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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 on record reviews, physician and staff interviews, the facility failed to immediately notify one of one sampled resident (Resident #1)	F 157	Past noncompliance: no plan of correction required.	8/12/16

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

Electronically Signed | 08/12/2016

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physician and responsible party of a right hip pain .
The findings included:
Resident #1 was admitted to the facility on 5/4/2016 with diagnoses of Alzheimer's disease, degenerative disease of nervous system, difficulty in walking, anxiety disorder, muscle weakness, hyperlipidemia and hypertension. The quarterly Minimum Data Set (MDS) dated 5/16/2016 revealed the resident had long and short term memory problems, decision making skills were moderately impaired and he needed limited assistance with 2 persons with bed mobility and transfer.
Review of the injury of unknown origin report dated 7/19/2016 documented "Resident noted to have a bruise to right hip, got an x- ray noted to have fracture to right femur."
NA (Nurse Aide) #9's statement dated 7/20/2016 documented "I took care of the resident on Friday 7/15/2016. There were no incidents. I didn't see any bruise on the resident's body. He didn't appear to be in any pain."
NA #1's statement dated 7/20/2016 documented "Friday 11-7 shift 7/15/2016 during care on Resident #1 he showed no sign of pain."
During the interview on 7/28/2016 at 1:40 PM, Nurse #1 who is also the Assistant Director of Nursing (ADON) was assigned to work with the resident on the second shift on Saturday 7/16/2016 reported that the resident was sitting in his recliner and the Nurse Aide reported to her that the resident was in pain. She added that she gave the resident the prn (as needed) medication and reported the resident's pain to the 11-7 shift nurse. The nurse stated she did not notify the doctor or the responsible party of the resident's pain.
NA #4's statement dated 7/19/2016 documented

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"When caring for the resident on Saturday July 16th 2016 11-7 shift I noticed that he was experiencing a vast amount of pain when changing him. It was extremely unbearable for him to move or for me to move him. Reported it to the ADON (Assistant Director of Nursing)

During the interview on 7/28/2016 at 3:08 PM, NA #4 reported she was assigned to work with Resident #1 on 7/16/2016 on third shift. She reported that the resident was in an excruciating pain at about 11 PM. NA #4 added that she reported the concern to the nurse. She also reported that on Sunday 7/17/2016 morning, the resident was in so much pain and she did not reposition the resident. NA #4 added she had to rip the resident's pull up in order to provide the incontinence care.

NA #2's statement dated 7/19/2016 documented "I was the sitter for 7-3 on 7/17/2016. The 11-7 sitter told me the resident was in pain most of the night (R leg) when I had him he was in pain I told Nurse #2, my nurse, and she gave him something for pain. He was in bed all shift for me."

During the interview on 7/28/2016 at 3:30 PM, NA #2 reported that she was assigned to work with the resident on Sunday 7/17/2016 during the second shift. She reported at 3: 00 PM when she was trying to turn the resident he would holler with pain yelling "don't touch me."

According to the MAR (Medication Administration Record) for July the resident was prescribed pain medication PRN (as needed medication) Motrin 800 mg (milligram). The MAR revealed the resident was given Motrin 800 mg one time on 7/17/16 at 8:00pm.

Nurse Aide (NA) #1's statement dated 7/18/2016 documented "On Sunday night 11-7 shift 7/17/2016 during the care on Resident # 1 the

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resident yelled out with pain. I stopped care and ask resident what's wrong where he was hurting, I noticed when turning him from the right side he shouted. I asked resident again show me where it hurts."
Review of the incident report completed by the DON (director of nursing) dated 7/18/2016 documented "Received report from oncoming day shift Nurse Aide on 7/18/16 that the resident had a bruise to upper right hip. Resident noted to have pain to right side knee and hip and favored his right side while in bed, resident remained in bed, leg stabilized moaned, did not want to be repositioned." Under immediate action taken subheading the report indicated "Pain medication provided, MD (Medical Doctor) called, X-ray ordered, Responsible party were called on 7/18/16." The injury of unknown origin first appeared with the resident's complaint of pain on 7/16/2016 during third shift.
During the interview with Nurse #3 on 7/28/2016 at 3:20 PM, She reported she was assigned to work with the resident on 7/18/2016 second shift. Nurse # 3 stated it was reported to her on 7/18/2016 first shift nurse that the resident had been refusing to get out of bed for 2 days. She added the first shift nurse reported to her that she had gotten an order for an x- ray but she did not know if it had been done since she had been in training for the last 2 hours. She decided to call the x- ray company later in the evening when she noticed they had not showed up to take the resident's x- ray. Nurse # 3 added when she received the result after the x-ray was taken, she called 911 to transport the resident to the emergency room at about midnight.
Review of the x-ray report dated 7/18/2016 indicated "there is acute trans cervical fracture of the right femur. No dislocation or subluxation.

