STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING _____ B. WING _____	C 09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=G	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 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 upon family, physician and staff interviews and record reviews, the facility failed to notify a	F 157	CROASDAILE VILLAGES RESPONSE TO THIS 2567 DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE OR THAT A DEFICIENCY EXISTED. WE ARE FILING THE POC TO MEET THE REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAW. CROASDAILE VILLAGE RESERVES THE RIGHT TO REFUTE ANY DEFICIENCIES ON THIS 2567 THROUGH THE INFORMAL DISPUTE RESOLUTION OR FORMAL APPEAL PROCESS. • **F157: NOTICE OF CHANGES (INJURY/DECLINE/ROOM, ETC.)** **RESIDENTS AFFECTED BY ALLEGED DEFICIENT PRACTICE** ONE OF THE THREE RESIDENTS REVIEWED WERE AFFECTED BY THE CITED DEFICIENCY. THE FOLLOWING ITEMS WERE PUT INTO PLACE FOR RESIDENT #1: 1. X-RAY ORDERED ON 9/14/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Denise Goodwin-Baker — TITLE: DON — (X6) DATE: 10/14/11

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 157	Continued From page 1 resident ' s legal representative and physician of a wrist fracture requiring physician intervention for 1 of 3 Residents (Resident #1) with a change in condition. Findings Include: Resident #1 was admitted to the facility on 8/26/11 with diagnoses of dementia, stroke, anxiety, and peripheral neuropathy. The minimum data set dated 9/6/11 indicated Resident #1 had a low mental status. She required limited to extensive assistance with ambulation, transfer and activities of daily living. Her balance was indicated as unsteady and she exhibited wandering behaviors. The care plan dated 9/7/11 indicated Resident #1 as a fall risk and exhibited episodes of wandering behavior. There were interventions documented for the fall risk and wandering behavior. A record review of the facility fall report for Resident #1 was conducted. It indicated a fall occurred on 9/13/11 at 3:30pm. There were no injuries indicated. Resident #1 vital signs were obtained. The contributing factors to the fall were decline in cognition. An interview with Nurse #1 on 9/28/11 at 3:00pm revealed she worked the day of the fall on 9/13/11. Nurse #1 indicated Resident #1 was unsteady and gets up frequently without her walker. Nurse #1 indicated her vitals were taken and the physician was notified the day of the fall. Nurse #1 checked Resident #1 from her toes up to her arms. She asked Resident #1 to wiggle her fingers. Resident #1 did not complain of pain. Nurse #1 did not notice any swelling or bruising.	F 157	2. FALLS COMMITTEE REVIEWED FALL AND RECOMMENDED SUPERVISION IN COMMON AREAS ON 9/14/11. 3. MDS WAS REVIEWED AND CNA CARE GUIDE WAS UPDATED ON 9/14/11. 4. THERAPY REFERRAL AND EVALUATION WAS COMPLETED ON 9/15/11. 5. WRIST SPLINT APPLIED ON 9/15/11. 6. PHARMACY CONSULTANT REVIEWED MEDICATIONS FOR RESIDENT #1 ON 9/16/11. **RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** ALL RESIDENTS HAVE THE POTENTIAL OF BEING AFFECTED BY THIS DEFICIENCY. AN AUDIT OF RESIDENTS WHO HAVE FALLEN OVER THE PAST 30 DAYS WAS COMPLETED TO ENSURE THAT THE PHYSICIANS AND RESPONSIBLE PARTIES WERE NOTIFIED OF ALL	

