

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2017
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345534 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 01/25/2017 |
| NAME OF PROVIDER OR SUPPLIER SANFORD HEALTH & REHABILITATION CO | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2702 FARRELL ROAD SANFORD, NC 27330 | | |
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| F 309 SS=D | <p>483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.</p> <p>483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interview the facility failed to provide pain management to one (1) of three (3) residents (Resident #1) after experiencing a fall that resulted in fracture of right hip Finding included: Resident (#1) was admitted to the facility on 12/20/16 with the diagnosis that included generalized muscle weakness, history of fracture to neck of Right femur, hypertension, dementia, anemia, chronic kidney disease and</p> | F 309 | <p>A)Resident #1 no longer resides at the facility.</p> <p>B)All residents have the potential to be affected. A 100% resident audit for complaint of or signs and symptoms of pain was completed on 1/26/17 by the Unit Managers x 2. No concerns were identified. A 100% licensed nurse in-service was initiated by the Director of Nursing on 1/27/17 for pain assessment</p> | 2/17/17 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/13/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 309 | <p>Continued From page 1</p> <p>hyperlipidemia. Review of the most recent MDS assessment dated 12/27/17 indicated Resident #1 required extensive assistance of one staff persons for activities of daily living (ADL ' s) in the areas of bed mobility, transfers and toilet use. The MDS further revealed resident #1 was severely cognitively impaired as evidenced by a brief interview for mental status (BIMS) score of 3.</p> <p>Review of Resident #1 ' s care plan dated 12/29/16 revealed a problem of " Pain " . The goal stated Resident #1 would verbalize relief of pain after receiving prescribed pain medications. The interventions included pain assessment on a scale of 1-10 with use of translator and assessment documented, pain medication administered as ordered, monitor for verbal and nonverbal clues of pain, contact Medical Doctor (MD) on ineffective pain medication to coordinate optimal control of pain, instruct alternate pain management such as relaxation techniques, assess location, frequency duration and intensity of pain and report any noted increased pain trend to MD.</p> <p>Review of incident report dated 1/10/17 revealed Resident #1 had an unwitnessed fall in her room. Resident #1 was observed lying on the floor at bedside, when nurse entered Resident #1 ' s room to administer bedtime (HS) medication. The report indicated Resident #1 had no bruising, skin tears or any signs or symptoms of pain. The incident report indicated a skin assessment and assessment to all extremities was completed.</p> <p>Review of the Electronic Medical Record [EMR] revealed no nursing notes on 1/10/17 and 1/11/17.</p> | F 309 | <p>and documentation to include a follow up assessment for effectiveness of medication administered. All newly hired licensed nurses will receive the in-service in orientation.</p> <p>C)Utilizing a Pain Monitoring QI Tool, the Unit Managers will review progress notes Monday through Friday for documentation for complaints of pain or signs/symptoms of pain to assure interventions were put in place and a follow up assessment was completed post-intervention. Any concerns with documentation will be followed up with the nurse by the Unit Manager(s). The Director of Nursing will review the audit tool weekly x 8 weeks, then monthly x 1 for trends or concerns. The Director of Nursing will review and initial the Audit Tools weekly x 8 then monthly x 1 for trends or concerns.</p> <p>D)The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends, concerns, and the need for continued monitoring.</p> | | |

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| F 309 | <p>Continued From page 2</p> <p>Review of nursing note dated 1/12/17 at 10:17 AM revealed Resident #1 refused restorative care in the morning. The note continued with resident #1 had pain in her left hip.</p> <p>Review of restorative care note dated 1/12/17 at 2:24 PM revealed the Resident #1 had refused to ambulate in the morning and was complaining of pain. Notes further revealed Resident #1 was given a pain pill by the nurse.</p> <p>Review of Resident #1 medication administration record (MAR) dated 1/12/17 revealed no pain medication was administered.</p> <p>Review of Resident #1 pain assessment dated 1/12/17 revealed a score of 0 (no pain) documented for 8 AM and 8 PM.</p> <p>Review of Physician Assistant (PA) note dated 1/13/17 revealed Resident #1 was seen for right leg pain .The note continued with Resident #1 was unable to stand for last couple of days, continued to rub leg in pain, frown and grimaced. The note also revealed Resident #1 was Spanish speaking and through an interpreter Resident #1 admitted to very bad pain in her right hip. Notes further revealed Resident #1 not having any pain control. The PA note indicated an order for Tylenol. If Resident #1 still expressed pain upon stating despite Tylenol, consider other measures. The note further revealed an order for an x-ray of Resident #1 ' s hip.</p> <p>Review of Physician Assistant (PA) order dated 1/13/17 at 12:45 PM revealed administer Tylenol 325mg (milligrams) PO (by mouth) every 6 hours. PRN (as needed) for pain and fever. The order</p> | F 309 | | | |

