STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 09/09/2015

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SUNNYBROOK REHABILITATION CENTER	25 SUNNYBROOK ROAD RALEIGH, NC 27610

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F 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section started a complaint investigation survey on 8/18/2015 and exited the facility on 08/20/2015. Upon review of the survey information at the State Agency office, the survey team decided that additional information was needed to rule out that the facility provided substandard quality of care. The survey team reentered the facility on 9/2/2015 and collected the additional information needed to determine that the facility had provided substandard quality of care at the Immediate Jeopardy level. A partial extended survey was conducted on 9/2/2015 and the survey team exited the facility on 09/03/2015. The survey team needed to conduct an additional telephone interview on 9/9/2015 which was determined to be the exit date of the survey. The Immediate Jeopardy began on 8/3/2015 and was removed on 9/3/2015.	F 000		
F 157 SS=J	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	F 157		9/22/15

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

Electronically Signed | 09/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, physician interview and the x-ray company ' s staff interviews, the facility failed to notify the physician of a positive x-ray result of the bilateral knees on 8/3/15 which revealed a fractured right femur for 1 of 3 residents (Resident #1) resulting in delayed medical treatment. The outcome resulted in Resident #1 having orthopedic surgery on 8/8/15 to bilateral fractured femurs. The Immediate Jeopardy began on 8/3/15 when Resident #1 had an x-ray to the bilateral knees and the positive results were not reported to the physician. The Immediate Jeopardy was removed on 9/3/15. The facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: a) Resident # 1 is currently	

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F 157	Continued From page 2 potential for more than minimal that is not an immediate jeopardy (D). The facility was in the process of full implementation and monitoring their correction action. The facility needs to include the nurse aides in their corrective measures. Findings included: Resident #1 was admitted on 10/13/13 with diagnoses of difficulty in walking, muscle weakness, osteoarthritis, osteoporosis, gout, urinary tract infections, glaucoma, peripheral vascular disease and cerebrovascular disease. A record review of the Minimum Data Set (MDS) significant change of status assessment dated 6/3/2015 revealed Resident #1 was moderately cognitively impaired, dependent for transfers with assist of two. Extensive assist with one assist with bed mobility. Extensive assist with assist of one with personal hygiene, eating, dressing and locomotion off and on the unit and dependent with one assist with toileting. Resident #1 used a wheelchair and was always incontinent of bowel and bladder. A record review of a nurse ' s note written on 8/3/15 at 12:27 am revealed Nurse #1 heard Resident #1 calling for help. The nurse found the resident sitting on the floor next to her bed. The bed was in the lowest position. The resident complained of bilateral knee pain. The resident was unable to explain to the nurse how the fall happened. The nurse reported she notified the physician of the fall as well as the responsible party on 8/3/15 at approximately 1:30 am. A record review of a nurse ' s note written on	F 157	discharged from the facility on 08/06/15 and did not return to the facility. b) Individual verbal re-education on accurately interpreting and communicating results of diagnostic studies to MD and family representative/resident was provided by the Regional Clinical Director to Employee directly involved with incident on 08/10/15. 2. Interventions for residents identified as having the potential to be affected: On 8/10/15, a physician order recap review of all new physician orders for previous 4 weeks was performed utilizing the "order recap review" and utilizing the "lab/diagnostic audit tool" to ensure proper follow-up including MD/RP notifications of change in condition (medication changes, diagnostic results etc...) This audit was performed by facility Unit Manager (UM) and Director of Nursing (DON) on current facility residents. On 08/10/15, all Licensed Nurses (across all shifts including weekend and as needed scheduled) were educated by the UM and DON on facility notification process related to change in condition and promptly communicating changes with MD/RP. Newly hired Licensed Nurses will be educated by the Staff Development Coordinator (SDC) during their orientation on facility notification process related to change in condition including ensuring	

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F 157	Continued From page 3 8/3/15 at 11:42 am revealed a urine sample was collected from Resident #1 for a urine analysis. Nurse #2 reported she also ordered an x-ray for the bilateral knees due to the swelling the nurse observed and the increased pain the resident was having. A record review of a radiology report dated 8/3/15 at 12:56 pm for Resident #1 revealed the resident had an acute oblique fracture involving the right distal femur with moderate displacement. The left knee resulted in no fracture or dislocation and showed modest osteoarthritis. A record review of a nurse ' s note written on 8/3/15 at 10:35 pm written by Nurse #2 revealed nurse received communication from the weekend nurse (Nurse #1) that Resident #1 fell and woke up in pain this morning to her bilateral knees. The nurse noted there was swelling to the resident ' s knees. The nurse ordered a bilateral knee x-ray. The nurse reviewed the x-ray and found the result to be negative. A record review of a nurse ' s note written on 8/6/15 by Nurse #2 at 12:23 pm revealed Resident #1 was continuing to complain of pain to her left knee. A physician ' s order was written on 8/6/15 by the physician to x-ray the left femur due to increased pain. A record review of a radiology report dated 8/6/15 at 12:04 pm revealed Resident #1 had a recent displaced spiral left femur fracture. A record review of a nurse ' s note written on 8/6/15 at 6:20 pm revealed Resident #1 had a positive x- ray result revealing a fracture to the left femur. The doctor assessed the resident and	F 157	x-ray results are promptly communicated with MD/RP. On 08/10/15, all Licensed Nurses (across all shifts including weekend and as needed) were educated on importance of Licensed Nurses utilizing facility Point Click Care (PCC) dashboard to communicate change of condition between shifts. Newly hired Licensed Nurses will be educated by the SDC during their orientation period on importance of Licensed Nurses utilizing facility PCC dashboard to communicate change of condition between shifts. All Licensed Nurses were re-educated on the notification phone call from Mobilex (X-ray Provider) when an x-ray is positive and the new notification procedure effective 10/1/15 which will include a "positive" watermark across the entire x-ray result page for all positive results. All Certified Nursing Assistants (CNA) were educated by the DON on ability and necessity of completing the Interact Stop and Watch tool on their Point Of Care input screens when they notice a change of condition of the resident. This information automatically shows up on the Point Click Care Clinical Alert Dashboard for the nurses to see. (All Licensed Nurses were re-educated by the DON on 9/02/15). 3. Systematic Change:	

