STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and physician interview, the facility failed to complete and submit an initial report (24 hour report) and investigation report (5 day report) to the State Agency of a femur fracture of unknown origin for 1 of 1 resident (Resident #1) reviewed for an injury of unknown origin.	F 609	F609 1. Event was investigated 8/12/19 by DHHS surveyor for resident # 1. 2.All residents have potential to be affected by this deficient practice. 100%	8/20/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/16/2019

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 609	Continued From page 1 Findings included: Resident #1 was admitted to the facility on 9/13/16. Review of a Quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 5/7/19 revealed Resident #1 was severely cognitively impaired and displayed no behaviors or rejection of care. All activities of daily living, except eating, required total assistance and there were no limb impairments. Active diagnoses included, but were not limited to, Alzheimer's disease, non-Alzheimer's dementia, dementia with behavioral disturbance, and Vitamin D deficiency. There were no falls documented since admission. Review of a progress note signed by the Director of Nursing (DON) and dated 8/1/19 read, in part, "A change in condition has been noted. The symptoms include: Other change in condition-Yellow bruising with approx. quarter sized purple bruise (R) (right) thigh to calf, pain with movement." Review of the radiology results dated 8/2/19 read, in part, "Results: There is an acute angulated oblique fracture of the distal femoral metaphysis without obvious intra-articular extension. Bones are markedly osteopenic and there is soft tissue swelling. There is no bone destruction. SFA (Superficial Femoral Artery) calcifications are prominent. Conclusion: "Acute fracture distal right femur." Review of a progress note signed by the Family Nurse Practitioner (FNP) and dated 8/2/19 read, in part, "Chief Complaint / Nature of Presenting	F 609	audit of all events that have occurred in the last 30 days will be reviewed by the Center Executive Director (CED),and/or Center Nurse Executive (CNE), and /or Unit Managers (UM) to ensure all events that are required to be reported to the state have been reported. 3. On 8/13/19 Regional Nurse provided education to CED, CNE and UM on the process for completing a thorough investigation after each event and reporting results to State Survey Agency, within 5 working days of the event and if the alleged violation is verified appropriate corrective action must be taken. Events will be reviewed by the clinical Leadership team 5 x weekly in Clinical Morning Meeting using the Event Tracking Log to ensure that any event that should be reported to the State Survey Agency has been or will be reported . 4. Regional Nurse will audit events weekly x 4 weeks to ensure complete and thorough investigations are completed and reported to State Survey Agency if required. Results of these audits will be shared with CED to report at the Quality Assurance and Performance Improvement (QAPI) Committee monthly with QAPI Committee responsible for ongoing compliance.	

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Problem: (Resident #1) seen for right hip and leg pain. History of Present Illness: (Resident #1) who has been here since Sept 2016 due to dementia. Staff has to help her with transfer, feeding, incontinent care, bathing, and dressing. Her (family member-FM) is in and tells me for last 3 days resident has had pain in her right hip/leg and she feels there is something wrong with her leg. Resident has not had any fall(s) per staff report. Resident does admit pain when asked. Physical Exam General: Lying in bed, alert, oriented to person only. Edema to right knee area, no warmth. Does grimace if try to move her leg. Musculoskeletal: Tenderness with palpation to right hip knee. Diagnosis and Assessment: Right hip pain Right knee pain, unspecified chronicity. Dementia in other diseases classified elsewhere without behavioral disturbance Advanced care planning/counseling discussion Plan: Right hip/knee pain: X-ray right hip knee and femur. Advanced dementia: supportive care. There is an acute angulated oblique fracture of the distal femoral metaphysis without obvious intra-articular extension. Bones are markedly osteopenic and there is soft tissue swelling. There is no bone destruction. SFA calcifications are prominent. Conclusion: Acute fracture distal right femur."

An interview was conducted with Resident #1's alert and oriented roommate on 8/12/19 at 4:00PM. She stated she had never witnessed Resident #1 fall and Resident #1 was never dropped by staff while being transferred with a lift.

An interview was conducted with a Nursing Assistant (NA #1) on 8/12/19 at 4:20PM. She stated she frequently cared for Resident #1 who

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required total care for all activities of daily living. She also stated to her knowledge Resident #1 had never fallen.

An interview was conducted with Nurse #1 on 8/12/19 at 4:30PM. She stated she had not received any reports of Resident #1 falling or being dropped while in the lift. She also stated Resident #1 required total assistance for all activities of daily living.

An interview was conducted with the DON on 8/13/19 at 7:45AM. She stated, "When an injury is found on a resident we assess the injury and resident and try to find a root cause. We notify the MD (Physician) or FNP and follow any orders they give. We interview staff for as far back as necessary. If an origin cannot be found we report it to the State within 2 hours if it's a significant injury and further the investigation with staff, witness, therapy, and all direct care staff interviews. We also interview ancillary staff like housekeeping and all other non-direct care staff. A fractured femur would be considered a significant injury. When we were notified about (Resident #1's) bruising I went in and assessed her leg. There was yellow bruising from mid-thigh to mid-calf and a dark spot directly behind her knee in the popliteal region. When her leg was touched she grimaced and winced so we called the doctor and got an order for an x-ray. We interviewed staff and during the 'investigation' we found out she was a lift transfer only. The bruising fit the parameters of the lift pad/sling. This was before the x-ray resulted. After the x-ray resulted and we found out she had a facture we spoke to (FNP) and she said (Resident #1) was 'eaten up' with osteopenia and just movement could result in a fracture. So we thought we had a cause for

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her injury."