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F 157	Continued From page 2 She indicated Resident #1 was monitored throughout the shift. A record review of the nurse notes was conducted. The nurse note dated 9/13/11 at 3:30pm indicated Resident #1 was found on the floor in the door way of Room 129. There were no injuries or pain indicated. At 8:10pm the Family Member #1 was notified of the fall. At 8:20pm the physician was notified of the fall and no new orders was indicated. The nurse note dated 9/14/11 at 2:10pm indicated the falls committee recommended keeping the resident in supervised areas when awake. It indicated Family Member #2 came to the facility that afternoon and saw Resident #1 wrist swollen. Family Member #2 wanted an x-ray of the left wrist. The physician was notified for an x-ray to be conducted on the left wrist and hand. The x-ray results were indicated as moderate osteoarthritis of the left hand but no fractures present. The results were reported to Family Member #1. An interview with Family Member #2 on 9/29/11 at 12:00pm revealed Family Member #1 was notified of the fall on 9/13/11 and was told there were no injuries. Family Member #2 visited the facility on 9/14/11 around 1:30pm. She noticed Resident #1 was sitting in a wheelchair across from the nurse station. Resident #1 was leaning over sweeping her hands across the floor. Family Member #2 bent over and barely touched Resident #1 left wrist to get her attention. Upon contact with the left wrist, Resident #1 yelled out " That hurts. " Family Member #2 then noticed the left wrist was swollen and misshapen. There was a bruise and cut on the elbow. The cut had dried up blood on it. She indicated to the Nurse	F 157	CHANGES IN THE RESIDENTS CONDITION. ANY COMPLIANCE ISSUES FOUND IN THESE AUDITS WAS ADDRESSED BY THE DON AND QA COMMITTEE. (ATTACHMENT #1). **SYSTEMIC CHANGES MADE TO ENSURE THAT THE ALLEGED DEFICIENT PRACTICE WILL NOT OCCUR:** INSERVICE WAS CONDUCTED ON OCTOBER 5th and 6th, 2011 WITH ALL NURSES. TOPICS INCLUDED: 1. PROPER NOTIFICATION OF PHYSICIANS AND FAMILY MEMBERS. 2. EPISODIC DOCUMENTATION POLICY. 3. EVENT REPORTING POLICY. 4. FALLS MANAGEMENT POLICY. 5. 72 HOUR EVENT FOLLOW-UP FORM COMPLETION. 6. C.N.A. CARE GUIDE COMPLETION. 72 HOUR EVENT FOLLOW UP FORM IMPLEMENTED TO ASSESS RESIDENT SKIN, PAIN, AND VITAL SIGNS FOLLOWING AN EVENT. (ATTACHMENT #2)	10/6/11

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F 157	Continued From page 3 to come over and view the wrist. The Nurse wanted to compare both wrists. Family Member #2 indicated the nurse decided not to implement anything for the wrist. Family Member #2 then requested an x-ray be conducted. The x-ray report was reported as negative for fractures to Family Member #1. Family Member #2 had then talked to Nurse #3 on 9/14/11 after the x-ray results. Family Member #2 felt there was something wrong with the wrist despite the x-ray results due to the increased swelling, bruising and pain. Family Member #2 indicated Nurse #3 reinterred the results only showed arthritis. Family Member #2 then requested the physician come by to see Resident #1 about the wrist. An interview with Nurse #3 on 9/28/11 at 3:28pm indicated Resident #1 family complained to her about the left arm being swollen and painful on 9/14/11. An x-ray was then requested around 6:00pm. The x-ray results came back around 8:00pm. Nurse #3 indicated she read the x-ray results. She only saw that Resident #1 had arthritis to the left hand. She called the family and notified them the results were negative. Nurse #3 revealed she had misread the results. She indicated when a positive or out-of-range test resulted, the physician should be called. The medication, Tylenol was given to Resident #1 due to the family had complained of pain. A record review of the x-ray report dated 9/14/11 indicated modest osteoarthritis of the left hand but no fracture or dislocation. The left wrist was indicated to have an acute fracture. An interview with Nurse #4 on 9/29/11 at 3:37pm revealed she was working the third shift on	F 157	QUALITY ASSURANCE COMMITTEE IMPLEMENTED AUDIT TOOL TO FOLLOW UP ON COMPLIANCE. (ATTACHMENT #1) **MONITORING FACILITY PERFORMANCE** THE QUALITY ASSURANCE COMMITTEE WILL BE CHARGED WITH THE RESPONSIBILITY TO ENSURE THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE DIRECTOR OF NURSING AND DESIGNATED QUALITY ASSURANCE REPRESENTATIVES WILL CONDUCT 10 AUDITS EACH MONTH FOR RESIDENTS WHO HAVE FALLEN TO VERIFY THE COMPLETION OF PROPER NOTIFICATIONS. THE DIRECTOR OF NURSING WILL REPORT HER FINDINGS TO THE QUALITY ASSURANCE COMMITTEE ON A MONTHLY BASIS FOR FURTHER REVIEW AND CORRECTIVE ACTION. THE QUALITY ASSURANCE COMMITTEE WILL MONITOR UNTIL COMPLIANCE IS ACHIEVED. THE QUALITY ASSURANCE COMMITTEE HAS THE AUTHORITY TO DISCONTINUE MONITORING ONCE THEY ARE CONFIDENT THAT THE CITED DEFICIENCY IS RESOLVED. (PLEASE SEE AUDIT TOOL-ATTACHMENT #1).	

