| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345534 | A. BUILDING _____ B. WING _____ | C 11/17/2019 |

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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted on 11/17/19. Event ID# HD0K11<br><br>1 of the 2 complaint allegations was substantiated with a deficiency. | F 000 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based upon resident interview, staff interview and medical record review it was determined that the facility failed to provide 2 persons for assistance during transfer from the lift to the bed causing injury to the leg of 1 of 2 residents (Resident #1) reviewed for accidents when she leaned on the resident while removing the lift pad. Resident #1 experienced a fractured leg and developed wound. Findings included:<br><br>Resident #1 was admitted to the facility on 12/22/17. The resident had diagnosis including chronic obstructive pulmonary disease and morbid obesity. She received a diagnosis of mild peripheral edema on 10/8/19. Review of the Resident's Quarterly MDS (minimum data set assessment) dated 10/4/19, revealed that the resident scored 15 on the brief interview of mental status indicating that the resident had no | F 689 | Past noncompliance: no plan of correction required. | 12/4/19 |

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

Electronically Signed | 12/04/2019

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| F 689 | Continued From page 1 | F 689 | | |

cognitive deficits. Resident #1 was coded as requiring extensive 2 + person physical assistance for bed mobility and personal hygiene. She was coded as being totally dependent for transfer with 2+ person physical assistance and as being totally dependent on staff for dressing and toileting with1 person physical assist. She required staff assistance to complete activities of daily living including dressing.

Review of Resident #1's care plan dated 10/11/19 stated problem as, Resident requires assistance from staff with activities of daily living care secondary to morbid obesity with noted functional deficits and impaired mobility. The goal for this problem stated, "Resident will have her needs met daily."

Medical record review on 11/17/19 revealed a Nurses note (NN) dated 10/29/19 7:11 AM which stated, "Resident complained of pain in right lower leg, resident stated CNA (Certified Nursing Assistant) bumped her elbow on resident leg. Tylenol was administered for pain, effective pain decreased. A few hours later resident awoke with complaints of severe pain and discomfort to right lower extremity. Small warm round swollen area noted to right lower extremity. Resident requested EMS. EMS called, resident currently at hospital. Staff will continue to monitor when resident returns. RP (responsible party) notified, MD was notified."

Review of hospital emergency department (ED) notes dated 10/29/19 stated Chief Complaint, "right leg swelling stated that it was from a staff member at the facility hitting the patients' with her elbow." ED notes (History of Present Illness) stated, EMS (emergency services) reports patient

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|---|---|---|---|---|
| F 689 | Continued From page 2 | F 689 | | |

from nursing home-staff there report an aide at their facility accidentally fell and struck the patient with her elbow on her right shin. Since then has had acute swelling of the right shin, with severe pain. No blood thinners on MAR (medication administration record). Pain is 8/10 intensity, without +/- factors, "it started easing up then started getting worse again." Denies any other problems with bleeding/bruising. Patient reports "she was sitting on the side of the bed and she leaned over and put her weight on me with her elbow."

Review of X-Ray documentation dated 10/29/19 from the ED revealed that there were 2 views of the right tibia/fibula. "On one view there is concern for a non-displaced proximal fibular fracture."

Review of ED note dated 10/29/19 9:38 stated, plain films read as possible non-displaced proximal fib fracture. ED dated 10/29/19 11:24 stated, pain improved status post fentanyl -leg swelling persists, but not as much tension-has multiple areas of serous drainage, consider close outpatient follow up versus. admission.

Hospital records review of ED note dated 10/29/19 12:28 stated, Patient feels better-recommend non-adherent dressing and will follow up in the clinic tomorrow. Patient agrees with discharge bac to rehab facility and follow up as outpatient. Has narcotic pain meds on her MAR.
Assessment/Plan
1. Fracture of right proximal fibula
2. Hematoma
3. Edema

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|---|---|---|---|---|
| F 689 | Continued From page 3 | F 689 | | |

Medical record review of NN dated 10/29/19 7:01 PM revealed that Resident #1 returned from the emergency department with a new diagnosis of fibula fracture.