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F 157	Continued From page 4 ordered the resident to be sent to the hospital. The resident was transported to the hospital via stretcher on 8/6/15. The responsible party was made aware of the transfer. A phone interview on 8/19/15 at 3:15 pm was conducted with Nurse #1 who noted the fall on 8/3/15 at 12:27 am. The nurse reported that she called the physician and left a message regarding the fall at approximately 1:00 am. The nurse reported she left a message for the physician that there was no injury and the range of motion did not change for the resident. The nurse also revealed she called the responsible party and left a message. The nurse reported the resident complained of pain to her knees but she had chronic pain to her knees due to osteoporosis. Nurse #1 reported she was medicated with two tablets of pain medication at 4:40 am for increased pain. The nurse reported she told Nurse #2 at the change of shift that she might need an x-ray due to the increased pain. During an interview on 8/19/15 at 2:15 pm, with Nurse #2, the nurse revealed she ordered an x-ray on 8/3/15 due to the increased pain and swelling the resident had to her knees. The nurse ordered this x-ray at 9:15 am on 8/3/15 per the record review of the physician ' s order. The nurse reported she looked at the results quick and she thinks she faxed it to the doctor, but she cannot remember. The nurse further added that she showed the results to the physician on 8/6/15 when the physician was at the facility. The nurse reported the resident was complaining of pain in the left knee and the physician ordered an x-ray on 8/6/15 of the left leg. The nurse was asked what the process was when you order an x-ray from the x-ray company. The nurse reported that	F 157	Change in Facility Notification Protocol: 08/10/15 and ongoing a) Lab/Diagnostic results are to be communicated to Physician (MD), Resident or Legal Guardian/Interested Family Member promptly after results are received. Follow-up with x - ray/lab Company will occur if results are not received timely. b) All change of condition, order changes or events will be noted on PCC dashboard by Licensed Nurse to ensure shift to shift communication. c) If Licensed Nurses are unable to contact MD or Legal Guardian/Interested Family Member, document attempt to contact with the reason and time in medical record and on PCC dashboard. Also notify oncoming nurse of need for follow-up. An audit is being performed utilizing the "Daily 24 Recap" form and "Lab/Diagnostic" audit tool on all new physician orders during clinical rounds daily (including weekends) to ensure change in condition notification of MD and Legal Guardian/Interested Family Member is evident. The audit has been performed by the DON and UM since 08/10/15 and will continue daily including weekends for four (4) weeks, twice weekly for (4) weeks, weekly for (4) weeks. 4. Monitoring of the change to sustain	

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F 157	Continued From page 5 first, you order the x-ray by phone. The x-ray company will come to the facility and do the x-ray. The x-ray company will fax the results to the facility. The nurse reported the nurse is to go to the fax machine and get the results or they are delivered to the nurse ' s station by the administrative staff. The nurse was asked why she did not get the results until after 10:00 pm when it was faxed from the x-ray company to the facility at 12:57 pm. The nurse replied, sometimes the nurses do not have time; the fax machine is on the other end of the room. An interview with Nurse #3 at 3:17 pm on 9/2/15 revealed Nurse #3 received a shift change report from Nurse #2. Nurse #2 reported to Nurse #3 Resident #1 had a fall on the morning of 8/3/15 and had an x-ray, but it was negative of a fracture. Nurse #3 did not receive in report the resident was having any pain nor did she see the x-ray. Nurse #3 reported on the night of 8/4/15 she assessed the resident when the NA came to her and told her the resident was in pain. The NA had just transferred the resident and was doing incontinent care and the resident was calling out in pain. The NA notified the nurse. The nurse found the resident to be in pain and medicated her with one tablet of Norco 5/325. The nurse reported when she reassessed the resident, she was sleeping. The nurse reported that her bilateral legs did not have any increased swelling. Nurse #3 reported the process when a nurse orders an x-ray is to call the x-ray company. They will come to the facility to do the x-ray and will fax the results to the facility. Nurse #3 also added that if the result is positive or there is an abnormal result, the x-ray company would call to speak to the nurse. If it is negative, the x-ray company sends the result via fax only. Nurse #3	F 157	system compliance ongoing: Monthly for a minimum of three months, the DON will report audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 157	Continued From page 6	F 157		

said she would check the fax machine for results during her shift. If she does not see them, she will call the x-ray company to see if they resulted. Nurse #3 said if the results are positive she would call the doctor and the responsible party with the results. If the results are negative, she faxes the result to the doctor.

An interview with Nurse #4 on 9/2/15 at 10:35 am revealed the resident had no complaints of pain while she worked the night shift on 8/3/15, 8/4/15, and 8/5/15. The nurse reported the resident slept during the night. The nurse reported she saw no increased swelling to her knees but the resident always had swelling to her knees down to her feet and she wore the topical medicated patches for pain due to her osteoporosis. The nurse reported the pain patches were put on her knees at 8:00 pm and taken off at 8:00 am. Nurse #4 was told by Nurse #2 that she had a fall and an x-ray was done on 8/3 and that the results were negative. Nurse #4 did not see the x-ray results. Nurse #4 reported the process when getting an x ray is to order the x-ray by phone. The x-ray company performs the x-ray and faxes the results to the nurse ' s station. If the results are negative, the nurse faxes the result to the doctor. If the results are positive, the nurse calls the physician for further orders. Nurse #4 revealed she did not receive a phone call from the x-ray company informing the nurse of the positive result of the x-ray.