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F 157	Continued From page 4 9/13/11 and 9/14/11. Nurse #4 indicated she received a report from Nurse #3 that the x-ray results were negative for fractures. There was no description of her arm reported. Later the evening of 9/14/11, she was getting paper work prepared and came upon the x-ray report in the physician ' s mailbox. Nurse #4 saw the x-ray report and noticed there was a fracture present. She did not call the physician. She did report the fracture to the next shift Nurse, Nurse #2. Nurse #4 indicated she should have called the physician regarding the x-ray results. An interview with Nursing Assistant (NA) #1 on 9/28/11 at 5:36pm revealed she was working the second shift on 9/14/11. She indicated Resident #1 was sitting out in front of the nursing station throughout most of her shift. She noticed Resident #1 had been more agitated after her fall. An interview with NA #2 on 9/29/11 at 10:12am revealed she was assigned to Resident #1 for 9/13/11, 9/14/11, and 9/15/11 on day shifts. On 9/15/11 at 7:00am she noticed swelling and discoloration to the left arm. She reported this to Nurse #2. Resident #1 was eating lunch around 11:30am on 9/15/11. NA #4 saw a hot dog was placed in Resident #1 left hand. Resident #1 dropped the hot dog onto the plate as if she might have been in pain and could not hold the hot dog. The Nurse #2 note dated 9/15/11 at 10:30am indicated there was edema to the left wrist. The color of the left wrist was purple and blue with warmth to the touch. The resident was brought back to bed. At 12:30pm Resident #1 was seen by the physician after reviewing the x-ray report. An order was sent for Resident #1 to go to an	F 157		

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F 157	Continued From page 5 orthopedic clinic for a fracture to the left wrist. An interview with Nurse #2 on 9/28/11 at 3:21pm revealed a third shift nurse reported to her that an x-ray was obtained on Resident #1 arm on 9/15/11. There were no results reported to her regarding the x-ray. The third shift nurse also indicated to her the family had complained about Resident #1 left arm being painful and swollen. Nurse #2 then went to check Resident #1 arm. She indicated Resident #1 left arm was swollen and bruised. On 9/15/11, Nurse #2 noticed the physician was in use of Resident #1 medical chart and was viewing what appeared to be a piece of paper in his hand. She assumed that the Physician was probably looking at the x-ray report in his hand. She concluded the physician was going to see Resident #1 and did not report the physical changes in Resident #1 arm. She indicated the physician was there for his regular weekly visit. The physician did see her and noticed the x-ray report indicated a fracture. A record review of the facility 24-hour report was conducted from 9/13/11 through 9/15/11. There was an indication of a fall without injuries on 9/13/11. There was an indication of a negative result for the left wrist x-ray on 9/14/11. There was then an indication of a fracture to the left wrist during the day shift on 9/15/11. A record review of the physician progress notes was conducted. The physician note dated 9/15/11 indicated Resident #1 had a fall two days ago and sustained an injury to her left wrist. There was swelling and tenderness with bruising. The physician indicated the x-ray showed a	F 157		