Medical record review revealed a Physician Assistant (PA) note dated 11/4/18 which stated, the resident's right lower extremity had significant swelling and bruising and the residents skin had extensive ecchymosis with superficial blisters and mixed bloody/purulent drainage. The note further stated, "suspect that the traumatic pressure that caused the fracture, and associated inflammation, have disrupted the integrity of the skin, causing superficial skin infection and an extensive trauma induced hematoma/blood filled bullae."

Review of PA note dated 11/12/19 revealed that the resident continued wound care and the hematoma had improved.

Review of a written interview statement dated 10/29/19 signed by the admissions director stated, "The CNA's (NA #1) and (NA #2) transferred me to the shower bed for my evening shower. NA #1 said, " have to give you a shower because, if I get one more complaint, I'm gonna get fired." After my shower NA #1 put me back in bed with the Hoyer lift by herself. She sat on the bed and leaned into my leg with her elbow, it felt like all her weight. I don't think she did it on purpose, but she is lazy and always tries to take care of me sitting on the side of my bed. After she leaned into my leg, I felt pain. I let the nurse know and she gave me something for the pain. The pain got a little better but when I woke up it was worse than before. (Nurse) sent me out to the hospital. I don't want NA #1 taking care of me

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| F 689 | Continued From page 4 | F 689 | | |

anymore. Resident describes the CNA, "tall, black lady, short hair, glasses and heavy set."

During interview with Resident #1 on 11/17/19 at 3:52 PM she stated, nursing assistant #1 (NA#1) gave her a shower which was fine. The NA put her in bed and leaned over her (Resident #1) to unclip the lift pad and put her elbow on her leg with all her(NA#1) body weight. The resident stated that she didn't really say anything. When NA moved her elbow the NA asked, "I didn't hurt you did I? Resident #1 reported that she told her, "I said I guess not." Per Resident #1, a nurse came in the room later and asked her if she had always had a bruise on her leg. The resident stated, "The next day, I'd never been in so much pain my life and I've had 2 children."

Interview with Resident #1's family member on 11/17/19 at 3:55 PM revealed that the resident's skin was not previously open on that area of her leg. The family reported that NA #1 had not been back in the room to work with the resident.

During interview with the Director of Nurses (DON) at 5:02 PM on 11/17/19 she reported that the nursing assistant (NA #1) was sitting on the bed talking to resident #1. NA #1 put pressure on the resident's leg when she got up. Resident #1 said ouch. The NA is no longer at the facility due to her sitting on the bed and for not telling nursing staff that the resident was in pain. The DON stated that NA #1 was automatically suspended. The facility did education with the nursing assistants regarding staff reporting pain, not being on cell phones, and reporting pain. The DON stated that NA # 1 was not a small lady.

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|---|---|---|---|---|
| F 689 | Continued From page 5 | F 689 | | |

Interview with Resident #1 at 5:39 PM 0n 11/17/19 revealed that her leg had not healed completely. She stated the leg was a little better. The resident reported that her leg still has some pain and that she gets medication prior to the dressing change because the area is still sore.

Review of a statement dated 10/29/19 signed by NA #1 stated, "the first time was getting ready to change her, I was sitting on the end of her bed; was looking for a black hand fan and I was looking under the covers etc. I couldn't find her fan, so I handed her her pocketbook. When I leaned across her, I was reaching for the blankets to look for her handheld fan. Residents states "oh my leg." I did not lay or put pressure on her leg. Resident never mentioned anything else about her leg to me. I did not have my cellphone with he in the room. I always sit on the end/edge of her bed and we talk about her grandkids, etc. I was looking for her hand held fan. I didn't realize I bumped her leg as she did not mention anything to me about any pain/issues with her leg during my shift."

