidities he had some better days cognitively than others and had intermittent confusion.

A phone interview on 9/17/19 at 4:16 pm with the Physician for Resident #6 revealed he was aware the resident had a fall on 9/1/19. He stated it was his understanding the resident displayed a change in his status and an x-ray was obtained. The Physician explained he believed there was some miscommunication regarding the x-ray results and the facility may have misread the results of the knee x-ray which was negative and missed the right hip results which were positive

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for a fracture. He added he wasn ' t sure that was what occurred or where the breakdown came from. He stated he did expect that a resident who had a positive x-ray result for a fracture would be sent right out to the hospital for further evaluation.

An interview on 9/17/19 at 5:33 pm with the Administrator revealed it was his expectation residents received adequate care and services. He stated that would include reading x-ray results correctly, notifying the residents medical provider and receive the appropriate treatment for pain. The Administrator explained the facility had developed a quality assurance plan regarding the incident to prevent a reoccurrence.

The quality assurance (QA) plan dated 9/9/19 was provided by the facility Chief Operating Officer and revealed:

In response to a review of the resident ' s chart / records and employee interviews, the facility created a new QA team (The x-ray monitoring and communication team) and an internal plan of correction / allegation of compliance to ensure best practice moving forward. The current QA team created, reviewed and implemented the internal plan items as part of a series of meetings on 9/9/19. We believed our plan of correction / allegation of compliance will be effective on 9/9/19. Actions included:

The resident in question was discharged to the hospital for follow-up on 9/7/19. The facility Director of Nursing (DON) notified the residents family via a phone call on 9/7/19 that she was aware the resident had been discharged to the hospital and she would investigate further and follow-up again with the family on 9/9/19. A f/u

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phone call was attempted on 9/9/19.

An audit by the DON and facility Unit Coordinators (UC ' s) of all residents with x-ray orders since 9/1/19 forward was completed on 9/9/19. The audit confirmed these residents had results provided to the facility and the results were followed up and communicated to the MD (Medical Doctor) or RP (Responsible Party) accordingly. The facility logged the x-ray audit results on a newly created internal QA x-ray tracking and communication form. This QA form will continue to be utilized by the administrative nursing team (DON and UC ' s) to track x-ray results (including to and focused on post fall x-ray results as well) moving forward.

The facility initiated a 100% in-service for nurses specific to follow-up expectations of x-ray results. The facility has now added an additional step to x-ray result reviews so that a second nurse is required to verify the x-ray results at the time they are received at the facility. This in-service was created by the QA team members and implemented by the DON. Any nurse who could not be in-serviced on 9/9/19 will be in-serviced before their next scheduled shift., including telephonically. Nurses who were not in-serviced on or before 9/10/19 will be in-serviced upon their return to work. The facility will also provide this same in-service to any newly hired nurses moving forward (as part of orientation).

To monitor if x-ray results are received and followed up accordingly, the administrative nurses will monitor and then document on the QA tool to ensure:

· The facility has x-ray results completed,

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F 600	Continued From page 11 received and followed up accordingly, including communication to the RP and MD. Any results not verified by the following day will be a priority follow-up the following day by the administrative nursing team. · A second nurse has reviewed the x-ray results prior to contacting the MD or RO to ensure follow-up is in fact appropriate. The x-ray monitoring and communication QA team will continue to meet and will expand in size for their next scheduled weekly meeting on 9/18/19. Additional attendees for the 2nd scheduled meeting will include unit coordinators who will remain active in compliance monitoring. This QA team will meet independent of the current facility weekly QA meetings for a least one month from the inception to ensure the plan of correction / allegation of compliance is being followed. The DON or Administrator will be responsible for brining the weekly x-ray audits / tracking to the weekly meetings. Once compliance has been achieved and sustained, the QA team in question will continue to meet and discuss / review ongoing compliance efforts during the weekly QA meetings through at least the next annual survey process. Note: The DON will also bring QA monitoring results and report to the Executive Quarterly QA Committee. The next quarterly meeting is scheduled for October 23, 2019. The facility alleges full compliance with this plan of correction / allegation of compliance as of 9/9/19. The facility QA plan was verified on 9/17/19. The in-service record identified 30 nurses received the training either in person or by phone. A sample of	F 600		

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THE SHANNON GRAY REHABILITATION & RECOVERY CENTER	2005 SHANNON GRAY COURT JAMESTOWN, NC 27282

(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 600	Continued From page 12 nurses interviewed confirmed they had been trained on the new x-ray process. The x-ray tracking and communication QA tool was reviewed and had been completed for x-rays obtained from 9/4/19 through 9/8/19. The facility ' s date of full compliance of 9/9/19 was verified.	F 600		