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F 157	Continued From page 6 fracture of the distal radius. Resident #1 was to be sent to an orthopedic clinic for evaluation. The physician note dated 9/22/11 indicated Resident #1 has been more agitated since her fall. An interview with the physician on 9/28/11 at 4:37pm revealed he received an email of no injuries regarding the x-ray. He indicated he visits the facility every Thursday for his regular rounds. There were no reports to him regarding bruising, pain or swelling of the arm. Upon his regular visit, he pulled the x-ray report from his mailbox and saw Resident #1 had a fracture of the left wrist. He visited Resident #1 for an examination of the left arm. He reported the arm was swollen with bruising. When he touched Resident #1 left arm, she snatched back her arm away from him. The physician sent Resident #1 to the orthopedic clinic after the examination. An interview with Family Member #1 on 9/28/11 at 5:05pm revealed Family Member #1 met with the Director of Nursing (DON) and Administrator on 9/27/11. They admitted to Family Member #1 that the x-ray results were misread. An interview with the DON on 9/29/11 at 12:32pm revealed she was notified of the fall on 9/14/11 by viewing the incident report. She indicated when there is a fall or injury; it should be reported on the incident sheet and to the physician. If an injury was noticed or suspected after the fall, an x-ray should have been obtained. When the x-ray reports are received with positive findings of a fracture, the physician should be contacted immediately.	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	• **F309: PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**	

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F 309	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based upon staff, physician and family interviews and record reviews, the facility failed to identify, assess and report a fractured wrist for 1 of 3 Residents Sampled (Resident #1). Findings Include: Resident #1 was admitted to the facility on 8/26/11 with diagnoses of dementia, stroke, anxiety, and peripheral neuropathy. The minimum data set dated 9/6/11 indicated Resident #1 had a low cognitive status. She required limited to extensive assistance with ambulation, transfer and activities of daily living. Her balance was indicated as unsteady and she exhibited wandering behaviors. The care plan dated 9/7/11 indicated Resident #1 as a fall risk and exhibited episodes of wandering behavior. There were interventions documented for the fall risk and wandering behavior. A record review of the facility fall report for Resident #1 was conducted. It indicated a fall occurred on 9/13/11 at 3:30pm. There were no injuries indicated. Resident #1 vital signs were obtained. The contributing factors to the fall were	F 309	**RESIDENTS AFFECTED BY ALLEGED DEFICIENT PRACTICE** ONE OF THE THREE RESIDENTS REVIEWED WERE AFFECTED BY THE CITED DEFICIENCY. THE FOLLOWING ITEMS WERE PUT INTO PLACE FOR RESIDENT #1: 1. X-RAY ORDERED ON 9/14/11. 2. MDS WAS REVIEWED AND CNA CARE GUIDE WAS UPDATED ON 9/14/11. 3. THERAPY REFERRAL AND EVALUATION WAS COMPLETED ON 9/15/11. 4. WRIST SPLINT APPLIED ON 9/15/11. 5. PHARMACY CONSULTANT REVIEWED MEDICATIONS FOR RESIDENT #1 ON 9/16/11. 6. SOCIAL WORKER BEGAN MONITORING RESIDENT #1 FOR ANY PSYCHOSOCIAL CHANGES ON 9/15/11 TO ENSURE RESIDENTS OVERALL WELL-BEING .	