During interview with NA#1 on 11/17/19 at 6:39 PM she stated, "Before I gave her a shower, I was looking under her cover and I guess my elbow hit her. She (Resident #1) did not get a shower until 3rd shift. I put her back in bed by myself as usual. Whole time while in the shower no complaints. I heard nothing about her leg until the next day when they called me." NA #1 said that the resident's bed was high and because the bed was high she leaned against the bed at the foot and talked to her (Resident #1).

Interview with the Facility Admissions Director at 6:58 PM revealed that she was asked to see how

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|---|---|---|---|---|
| F 689 | Continued From page 6 | F 689 | | |

Resident #1 was doing and to get her statement. The Admissions Director stated that she believed that NA #1 put Resident #1 back in bed. The NA was leaning over her or sitting on the bed. The Admissions Director said that her written statement is how the resident laid out the incident for her.

Interview with the Physician's Assistant (PA) was conducted at 7:45 on 11/17/19. The PA stated that Resident#1's current wound is a direct result of the injury she sustained by the NA leaning on her leg. The fracture caused a lot of inflammation and the resident already had some chronic edema due to size. Per the PA, the resident's skin opened as a result of the injury, resident size and immobility. The large hematoma opened up and atypical of a simple fracture has been very slow to heal.

Facility Plan of Correction Date 10/28/19.

Facility alleged date of compliance 11/1/19.

Corrective Action for the resident involved, (Resident #1):
Resident sent to hospital for evaluation on 10/28/19.

Identification of potentially affected resident and corrective actions taken:
Facility performed 100% audit on all residents for pain and skin assessments. All residents identified with pain or skin issues were addressed and all concerns resolved by 10/30/19

Measures put in place or systemic changes that were made to ensure that the deficient practice will not reoccur:

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| F 689 | Continued From page 7 | F 689 | | |

Facility completed 100% in-service to all nursing assistants and nurses regarding reporting pain and completing pain assessments, no phone use in resident care areas, and no sitting on resident beds. In-service to be completed by 10/30/19. Employees will not be allowed to work until in-serviced.

Unit Managers or Designee to perform random skin and pain assessments on 5 residents a week X 4 weeks, then 3 residents a week X 4 weeks, then monthly thereafter X2. Results will be reviewed weekly X4 weeks by DON and will be brought to QA monthly X1 then will determine continued need for monitoring.

Review of the facility's Plan of Correction on 11/17/19 revealed an In-Service dated 10/30/19 for checking/reviewing care guides. Program content stated Care guides are located at each nursing station and completed for each resident on the hall. Care guides should be checked daily at the start of your shift and throughout your shift. You should always check the care guide prior to transferring a resident or providing any direct care to the resident. Care guides are updated daily and frequently so it should be checked prior to any care provided to determine if any changes have been made.
An In-service was conducted 10/28/19 regarding Reporting Pain. In-Service content included reporting a resident complaints of pain, reporting signs of pain such as facial grimaces to the nurse right away, and pain as the 5th vital sign. Nurses must perform pain assessments under observations.
An In-service was conducted 10/28/19 regarding Customer Service. In-Service content included not sitting on resident beds and no use of cell

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| F 689 | Continued From page 8<br>phones while providing care.<br>Review of facility monitoring on 11/17/19 revealed Resident skin assessments were conducted 10/29/19. Follow up assessments were conducted on the following dates 11/4, 11/5, 11/7, 11/11, 11/12, 11/13, 11/14 and 11/15. Review of the facility tracking sheets revealed that monitoring/audits were conducted per the plan of correction.<br>Interview with facility staff on 11/17/19 at 7:50 PM and 8:08 PM revealed that they participated in In-Service training regarding cell phone, sitting on residents bed, checking care guides and reporting resident pain.<br>Date of 11/1/19 was verified as the facility's date of correction. | F 689 | | |