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| F 309 | <p>Continued From page 3</p> <p>further indicated an x-ray of Resident #1s right hip.</p> <p>Review of Restorative care note dated 1/13/17 at 1:57 PM revealed Resident #1 was complaining of pain on the right side and was not able to stand up with 2 person assist.</p> <p>Review of Resident #1 MAR dated 1/13/17 revealed no pain medication was administered.</p> <p>Review of Resident #1 pain assessment dated 1/13/17 revealed a score of 0 (no pain) documented for 8AM and 8PM.</p> <p>Review of physician order dated 1/14/17 at 1: 46 PM revealed the resident sent to Emergency Department (ED) for evaluation for ambulatory. Record also revealed X-ray of left hip.</p> <p>Review of Radiology report dated 1/14/17 at 2:29 PM revealed images of Resident #1 ' s right hip showed a long linear fracture that appeared acute and extended from the medial aspect of the base of the lesser femoral trochanter distally and laterally to the shaft, just distal to the level of the tip of this stem of the right hip prosthesis. There was trace medial and posterior displacement of the distal fragment. No angulation was seen. Images of the left hip show no evidence of fracture and dislocation. There was osteopenia. Images of the pelvic showed advanced osteopenia without fracture or destructive lesions, there was no definite acute pubic rami fractures or ischial fractures.</p> <p>Review of Physician note dated 1/14/17 at 2:40 PM revealed Resident #1 complaining of left hip pain and right thigh pain, physician was notified</p> | F 309 | | | |

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| F 309 | <p>Continued From page 4</p> <p>by resident ' s nurse. The note continued with resident fell last week and complaining of pain yesterday. Resident family at bedside and wanted ED evaluation.</p> <p>Review of nursing note dated 1/14/17 at 6:44 PM revealed Resident #1 ' s hip x-ray radiology report was sent to the physician. The note also revealed Resident #1 was assessed by the physician and sent to the hospital for further evaluation.</p> <p>Review of Resident #1 pain assessment dated 1/14/17 revealed a score of 0 (no pain) documented for 8 AM. Review of Resident #1 MAR dated 1/14/17 revealed no pain medication was administered.</p> <p>During an interview with restorative aide #2 on 1/24/17 at 3:05 PM, restorative aide #2 stated that she had worked with Resident #1 on 1/7/17 and Resident #1 was not having any pain or discomfort when standing or walking. She further stated that on 1/12/17 Resident #1 was unable to stand and indicated pain by rubbing her hip and refused therapy. She stated that nurse #3 was notified regarding Resident #1 ' s pain and pain medications were administered by the nurse #3.</p> <p>During an interview with Nurse #1 on 1/24/16 at 3:10 PM. Nurse #1 stated that on 1/14/17 the X-ray tech had given her the X-ray results and informed her about Resident #1 fractures. She stated that she informed the medical doctor (MD) about the results. She also stated that Resident #1 was assessed by MD and MD decided to have the Resident #1 evaluated by the ED. She further stated that on 1/14/17, she observed Resident #1 trying to get out of her wheel chair</p> | F 309 | | | |

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| F 309 | <p>Continued From page 5 without any signs of pain or discomfort.</p> <p>During an interview with Nurse #2 on 1/24/17 at 3: 40 PM, nurse stated that on 1/13/17, she had noticed Resident #1 grimace in pain. She stated that the Resident #1 could not stand up and was rubbing her hip. She further stated that she had informed the PA and the PA ordered an x- ray after completing an assessment.</p> <p>An interview with Nurse #3 was conducted via phone on 1/25/17 at 9:25 AM. Nurse #3 stated that she communicated with Resident #1 in Spanish. Nurse #3 stated on 1/12/17 during her shift she was notified by restorative therapy regarding Resident #1 ' s pain and Resident #1 refusing therapy. She further stated that she did not recollect clearly, however she must have given the Resident #1 pain medication if NA ' s reported pain. She also indicated that she was unsure if it was narcotic or Tylenol.</p> <p>An interview with Nurse # 4 was conducted via phone on 1/25/17 at 10:44 AM. Nurse # 4 stated on 1/10/17 during HS med pass she noticed the Resident #1 was on the floor. She stated Resident #1 was lying beside her bed, on her back with legs in front of her. She stated that with the assistance of 2 NA ' s they moved Resident #1 back in her bed. She also stated that an assessment was done and no injuries were noted and Resident #1 was not in any pain. She revealed that Resident #1 was later transferred to a wheel chair and wheeled to the day room. She stated that Resident #1 had not tried to walk much during that shift following the fall. She further indicated that, she did not speak Spanish and Resident#1 usually communicated pain through body language and on 1/10/17 Resident</p> | F 309 | | | |