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F 309	Continued From page 8 decline in cognition. An interview with Nurse #1 on 9/28/11 at 3:00pm revealed she worked the day of the fall on 9/13/11. Nurse #1 indicated Resident #1 was unsteady and gets up frequently without her walker. Nurse #1 indicated her vitals were taken and the physician was notified the day of the fall. Nurse #1 checked Resident #1 from her toes up to her arms. She asked Resident #1 to wiggle her fingers. Resident #1 did not complain of pain. Nurse #1 did not notice any swelling or bruising. She indicated Resident #1 was monitored throughout the shift. A record review of the nurse notes was conducted. The nurse note dated 9/13/11 at 3:30pm indicated Resident #1 was found on the floor in the door way of Room 129. There were no injuries or pain indicated. At 8:10pm the Family Member #1 was notified of the fall. At 8:20pm the physician was notified of the fall and no new orders was indicated. The nurse note dated 9/14/11 at 2:10pm indicated the falls committee recommended keeping the resident in supervised areas when awake. It indicated Family Member #2 came to the facility that afternoon and saw Resident #1 wrist swollen. Family Member #2 wanted an x-ray of the left wrist. The physician was notified for an x-ray to be conducted on the left wrist and hand. The x-ray results were indicated as moderate osteoarthritis of the left hand but no fractures present. The results were reported to Family Member #1. An interview with Family Member #2 on 9/29/11 at 12:00pm revealed Family Member #1 was	F 309	**RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** ALL RESIDENTS MAY HAVE THE POTENTIAL OF BEING AFFECTED BY THIS DEFICIENCY. **SYSTEMIC CHANGES MADE TO ENSURE THAT THE ALLEGED DEFICIENT PRACTICE WILL NOT OCCUR:** INSERVICE WAS CONDUCTED ON SEPTEMBER 20, 2011 WITH ALL NURSES. TOPICS INCLUDED: 1. X-RAY REPORT REVIEW AND VERIFICATION WITH PHYSICIAN 2. SKIN ASSESSMENT COMPLETION 3. 72 HOUR EVENT FOLLOW-UP DOCUMENTATION 4. DOCUMENTING SKIN ISSUES IN CARETRACKER 5. ASSESSING FOR PAIN, SWELLING, AND BRUISING ON EACH SHIFT FOLLOWING AN EVENT.	10/13/11