A phone interview was conducted with a technician from the x-ray company at 11:33 am on 9/2/15 regarding the results of Resident #1 ' s x-ray on 8/3. The technician reported the x-ray was done on 8/3 at 12:15 pm and resulted at 12:57 pm and faxed to the facility at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 7	F 157		

An interview with the call center supervisor from the x-ray center, reported the result was phoned into (Nurse #4) on 8/5/15. The call center supervisor further added that the phone call is a courtesy call the x-ray company does. Sometimes they are very busy and cannot get to it right away but the name of the facility stays up on the call back screen until the x-ray company contacts the facility. The supervisor reported the x-ray company would only make this courtesy call for positive or abnormal results.

An interview with Nurse #4 on 9/2/15 at 3:00 pm revealed Nurse #4 received a phone call from the x-ray company on 8/5/15 asking if we received the results for resident. Nurse #4 reported she asked Nurse #2 if we received the results and Nurse #2 said, yes. Nurse #4 was asked why she did not inquire about the x-ray when the x-ray company called. Nurse #4 reported that the x-ray company did not say it was a positive result, they just asked if we got the results. Nurse #4 was asked if the x-ray company is calling to verify results were received, doesn ' t it mean they were positive? Nurse #4 reported that they call us with negative and positive results.

At 1:50 pm on 9/2/15, the Account Manager from the x-ray company arrived to facility. The Account Manager reviewed the x-ray results from 8/3 and 8/6 and reported she would have a case review done by the company ' s radiology group to review the x-ray films again from 8/3/15 The Account Manager also reported that the x-ray company only makes courtesy calls to the facility when the results are positive. They do not call the facility when the result is negative or normal.

During an interview on 8/19/15 at 3:00 pm, with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 8	F 157		

the physician, it was revealed she was not aware of the x-ray result on 8/3/15. The physician added that if she had known about the acute fracture to the right femur she would have ordered the facility to send the resident to the hospital right away. The physician recalled being at the facility on 8/6/15 and being told the resident was having knee pain. The physician reported she ordered an x-ray for the resident and it showed a left fractured femur. The physician reported she was shown the x-ray result from 8/3/15 on 8/6/15 by Nurse #2. The physician asked why she was not told about the 8/3/15 result and Nurse #2 reported, she read the upper part of the result and missed the lower part. The physician reported her expectation of the nurses is to report any abnormal diagnostic test or lab value immediately to the doctor via phone or fax.

An interview with the physician was conducted on 9/2/15 at 12:30 pm. The physician was asked if the condition worsened to Resident #1 due to not having the resident evaluated as a result of the x-ray on 8/3/15. The physician suggested that maybe the radiologist missed it if there was no displacement in the fracture. The physician reported that if it was not displaced, the fracture could be hard to see. In addition, she reported that with any kind of repositioning or lifting with a resident with osteoporosis a fracture could occur. The physician recommended speaking to the radiologist to get further clarification of the x-ray on 8/3/15. A record review of the case review form by the company ' s radiology facility on 9/2/15 revealed the exams from 8/6/15 and 8/3/15 were reviewed to determine if the fracture shown on 8/6 was not visible or present on the prior study. The review comment revealed the left femur spiral fracture described on 8/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 9	F 157		

exam is not visible on images of the left knee on 8/3/15. The physician revealed the resident was sent to the hospital where she had splints placed on both her legs and was transported to another hospital. On 8/8/15, the resident had bilateral surgery to her fractured femurs. Resident #1 did not return to the facility. The resident was admitted to another nursing home.

On 8/20/15 at 10:45 am, an interview with the Director of Nursing (DON) revealed the expectation of the nurses is to notify the physician immediately when there is a positive diagnostic or lab result via fax or a phone call. The DON reported her expectation is that the nurses also follow up to be sure the physician received the phone call or the fax to see if there are further orders from the physician. The DON further added that her expectation of the nurse is that if the nurse ordered the lab or diagnostic test, they should check the fax room thru out their shift for the result.

The Administrator was notified of the immediate jeopardy on 9/2/15 at 12:00 pm.
The facility provided an acceptable credible allegation on 9/3/15 at 12:30 pm

Resident # 1 had a fall on 8/3/15. The nurse evaluated the resident post fall; finding no injuries, range of motion unchanged with complaint of bilateral knee pain. An x-ray was completed on 8/3/15 with positive results of a right fractured femur. The nurse read the results as negative and did not notify the physician. The resident had increased pain and swelling and a second x-ray was ordered and performed on 8/6/15. The results were positive for a left femur fracture. The resident was sent to the hospital via

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 10	F 157		

ambulance and was later admitted to another hospital where orthopedic surgery was performed to bilateral femurs to repair the fractures. The resident did not return to the facility after the surgery. The resident was admitted to another nursing home facility.

On 8/10/15 the " lab diagnostic tool " was implemented and includes the resident name, room number, test type and date, date responsible party notified and dated the physician was notified. The " order recap audit tool " which consists of tracking all new orders within the previous 24 hours per nurse station was also initiated.

Individual verbal re-education on accurately interpreting and communicating results of diagnostic studies to physician, family and resident was provided by the Regional Clinical Director to the employee involved on 8/10/15.