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| F 309 | <p>Continued From page 6</p> <p>#1 had not shown any signs of pain. She also stated she did not recall any staff notify her of Resident #1 being in pain.</p> <p>During an interview with PA on 1/24/17 at 3:35 PM. PA stated that she was made aware of Resident #1 ' s pain by nursing staff. She stated that she had completed Resident #1 ' s assessment on 1/13/17 with the assistance of a Spanish speaking NA. She also stated that Resident #1 ' s expression indicated pain when PA touched Resident #1 ' s hip. She further stated that the Resident #1 refused to move her leg during the assessment. PA indicated that as a result of her assessment, she had ordered an X-ray.</p> <p>During an interview with the facility Physician on 1/25/17 at 8:54 AM via phone. MD stated that the Resident #1 was Spanish speaking and had advanced dementia. MD indicated that Resident #1 had a behavior disorder and she tried to ambulate without assistance. He further stated that Resident #1 had a right hip fracture due a previous fall. MD also indicated that it was his expectation that if there was concern about pain or movement after a fall, the facility staff should contact physician, so an x-ray could be ordered.</p> <p>During an interview with the Unit Manager on 1/25/17 at 11: 36 AM, Unit Manager indicated that Resident #1 ' s incident report was completed by Nurse #4. She also indicated that nurse #4 had completed an assessment for all extremities and pain assessment for Resident #1. The Unit Manage indicated that she could not locate any documentation for assessments regarding extremities and pain as noted in the incident reports.</p> | F 309 | | | |

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| F 309 | Continued From page 7 During an interview with Unit Manager on 1/25/16 at 2:15 PM, Unit Manager indicated that she was not sure if the Resident #1 was given any pain medication by the nurse as it was not documented. She stated that she did not have documentation to support pain medications administration and pain medications effectiveness. She further stated that it was her expectation that any standing order be transcribed and documented for effectiveness. During an interview with Director of Nursing (DON) on 1/25/17 at 2:30 PM, DON indicated that the 24 hour nursing report on 1/12/17 stated Resident #1 reported pain and pain medication was administered. She stated that the pain assessment on the MAR indicated that Resident #1 was not in pain. The DON also stated that on 1/13/17 and 1/14/17, she called the unit to inquire if Resident #1 was in pain. She stated that she was informed by the Nurse on duty that Resident #1 was not in any pain nor was showing any signs of discomfort. She further indicated that on 1/13/17, the Nurse on duty had informed the PA that the Resident #1 was not ambulating for a couple of days and wanted the physician to check on the resident. The DON stated that she was unaware of Resident #1 having any pain or change in range of motion. She stated that when a resident had a fall, it is her expectation that nurse completed an assessment to include pain and documented for 3 day as a follow up for falls. She stated she expected pain medications be transcribed, given as ordered and effectiveness document. The DON expected that the MD be made aware of any significant change so that Physician can assess residents as needed. The DON indicated that she could not locate any | F 309 | | | |

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| F 309 | <p>Continued From page 8</p> <p>documentation to support the Resident #1 pain was assessed other than the assessments completed at 8 AM and 8 PM on the MAR.</p> <p>During an interview with the Administrator on 1/25/17 at 3:21 PM, revealed that when NA reports of resident is in pain, he expected nurses to complete a pain assessment and take action as needed. He also stated that it was his expectation that any resident with fall, Nurses should notify the MD. He stated that it was his expectation that when a resident was administered medication, it should be documented and staff should reevaluate the resident for effectiveness of the medication.</p> <p>Review of hospital records dated 1/14/17 revealed Resident #1 was sent to the Emergency Department and orthopedic evaluation for bilateral leg pain on 1/14/17 at 3:12 PM. Records indicated that Resident # 1 presented with an injury and pain that was acute. Records also indicated Resident # 1 complained of pain related to left and right leg and was aggravated with movement and weight bearing. Severity of symptoms for Resident #1 were moderate. Bilateral hip and pelvic x-rays were performed. Resident #1 had a history of right hip arthroplasty. X-ray read was right hip oblique fracture involving prosthesis and cortical irregularity in the base of the femoral head of left hip suggestive of impacted subcapital fracture. Resident #1 was not a candidate for surgery due to advanced age and comorbidities. Resident #1 was treated with PRN Norco for pain and conservative treatment for fractures.</p> | F 309 | | | |