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F 309	Continued From page 9 notified of the fall on 9/13/11 and was told there were no injuries. Family Member #2 visited the facility on 9/14/11 around 1:30pm. She noticed Resident #1 was sitting in a wheelchair across from the nurse station. Resident #1 was leaning over sweeping her hands across the floor. Family Member #2 bent over and barely touched Resident #1 left wrist to get her attention. Upon contact with the left wrist, Resident #1 yelled out " That hurts. " Family Member #2 then noticed the left wrist was swollen and misshapen. There was a bruise and cut on the elbow. The cut had dried up blood on it. She indicated to the Nurse to come over and view the wrist. The Nurse wanted to compare both wrists. Family Member #2 indicated the nurse decided not to implement anything for the wrist. Family Member #2 then requested an x-ray be conducted. The x-ray report was reported as negative for fractures to Family Member #1. Family Member #2 had then talked to Nurse #3 on 9/14/11 after the x-ray results. Family Member #2 felt there was something wrong with the wrist despite the x-ray results due to the increased swelling, bruising and pain. Family Member #2 indicated Nurse #3 reinterred the results only showed arthritis. Family Member #2 then requested the physician come by to see Resident #1 about the wrist. An interview with Nurse #3 on 9/28/11 at 3:28pm indicated Resident #1 family complained to her about the left arm being swollen and painful on 9/14/11. An x-ray was then requested around 6:00pm. The x-ray results came back around 8:00pm. Nurse #3 indicated she read the x-ray results. She only saw that Resident #1 had arthritis to the left hand. She called the family and notified them the results were negative.	F 309	INSERVICE WAS CONDUCTED ON OCTOBER 5, 2011 WITH ALL NURSES. TOPICS INCLUDED: 1. PROPER NOTIFICATION OF PHYSICIANS AND FAMILY MEMBERS. 2. EPISODIC DOCUMENTATION POLICY. 3. EVENT REPORTING POLICY. 4. FALLS MANAGEMENT POLICY. 5. 72 HOUR EVENT FOLLOW-UP DOCUMENTATION 6. C.N.A. CARE GUIDE DOCUMENTATION TEAM MEETING HELD ON OCTOBER 11, 2011 WITH ALL NURSING TEAM MEMBERS. TOPICS INCLUDED: 1. COMPLAINT SURVEY FINDINGS 2. POST FALL ASSESSMENTS 3. 72 HOUR REPORT DOCUMENTATION	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345501	A. BUILDING _____ B. WING _____	C 09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROASDAILE VILLAGE	2600 CROASDAILE FARM DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 Nurse #3 revealed she had misread the results. She indicated when a positive or out-of-range test resulted, the physician should be called. The medication, Tylenol was given due to the family had complained of pain. A record review of the x-ray report dated 9/14/11 indicated modest osteoarthritis of the left hand but no fracture or dislocation. The left wrist was indicated to have an acute fracture. An interview with Nurse #4 on 9/29/11 at 3:37pm revealed she was working the third shift on 9/13/11 and 9/14/11. Nurse #4 indicated she received a report from Nurse #3 that the x-ray results were negative for fractures. There was no description of her arm reported. Later the evening of 9/14/11, she was getting paper work prepared and came upon the x-ray report in the physician ' s mailbox. Nurse #4 saw the x-ray report and noticed there was a fracture present. She did not call the physician. She did report the fracture to the next shift Nurse, Nurse #2. Nurse #4 indicated she should have called the physician regarding the x-ray results. An interview with Nursing Assistant (NA) #1 on 9/28/11 at 5:36pm revealed she was working the second shift on 9/14/11. She indicated Resident #1 was sitting out in front of the nursing station throughout most of her shift. She noticed Resident #1 had been more agitated after her fall. An interview with NA #2 on 9/29/11 at 10:12am revealed she was assigned to Resident #1 for 9/13/11, 9/14/11, and 9/15/11 on day shifts. On 9/15/11 at 7:00am she noticed swelling and discoloration to the left arm. She reported this to	F 309	4. PHYSICIAN/FAMILY NOTIFICATION 5. OVERALL DOCUMENTATION 72 HOUR EVENT FOLLOW UP FORM IMPLEMENTED TO ASSESS RESIDENT SKIN, PAIN, AND VITAL SIGNS FOLLOWING AN EVENT. (ATTACHMENT #2) QUALITY ASSURANCE COMMITTEE IMPLEMENTED AUDIT TOOL TO FOLLOW UP ON COMPLIANCE. (ATTACHMENT #1) **MONITORING FACILITY PERFORMANCE** THE QUALITY ASSURANCE COMMITTEE WILL BE CHARGED WITH THE RESPONSIBILITY TO ENSURE THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE DIRECTOR OF NURSING AND DESIGNATED QUALITY ASSURANCE REPRESENTATIVES WILL CONDUCT 10 AUDITS EACH MONTH FOR RESIDENTS WHO HAVE FALLEN TO VERIFY THE COMPLETION OF PROPER NOTIFICATIONS. THE DIRECTOR	