· On 8/10/15, a physician order recap review of all new physician orders for previous 4 weeks was performed utilizing the " order recap review " and utilizing the " lab/diagnostic audit tool " to ensure proper follow-up including physician and responsible party (MD/RP) notifications of change in condition (medication changes, diagnostic results etc.). This audit was performed by the facility Unit Manager (UM) and Director of Nursing (DON) on current facility residents.
· On 08/10/15, All Licensed Nurses (across all shifts including weekend and as needed scheduled) were educated by the UM and DON on facility notification process related to change in condition and promptly communicating changes with MD/RP.
· Newly hired Licensed Nurses will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 11 educated by the Staff Development Coordinator (SDC) during their orientation on facility notification process related to change in condition including ensuring x-ray results are promptly communicated with MD/RP. · On 08/10/15, All Licensed Nurses (across all shifts including weekend and as needed) were educated on importance of Licensed Nurses utilizing facility Point Click Care (PCC) dashboard to communicate change of condition between shifts. · On 8/10/15, newly hired Licensed Nurses will be educated by the SDC during their orientation period on importance of Licensed Nurses utilizing facility PCC dashboard to communicate change of condition between shifts. · An audit is being performed utilizing the " Daily 24 Recap " form and " Lab/Diagnostic " audit tool on all new physician orders during clinical rounds daily (including weekends) to ensure change in condition notification of MD and Legal Guardian/Interested Family Member is evident. The audit is being performed by the DON and UM since 08/10/15 and will continue daily including weekends for four (4) weeks, twice weekly for (4) weeks, weekly for (4) weeks. Change in Facility Notification Protocol: 08/10/15 and ongoing Ø Lab/Diagnostic results are to be communicated to Physician (MD), Resident or Legal Guardian/Interested Family Member promptly after results are received. Follow-up with x - ray/lab Company will occur if results are not received timely. Ø All change of condition, order changes or events will be noted on PCC dashboard by Licensed Nurse to ensure shift to shift	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 09/09/2015

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F 157	Continued From page 12 communication. Ø If Licensed Nurses unable to contact MD or Legal Guardian/Interested Family Member, document attempt to contact with the reason and time in medical record and on PCC dashboard. Also, notify oncoming nurse of need for follow-up. All other residents were assessed utilizing the 24 hour report, chart reviews, staff interviews, the order recap review and the lab/diagnostic audit tool to ensure proper follow-up including physician and responsible party notifications of change in condition. This was done by the (UM) and the DON on 8/10/15. Validation on 9/3/15 at 12:30 pm verified the credible allegation was evidenced by interviews of direct nursing staff related to education on interpreting and communicating results of diagnostic studies to the physician by utilizing the order recap review tool, the lab/diagnostic audit tool, and the Point Click Care dashboard to communicate change of condition between shifts. The DON and the UM will utilize the Daily 24 Recap form and the Lab/diagnostic audit tool on all new physician orders daily for four weeks, twice weekly for 4 weeks and weekly for 4 weeks.	F 157		
F 309 SS=J	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.	F 309		9/22/15

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F 309	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, physician interviews, and x-ray facility staff interviews, the facility failed to identify the need for a medical intervention for 1 of 3 residents (Resident #1) with a significant change of condition of increased pain and swelling to bilateral knees after sustaining a fall. The Immediate Jeopardy began on 8/3/15 when the resident developed pain and swelling after a fall. The resident had a positive x-ray result of a right fractured femur and she did not receive medical attention until 8/6/15. The immediate jeopardy was removed on 9/3/15 when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal that is not an immediate jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. Findings Included: Resident #1 had diagnoses of difficulty in walking, muscle weakness, osteoarthritis, osteoporosis, gout, urinary tract infections, glaucoma, peripheral vascular disease, cerebrovascular disease. A record review of the Minimum Data Set (MDS) significant change of status assessment dated 6/3/2015 revealed Resident #1 was moderately cognitively impaired, dependent for transfers with assist of two. Extensive assist with one assist	F 309	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: Resident # 1 is discharged from the facility on 08/06/15 and did not return to the facility. 2. Interventions for residents identified as having the potential to be affected: An in-service was provided by the Director of Nursing (DON) to Licensed Nurses (across all shifts including weekend and as needed scheduled) on 08/10/15. Education included the following: If a fall occurs the nurse on duty will perform the following post fall actions: a) Provide immediate care to	

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F 309	Continued From page 14 with bed mobility. Extensive assist with assist of one with personal hygiene, eating, dressing and locomotion off and on the unit and dependent with one assist with toileting. Resident #1 used a wheelchair and was always incontinent of bowel and bladder. A record review of care plans updated on 5/20/15 revealed a care plan was in place for risk for falls. Interventions included getting resident out of bed to wheelchair upon waking in the morning if she chooses, cue for safety awareness, encourage out of room activities, keep call light within reach, and keep wedge on right side of bed while in bed. A care plan for impaired cognitive function related to dementia was in place with interventions to keep routine consistent and require approaches that maximize involvement in daily decision. A care plan for weakness related to decrease functional mobility and falls was in place. Interventions included offering assistance with toileting, provide two person assist with sit to stand transfers to and from wheelchair. A care plan for potential for pain related to gout/osteoarthritis was in place. Interventions included inviting and escorting as needed to activities of interest, medication for pain to knees as ordered and monitor effectiveness. The resident participated in activities daily. A record review of the physician ' s orders revealed Resident #1 had an order written on 3/26/15 to apply topical pain patches to bilateral knees for knee pain daily. The resident also had a physician ' s order written on 3/3/15 for a narcotic pain medication, one tablet by mouth every six hours as needed for moderate pain, and two tablets by mouth every six hours as needed for severe pain. A record review of the Electronic Medication Administration Record (eMAR) for the month of	F 309	address any injuries, and resident safety. b) Evaluate resident for any additional injury which would require medical intervention. Evaluation includes but is not limited to: *Vital Signs *Skin Evaluation *Musculoskeletal assessment *Change of Condition *Pain Assessment *Neurological assessment as indicated c) Thoroughly document clinical findings in medical record. d) Interview resident and staff to determine if cause of fall can be determined. e) Notify MD in person or by telephone of all falls, assessment findings and document notification in medical record. f) Notify family (responsible party) and document notification in medical record. g) Complete post fall assessment and formulate interventions based off evaluated clinical information. h) Communicate established interventions to the care giving staff. i) Document post fall every shift for 72 hours.	