An interview was conducted with the FNP, on 8/13/19 at 8:30AM. She stated, "I saw (Resident #1) on Friday and she was in her usual state of health. She had advanced dementia so she had good days and bad. Sometimes she would talk to you sometimes she wouldn't. On Friday, she had bruising to the posterior side of her right lower extremity. I asked staff about any injuries or falls and they said no. She was only transferred with a lift so she had not gotten out of bed on her own. She never attempted to get out of bed independently. The x-ray showed a fractured femur. It looks like it was pathological not mechanical, but a radiologist would be better to ask. She had extensive osteopenia. In fact, she wore a cervical collar because she had no boney structure r/t osteopenia to support her head and neck so the cervical collar kept her in cervical alignment."

An interview was conducted on 8/13/19 at 9:40AM with NA#2. She stated, "I typically cared for (Resident #1). We didn't get her out of bed at all on 3rd shift and I don't know of any falls. No one reported she had any falls." She also stated Resident #1 was total care for all activities of daily living.

An interview was conducted with Nurse #2 on 8/13/19 at 9:46AM. She stated, "I work the 7:00PM-7:00AM shift and took care of (Resident #1). I work every Saturday, Sunday, and Monday and I didn't receive any reports about her falling or being dropped." She also stated Resident #1 was total care for all activities of daily living.

An additional interview was conducted with the

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DON on 8/13/19 at 1:05PM. "Any time there is an allegation of abuse (neglect, physical, mental, misappropriation) we immediately initiate an investigation. (The Administrator) is notified, and a 24 hour report (initial allegation) is sent to the State. We start the investigation. We assess for any injuries, changes in mental state, and notify the MD based on the assessment. Then we interview staff and other residents who are interviewable. If it's on one particular hall we interview residents on that hall. Based on the findings we make a decision about substantiated vs. (versus) unsubstantiated. We send the 5 day report (investigation report) in to the state after the investigation. With injuries of unknown origin we will initiate a 24 hour report and investigate as stated above. If there's serious injury we have to report it within 2 hours to the state. A femur fracture is a serious injury. We did not make a report to the state because when we started our investigation she (Resident #1) was only bruised and we obtained orders for x-ray. The x-ray showed a femur fracture. We did not report it to the state then because the FNP said it was because of osteopenia and just movement could have caused the fracture. The resident could not tell us how she was injured. There were no witnesses to what happened. We cannot say how exactly the injury occurred so we should have filed a report with the state."

An interview was conducted with the Administrator on 8/13/19 at 1:22PM. He stated, "When we get a report of abuse we go back and find out if there was actual evidence of immediate abuse. If so, we report it within 2 hours. If there's no bruising or any signs to lead us to believe there was abuse we begin our investigation. We ask staff and the roommate if they're alert and

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oriented about being abused. If there was an injury of unknown source then we would report it. If it's physical abuse we call the police. If they were complaining of physical abuse or anything of that nature of course we'd start the investigation and file a report within 24 hours. Then we investigate and file our report in 5 days. Nursing will look at bruising and nursing would look at the MAR (Medication Administration Record) for any medications that could have caused bruising. With Resident #1 we had been planning for a power outage drill with (Energy Company) last Thursday so we were here Thursday night. While we were going around the facility, our DON and ADON (Assistant Director of Nursing) had found a bruise on (Resident #1) right around the hip area. It extended down into the leg. I'm not exactly sure how far it extended. The DON started talking to the NA's about anything they had seen or heard. The NA's said she did cry out a little bit when they turned her so (DON) ordered an x-ray. They did say the bruise fit exactly in the sling/pad area and matched the lift sling pattern. The next day they got the x-ray results back and (DON) called me and said there was a femur fracture and while she was talking to me she was talking to the NP and the NP said she had a lot of osteopenia and that was probably what caused the break. The NP said even moving her in the bed could cause a break. So we had already determined we felt 100% sure the bruise had come from the sling. We felt like that was the cause so we didn't feel we needed to report it at that time. The resident was not able to tell us how the injury occurred. Once we heard about the osteopenia and heard about the bruise we were pretty confident there was no incident of a fall. And then, if I'm not mistaken (DON) spoke to the roommate and the roommate said she hadn't

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F 609	Continued From page 7 fallen. I feel 100% certain I made the right decision in not reporting this." He also stated nursing administration (the DON, ADON, or Unit Manager) were responsible for completing incident reports. An interview was conducted on 8/13/19 at 6:35PM with a Radiologist from the x-ray company used by the facility. He stated Resident #1's right femur fracture appearance was not consistent with an impaction fracture as would be seen with a fall from a significant height. He stated it was more of a twisting or bending action based on the displacement and angulation of the fracture.	F 609		