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F 309	Continued From page 11 Nurse #2. Resident #1 was eating lunch around 11:30am on 9/15/11. NA #4 saw a hot dog was placed in Resident #1 left hand. Resident #1 dropped the hot dog onto the plate as if she might have been in pain and could not hold the hot dog. The Nurse #2 note dated 9/15/11 at 10:30am indicated there was edema to the left wrist. The color of the left wrist was purple and blue with warmth to the touch. The resident was brought back to bed. At 12:30pm Resident #1 was seen by the physician after reviewing the x-ray report. An order was sent for Resident #1 to go to an orthopedic clinic for a fracture to the left wrist. An interview with Nurse #2 on 9/28/11 at 3:21pm revealed a third shift nurse reported to her that an x-ray was obtained on Resident #1 arm on 9/15/11. There were no results reported to her regarding the x-ray. The third shift nurse also indicated to her the family had complained about Resident #1 left arm being painful and swollen. Nurse #2 then went to check Resident #1 arm. She indicated Resident #1 left arm was swollen and bruised. On 9/15/11, Nurse #2 noticed the physician was in use of Resident #1 medical chart and was viewing what appeared to be a piece of paper in his hand. She assumed that the Physician was probably looking at the x-ray report in his hand. She concluded the physician was going to see Resident #1 and did not report the physical changes in Resident #1 arm. She indicated the physician was there for his regular weekly visit. The physician did see her and noticed the x-ray report indicated a fracture. An interview with Nurse #2 on 9/28/11 at 4:30pm indicated she did not recheck Resident #1 left	F 309	OF NURSING WILL REPORT HER FINDINGS TO THE QUALITY ASSURANCE COMMITTEE ON A MONTHLY BASIS FOR FURTHER REVIEW AND CORRECTIVE ACTION. THE QUALITY ASSURANCE COMMITTEE WILL MONITOR UNTIL COMPLIANCE IS ACHIEVED. THE QUALITY ASSURANCE COMMITTEE HAS THE AUTHORITY TO DISCONTINUE MONITORING ONCE THEY ARE CONFIDENT THAT THE CITED DEFICIENCY IS RESOLVED. (ATTACHMENT #1).	

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arm after her initial observation on 9/15/11.

An interview with Nurse #2 on 9/29/11 at 9:32am revealed when she examined Resident #1 wrist around 8:00am on 9/15/11. The third shift nurse reported to her about the family complaints of pain, swelling and bruising of the left arm. Her examination of the arm involved looking at the left arm. She touched the front of the forearm and hand. This was documented on a 24-hour report. She indicated nurses communicate with each shift. Their reports are documented on the 24 hour report. The day shift nurse gets a new sheet at the beginning of the shift. When third shift approaches, the sheet is completely filled out and filed.

A record review of the facility 24-hour report was conducted from 9/13/11 through 9/15/11. There was an indication of a fall without injuries on 9/13/11. There was an indication of a negative result for the left wrist x-ray on 9/14/11. There was then an indication of a fracture to the left wrist during the day shift on 9/15/11.

A record review of the physician progress notes was conducted. The physician note dated 9/15/11 indicated Resident #1 had a fall two days ago and sustained an injury to her left wrist. There was swelling and tenderness with bruising. The physician indicated the x-ray showed a fracture of the distal radius. Resident #1 was to be sent to an orthopedic clinic for evaluation. The physician note dated 9/22/11 indicated Resident #1 has been more agitated since her fall.

An interview with the physician on 9/28/11 at 4:37pm revealed he received an email of no

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F 309	Continued From page 13 injuries regarding the x-ray. He indicated he visits the facility every Thursday for his regular rounds. There were no reports to him regarding bruising, pain or swelling of the arm. Upon his regular visit, he pulled the x-ray report from his mailbox and saw Resident #1 had a fracture of the left wrist. He visited Resident #1 for an examination of the left arm. He reported the arm was swollen with bruising. When he touched Resident #1 left arm, she snatched back her arm away from him. The physician sent Resident #1 to the orthopedic clinic after the examination. A record review of medications revealed a physician order was started on 9/15/11 for Tylenol 650 milligrams (mg) every four hours as needed. The order was changed 9/22/11 to 650mg four times daily. The indicated use for the medication was for pain. An interview with Family Member #1 on 9/28/11 at 5:05pm revealed Family Member #1 met with the Director of Nursing (DON) and Administrator on 9/27/11. They admitted to Family Member #1 that the x-ray results were misread. An interview with the DON on 9/29/11 at 12:32pm revealed she was notified of the fall on 9/14/11 by viewing the incident report. She indicated when there is a fall or injury; it should be reported on the incident sheet and to the physician. If an injury was noticed or suspected after the fall, an x-ray should have been obtained. When the x-ray reports are received with positive findings of a fracture, the physician should be contacted immediately.	F 309		