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F 309	Continued From page 15 July revealed the daily pain assessment indicating the resident had no pain during the month of July. Additionally, the resident had not received any pain medication during the month of July. A record review of a nurse ' s note written on 8/3/15 at 12:27 am revealed that Nurse #1 heard resident #1 calling for help. The nurse found the resident sitting on the floor next to the bed. The bed was in the lowest position. The resident complained of bilateral knee pain. The resident was unable to explain to the nurse how the fall happened. The nurse reported she notified the physician of the fall as well as the responsible party on 8/3/15 at approximately 1:30 am. A record review of a nurse ' s note written on 8/3/15 at 4:40 am by Nurse # 1 revealed the nurse administered two tablets of a pain medication for severe pain. A record review of a nurse ' s note written on 8/3/15 at 11:42 am by Nurse # 2 revealed a urine sample was collected from Resident # 1 for a urine analysis. Nurse #2 reported she also ordered an x-ray for the bilateral knees due to the swelling the nurse observed and the increased pain the resident was having. A record review of a radiology report dated 8/3/15 at 12:56 pm for Resident #1 revealed the resident had an acute oblique fracture involving the right distal femur with moderate displacement. The left knee resulted in no fracture or dislocation and showed modest osteoarthritis. A record review of a nurse ' s note written on 8/3/15 at 8:21 pm revealed Nurse # 2 administered two tablets of pain medication (Norco 5/325 milligrams) for severe pain. A record review of a nurse ' s note written on 8/3/15 at 10:35 pm revealed Nurse #2 received communication from the weekend nurse (Nurse	F 309	All Certified Nursing Assistants (CNA) were educated by the DON on ability and necessity of completing the Interact Stop and Watch tool on their Point Of Care input screens when they notice a change of condition of the resident. This information automatically shows up on the Point Click Care Clinical Alert Dashboard for the nurses to see (Nurses in-serviced by the DON on 9/02/15). All newly hired Licensed Nurses will be educated by the Staff Development Coordinator (SDC) on post fall assessment and documentation during their orientation period. All newly hired CNAs will be educated by the SDC during their orientation period on ability and necessity of completing the Interact Stop and Watch tool on their Point Of Care input screens when they notice a change of condition of the resident. 3. Systematic Change: The DON and the Unit Managers are responsible for the implementation and monitoring of the Falls Management Program. All fall occurrences will be reviewed ongoing daily (Monday- Friday) at stand up meeting, weekly in Quality Assurance Risk Management meeting by the DON/Unit Managers and the Week-end Supervisor/On Call Administrative Registered Nurse on Saturday and Sunday.	

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F 309	Continued From page 16 #1) that Resident #1 fell and woke up in pain this morning to her bilateral knees. Nurse #2 noted there was swelling to the resident ' s knees. The nurse ordered a bilateral knee x-ray. The nurse reviewed the x-ray and found the result to be negative. A record review of a nurse ' s note written on 8/4/15 revealed Resident # 1 received pain medication on 8/4/15 at 5:00 pm. At 9:45 pm on 8/4/15, the resident received one tablet of pain medication for moderate pain. Resident #1 received one tablet of pain medication for moderate pain on 8/5/15 at 10:00 pm. A record review of a nurse ' s note written on 8/6/15 by Nurse #2 at 12:23 pm revealed Resident #1 was continuing to complain of pain to her left knee. A physician ' s order was written on 8/6/15 by the physician to x-ray the left femur due to increased pain. A record review of a radiology report dated 8/6/15 at 12:04 pm revealed Resident #1 had a recent displaced spiral left femur fracture. A record review of a nurse ' s note written on 8/6/15 at 6:20 pm revealed Resident #1 had a positive x- ray result revealing a fracture to the left femur. The doctor assessed the resident and ordered the resident to be sent to the hospital. The resident was transported to the hospital via stretcher on 8/6/15. The responsible party was made aware of the transfer. A phone interview on 8/19/15 at 3:15 pm was conducted with Nurse #1 who noted the fall on 8/3/15 at 12:27 am. The nurse reported that she called the physician and left a message regarding the fall at approximately 1:00 am. The nurse reported she left a message for the physician that there was no injury and the range of motion did not change for the resident. The nurse also revealed she called the responsible party and left	F 309	Beginning 09/02/15, all residents will be assessed post fall within 24 hours by the facility Unit Manager (UM), Director of Nursing (DON) or Nurse Supervisor. On 09/02/15, the Facility Regional Clinical Director educated UM, DON and Nurse Supervisor on expectation of assessing all residents post fall and documenting assessment findings in medical record. Facility DON, UM or Nurse Supervisor will perform "mock" fall drills twice monthly (across all shifts) for three (3) months to ensure proper Licensed Nurse evaluation, notification, and follow-up of residents post fall. Licensed Nurse will be required to perform a head to toe evaluation and discuss findings of assessment with RN evaluator. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three months, the DON will report "mock" fall drill audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 309	Continued From page 17	F 309		

a message. The nurse reported the resident complained of pain to her knees but she had chronic pain to her knees due to osteoporosis. The nurse added the resident wears pain patches to her bilateral knees for the chronic pain. Nurse # 1 reported she was medicated with two tablets of pain medication (Norco 5/325 milligrams) at 4:40 am for increased pain. The nurse reported she told Nurse #2 that she might need an x-ray due to the increased pain. Nurse # 1 reported there was no increased swelling noted at the time she administered the pain medication.
During an interview on 8/19/15 at 2:15 pm, with Nurse #2, the nurse revealed she ordered an x-ray on 8/3/15 due to the increased pain and swelling the resident had to her knees. The nurse ordered this x-ray at 9:15 am on 8/3/15 per the record review of the physician ' s order. The nurse reported she could not remember if she faxed or called the results in to the doctor. The nurse reported she looked at the results quick and she thinks she faxed it to the doctor, but she could not remember. The nurse further added that she showed the results to the physician on 8/6/15 when the physician was at the facility. The nurse reported the resident was complaining of pain in the left knee and the physician ordered an x-ray on 8/6/15 of the left leg. The nurse was asked what the process was when you order an x-ray with the x-ray company. The nurse reported that first, you order the x-ray by phone, and the x-ray company will come to facility and do the x-ray. The x-ray company will fax the results to the facility. The nurse reported the nurse is to go to the fax machine and get the results or they are delivered to the nurse ' s station by the administrative staff. The nurse was asked why she did not get the results until after 10:00 pm when it was faxed from the x-ray company to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 18	F 309		

facility at 12:57 pm. The nurse replied, sometimes the nurses do not have time; the fax machine is on the other end of the room.

An interview with Nursing Assistant (NA) #1 at 9:35 am on 9/2/15 revealed the NA recalled Resident #1 had complained about pain after the fall on 8/3/15. NA #1 reported it was getting harder to assist her. The resident was a two-person assist with transfers and was only a one person most of the time with activities of daily living (ADL ' s) but after her fall, she needed two people to assist her at all times. The NA noticed swelling to her left leg and reported it to the nurse. The resident stayed in bed on the day shift on 8/3/15 and the resident refused to get out of bed due to her pain. When the resident complained of pain, the NA told the Nurse #2. The NA believes she was medicated with pain medication. The NA reported the resident had a lot of pain when being repositioned. Prior to the fall, the resident would sit at the edge of the bed and bath the upper part of her body. She would get out of bed every day after breakfast and go to activities. The resident liked to be up and out of bed early. The NA did not recall if the resident had any pain prior to the fall.

An interview with NA #2 at 4:27 pm on 9/2/15 revealed when the NA arrived to her shift at 3:00 pm, the resident is up and in her wheelchair. NA #2 revealed she was there the night the resident fell. NA #2 reported the resident slid out of bed. The resident ' s bed was in the lowest position and the wedge was by the bed. The resident complained of leg pain but NA #2 could not remember which leg. The NA could not tell if she had swelling after the fall, but before the fall she was fine, she had no swelling. The NA reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 09/09/2015

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F 309	Continued From page 19	F 309		

the resident fell after shift change. NA # and Nurse #1 assisted the resident back to bed. The NA reported the resident had no complaints of pain at the time that she could recall. The NA reported that Resident #1 did not walk and reported she did not have any complaints of pain prior to the fall on 8/3/15. The NA reported the resident ' s routine was to stay up until after dinner. Around seven or so depending on her mood, she would go to bed. The resident ate dinner in her room. The resident utilized a sit to stand lift to transfer with an assist of two NAs. The resident did not have any complaints of pain during her transfers prior to the fall. The resident did complain of pain after her fall during the transfers. The interventions that were in place were to have the bed in the lowest position and a wedge positioned on her right side while in bed. The resident was complaining of pain on Tuesday 8/4/15 and the NA reports she made Nurse #3 aware. The resident did get out of bed on Tuesday but on Wednesday and Thursday, she was in bed when the NA started the shift at 3:00 pm.

A phone interview with NA #3 on 9/2/15 at 12: 15 pm revealed Resident #1 got up every day using the Sit and Stand Lift. The NA reported she had no complaints of pain and the resident always wanted to get up and get ready to go in the morning. The resident had breakfast in her room and then got ready to go to activities. The resident ate lunch in the dining room. The NA reported that after the fall, she did refuse to get out of bed and she noticed the resident had swelling to her knees. The NA reported she told Nurse #2. The NA said the resident had arthritis and did complain her knees ached, but she wore the patches to help with that.

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F 309	Continued From page 20	F 309		

A phone interview with NA #4 on 9/2/15 at 1:08 pm revealed Resident #1 had a lot of pain after the fall. She did not want to be moved or have anyone touch her legs. The NA reported she told Nurse #2 about her pain and the swelling which the NA observed. The NA reported she does not know what the nurse did, but she knows the nurse went in to see the resident. The NA reported the resident was resting quietly in bed and it was not until you moved the resident, that she said she had pain to her legs.

An interview with Nurse #3 at 3:17 pm on 9/2/15 revealed Nurse #3 (3-11 shift) received change of shift report from Nurse #2 (7-3 shift) on 8/4/15. Nurse #2 reported Resident #1 had a fall on the morning of 8/3/15 and had an x-ray, but it was negative of a fracture. Nurse #3 did not receive in report the resident was having any pain nor did she see the x-ray. Nurse #3 reported on the night of 8/4/15 she assessed the resident when the NA came to her and told her the resident was in pain. The NA had just transferred the resident and was doing incontinent care and the resident was calling out in pain. The NA notified the nurse. The nurse found the resident to be in pain and medicated her with one tablet of Norco 5/325. The nurse reported when she reassessed the resident, she was sleeping. The nurse reported that her bilateral legs did not have any increased swelling. Nurse #3 reported the process when a nurse orders an x-ray is to call the x-ray company. The x-ray company will come to the facility to do the x-ray. The x-ray company will fax the results to the facility. Nurse #3 also added that if the result is positive or there is an abnormal result, the x-ray company would call to speak to the nurse. If it is negative, the x-ray

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 09/09/2015

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F 309	Continued From page 21	F 309		

company sends the fax only. Nurse #3 said she would check the fax machine for results during her shift. If she does not see them, she will call the x-ray company to see if they resulted. Nurse #3 said if the results are positive she would call the doctor and the responsible party with the results. If the results are negative, she faxes the result to the doctor.

An interview with Nurse #4 on 9/2/15 at 10:35 am revealed the resident had no complaints of pain while she worked the night shift on 8/3/15, 8/4/15, and 8/5/15. The nurse reported the resident slept during the night. The nurse reported she saw no increased swelling to her knees but the resident always had swelling to her knees down to her feet and she wore the topical medicated patches for pain due to her osteoporosis. The nurse reported the Salon pas were put on at 8:00 pm and taken off at 8:00 am. Nurse #4 was told by Nurse #2 that she had a fall and an x-ray was done on 8/3 and that the results were negative. Nurse #4 did not see the x-ray results. Nurse #4 reported the process when getting an x ray is to order the x-ray by phone. The x-ray company performs the x-ray and faxes the results. The faxes go to a fax machine at the nurse ' s station. If the results are negative, the nurses fax the result to the doctor. If the results are positive, the nurse calls the physician for further orders. Nurse #4 revealed she did not receive a phone call from the x-ray company informing the nurse of the positive result of the x-ray.

A phone interview was conducted with an employee from the x-ray company at 11:33 am on 9/2/15 regarding the results of Resident #1 ' s x-ray on 8/3. The employee reported the x-ray was done on 8/3 at 12:15 pm and resulted at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 09/09/2015

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F 309	Continued From page 22	F 309		

12:57 pm and faxed to the facility at this time. An interview with the call center supervisor from the x-ray company, reported the result was phoned into (Nurse #4) on 8/5/15. The supervisor further added that the phone call is a courtesy call that the x-ray company does. Sometimes they are very busy and cannot get to it right away but the name of the facility stays up on the call back screen until the x-ray company contacts the facility. The supervisor reported that the x-ray company would only make courtesy calls for positive or abnormal results.

On 9/2/15 at 1:50 pm, the account manager from the x-ray company arrived at the facility. The account manager reviewed the x-ray results from 8/3 and 8/6 and reported she would have a case review done by the x-ray company ' s radiology facility to review the x-ray films again from 8/3/15. . The account manager also confirmed the x-ray company only makes courtesy calls to the facility when the results are positive. They do not call the facility when the result is negative or normal.

On 8/20/15 at 10:45 am, an interview with the Director of Nursing (DON) revealed the expectation of the nurses is to notify the physician immediately when there is a positive diagnostic or lab result via fax or a phone call. The DON reported her expectation is that the nurses also follow up to be sure the physician received the phone call or the fax to see if there are further orders from the physician. The DON further added that her expectation of the nurse is that if the nurse ordered the lab or diagnostic test, they should check the fax room thru out their shift for the result. The DON provided in-services to licensed nurses on all shifts on 8/10/15 that if a fall occurs the nurse on duty would perform the

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	345077	A. BUILDING _____ B. WING _____	C 09/09/2015

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F 309	Continued From page 23	F 309		

following post fall actions:
1. Provide immediate care to address any injuries and resident safety
2. Evaluate resident for any additional injury which would require medical intervention which includes:
>Vital Signs
>Skin Evaluation
>Musculoskeletal assessment
>Change of condition
>Pain Assessment
>Neurological assessment as indicated
3. Thoroughly document clinical findings in medical record
4. Interview resident and staff to determine if cause of fall can be determined
5. Notify MD in person or by telephone of all falls, assessment findings and document in the medical record.
6. Notify family and document notification in medical record
7. Complete post fall assessment and formulate interventions based off evaluated clinical information.
8. Communicate established interventions to the care giving staff
9. Document post fall every shift for 72 hours.

During an interview with the DON and the Administrator, The DON reported at 12:00 pm on 9/2/15 that when the nurses order an x-ray the process is for them to call the x-ray company. The x-ray company performs the x-ray; the results are faxed to the facility. The DON or the secretary will check the fax machine in the morning and deliver any faxes to the nurses if they are sent to their fax machines, or the nurses will receive the result via fax at the nurse ' s

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F 309	Continued From page 24	F 309		

station. The DON added the x-ray company would call the facility and speak to the nurse if they have a positive result.

During an interview on 8/19/15 at 3:00 pm, with the physician, it was revealed she was not aware of the x-ray result on 8/3/15. The physician added that if she had known about the acute fracture to the right femur she would have ordered the facility to send the resident to the hospital right away. The physician recalled being at the facility on 8/6/15 and being told the resident was having knee pain. The physician reported she ordered an x-ray for the resident and it showed a left fractured femur. The physician reported she was shown the x-ray result from 8/3/15 on 8/6/15 by Nurse #2. The physician asked why she was not told about the 8/3/15 result and Nurse #2 reported, she read the upper part of the result and missed the lower part. The physician reported her expectation of the nurses is to report any abnormal diagnostic test or lab value immediately to the doctor via phone or fax.

An interview with the physician was conducted on 9/2/15 at 12:30 pm. The physician was asked if the condition worsened to Resident #1 due to not having the resident evaluated as a result of the x-ray on 8/3/15. The physician suggested that maybe the radiologist missed it if there was no displacement in the fracture. The physician reported that if it was not displaced, the fracture could be hard to see. In addition, she reported that with any kind of repositioning or lifting with a resident with osteoporosis a fracture could occur. The physician recommended speaking to the radiologist to get further clarification of the x-ray on 8/3/15. A record review of the case review form by the x-ray company ' s radiology facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. BUILDING _____ B. WING _____	C 09/09/2015

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F 309	Continued From page 25	F 309		

9/2/15 revealed the exams from 8/6/15 and 8/3/15 were reviewed to determine if the fracture shown on 8/6 was not visible or present on the prior study. The review comment revealed the left femur spiral fracture described on 8/6/15 exam is not visible on images of the left knee on 8/3/15

The physician revealed the resident was sent to the hospital where she had splints placed on both her legs and was transported to another hospital on 8/7/15 where the resident had bilateral surgery to her fractured femurs on 8/8/15.

A phone interview was conducted on 9/9/15 at 10:40 am with the radiologist who read the x-ray results on 8/3/15 of the right knee and the left knee. The radiologist reported that the results on 8/3/15 were accurate. He could not see a fracture to the distal femur. The radiologist reported the 8/3/15 x-ray was also read by another radiologist. The other radiologist confirmed the 8/3/15 results were accurate.

A phone interview was conducted on 9/9/15 at 11:14 am with the radiologist who read the x-ray result on 8/6/15 of the left femur. The radiologist reported that the fracture looks new as it shows no signs of healing. The radiologist felt that the fracture happened within one week.

The administrator was notified of the immediate jeopardy on 9/2/15 at 12:00 pm.
The facility provided an acceptable credible allegation on 9/3/15 at 12:28 pm.

Resident # 1 was found on the floor beside her bed on 8/3/15. The nurse evaluated the resident post fall; finding no injuries, range of motion unchanged with complaint of bilateral knee pain.

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F 309	Continued From page 26	F 309		

An x-ray was completed on 8/3/15 resulting in a right fractured femur. The nurse read the results as negative and did not notify the physician. Resident had increased pain and swelling and a second x-ray was ordered and performed on 8/6/15. The results were positive for a left femur fracture. The resident was sent to the hospital via ambulance and was later admitted to another hospital where orthopedic surgery was performed to bilateral femurs to repair the fractures. The resident did not return to the facility after the surgery. The resident was admitted to another nursing home facility.

All NAs will be educated on the ability and necessity of completing the interact stop and watch tool on
their Point of Care input screens when they notice a change of condition of the resident on 9/2/15. This
information automatically shows up on the Point Click Care Clinical Alert dashboard for the nurses to see.

All nurses were educated on 9/2/15 of the positive confirmation phone call from the x-ray company until the change in procedure occurs on 10/1/15. The new procedure includes a " positive " watermark across the entire page for all positive results.

All newly hired licensed nurses will be educated by the Staff Development Coordinator on post fall assessments and documentation during their orientation period.
The DON and the Unit Managers are responsible for the implementation and monitoring of the Falls Management Program. All fall occurrences will be reviewed ongoing daily (Monday - Friday) at

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F 309	Continued From page 27 stand up meeting, weekly in Quality Assurance Risk Management meeting by the DON/Unit Managers and the Week-end Supervisor/On Call Administrative Registered Nurse on Saturday and Sunday. Beginning 9/2/15 all residents will be assessed post fall within 24 hours by the facility Unit Manager, Director of Nursing or Nurse Supervisor. All other residents were assessed utilizing the 24 hour report, chart reviews, staff interviews and resident observations for changes in condition as a result of a fall on 9/3/15 by the DON. Validation on 9/3/15 at 12:30 pm verified the credible allegation was evidenced by interviews of direct nursing staff related to education on reading and reporting positive x-rays results to the physician as well as accurate assessments and implementing interventions post fall. In-services to NAs and nurses related to falls and completing accurate assessments were implemented on 8/10/15. The DON and Unit Manager verified they will assess post fall residents within 24 hours which was implemented on 9/2/15.	F 309		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		9/22/15

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F 520	Continued From page 28 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facilities ' Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place in July of 2015. This was for a recited deficiency, which was originally cited in July of 2015 on a yearly recertification survey. The deficiency was in the area of notification. The continued failure of the facility since the last survey of record show a pattern of the facilities ' inability to sustain an effective Quality Assurance Program. Findings Included: This tag is cross-referred to: 1. F157: Failure to Notify: Based on record reviews, staff interviews, physician interview and the x-ray company ' s staff interviews, the facility failed to notify the physician of a positive x-ray	F 520	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Interventions for affected resident: An additional Quality Assessment and	

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F 520	Continued From page 29 result of the bilateral knees on 8/3/15 which revealed a fractured right femur for 1 of 3 residents (Resident #1) resulting in delayed medical treatment. The outcome resulted in Resident #1 having orthopedic surgery on 8/8/15 to bilateral fractured femurs. During an interview on 9/3/15 at 9:35 with the Administrator, Regional Clinical Coordinator, and the Director of Nursing, it was stated a quality assurance and performance improvement plan was initiated on 8/10/15 (referring to the 8/3/15 incident). The DON will present audit results to the committee. Audits will be reviewed and the committee will make recommendations to ensure compliance is maintained ongoing. The audit results will be reviewed in monthly quality assurance meeting for a minimum of three months.	F 520	Assurance Committee (QA&A Committee) was held on 9/5/15 to review all audit findings related to Notification of Change in Condition. Director of Nursing presented audits thus far to the committee for review. No issues were identified. Resident # 1 was discharged from the facility on 8/6/15 and has not returned. 2. Interventions for residents identified as having the potential to be affected: Re-education was provided to the facility Quality Assessment and Assurance Committee (QA&A Committee) by the Regional Clinical Director. Education included importance of maintaining an effective QA&A Committee. Education emphasized ensuring the QA &A Committee oversees and identifies all efforts that improve the quality of care in the facility by monitoring performance measures, directing improvement actions by correcting and sustaining compliance and evaluating the effectiveness of quality management activities. 3. Systematic Change: The facility QA&A Committee will meet twice monthly for a minimum of three months to ensure facility QA processes for Change in Condition Notification are reviewed thoroughly and recommendations of quality improvement sustained ongoing. 4. Monitoring of the change to sustain	

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F 520	Continued From page 30	F 520	system compliance ongoing: Twice monthly for a minimum of three months, the DON will report audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	