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The visualized bony structures appear unremarkable."
Review of the Hospital discharge summary dated 7/28/2016 documented "The patient presented to the emergency department via EMS (Emergency Medical Services) from the nursing home secondary to a fall with subsequent right hip fracture." The resident's discharge plan indicated: "Right hip fracture post mechanical fall. The patent is postoperative day # 6. The patient is awaiting rehabilitation placement."
During the interview on 7/28/2016 at 2:15 PM, the Physician reported that he was not notified about the change in the resident's level of pain until Monday 7/18 /2016 around 3pm. He added that the nurse should have notified him of the resident's pain on Saturday 7/16/2016 when they noticed that the resident continued to be in excruciating pain after attempting prn (as needed medication). Physician also added that the medication that was being given to the resident was not enough to stop the resident's pain since the pain was as a result of a fracture.
Review of the facility's investigation report revealed the facility submitted to the Health Care Personnel Investigation (HCPI) a 24 hour report on 7/19/2016 and a 5 day report on 7/25/2016. The report was indicating an investigation on Resident #1's injury of unknown origin.
During the interview on 7/28/2016 at 3:40 PM, The Director of Nursing (DON) reported she was made aware of the resident's fracture on 7/18/2016 during first shift around 10am. She stated the doctor was made aware of the x-ray results and the resident was sent out to the emergency room. She also acknowledged that the staff should have reported to the doctor on Saturday 7/16/2016 the change in the level of resident's pain than later on Monday. She also

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F 157	Continued From page 5 added the family should have been notified on Saturday of the change in the resident's pain when it was first noticed. The DON also reported she conducted an investigation to find the cause of the resident's fracture and she could not identify the cause. She reported she faxed to the state agency a 24 hour report on 7/19/2016 and 5 days report on 7/25/2016 reporting injury of unknown origin. She also reported she had completed a plan of correction to make sure the incident does not happen again. The corrective action for past non-compliance dated 7/25/2016 included: Resident # 1 had a bruise of unknown origin on 7/18/2016, and x-ray showed a femur fracture of a left hip. Resident # 1 currently is discharged from facility to the hospital. A 100% body assessment audit of all resident with Brief Interview for Mental Status (BIMS) score of less than 13 were checked and assessment completion date is 7/22/2016 by hall nurses. All resident with BIMS score of 13-15 were interviewed for possible abuse, neglect or injuries and the completion date is 7/22/2016 by the Social worker. Staff facilitator assistant, and/or administrator reviewed all clinic notes, entries, and 24 hour summaries for possible injuries, changes in conditions and increased pain occurrence for the last 30 days. The completion date is 7/19/2016 by Director of Nursing (DON). Corrective action taken per policy. 100% in-servicing of all nurses will be provided by the staff facilitator on abuse, reporting abuse, types of abuse, changes in condition assessment and timely treatment which will include the doctor and responsible party notification, as well as documentation for changes in condition prior to reporting to duty. The staff will be unable to take the floor until the completion of the in-servicing.	F 157		

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F 157	Continued From page 6 100% in-service of all Nurse's Aide will be provided by the staff facilitator on abuse, reporting abuse, types of abuse, reporting changes in condition to chain of command, documentation for changes in condition in appropriate portals prior to reporting to duty and the staff will be unable to take the floor until completion of in-service. All newly hired staff will be in -serviced upon hire by staff facilitator. Face to face director of nursing meeting will be conducted with nurses and Nurse Aide. They will be discussing documentation, changes in condition, and resources for reporting any nursing concerns to the administrative staff if they do not feel their concerns or issues are not being addressed. The completion date for Nurses and Nurse Aides is 7/25/2016 and for the DON is 7/25/2016. Any employee unable to attend the meeting will be in-serviced prior to reporting to duty and will not be able to take the floor until completion of the in-service. Incident interventions and daily charting will be monitored by DON, ADON (Assistant Director of Nursing), and Supervisor nurse daily from Monday through Friday. The resident population which includes Resident # 1 upon return to the facility will be monitored indefinitely, using a 24 hour shift summary QI (Quality Improvement) tool. Concerns will be addressed immediately and retraining will be conducted for any identified areas of concern by Staff facilitator, DON, ADON, and/ or QI nurse. The completion date is 10/18/2016 This will be monitored by the executive committee weekly x 4 and monthly x 2, and concerns will be addressed appropriately. The completion date is 10/18/2016 As part of the validation process on 7/28/2016,	F 157		

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F 157	Continued From page 7 the entire plan of correction was reviewed including re-education of staff .The named resident was not at the facility during the validation. Interviews of the nurse aides and nurses revealed they were aware of reporting of change in the residents' condition which included reporting to the physician of increase in the level of pain on residents and the family member. A review of the monitoring tools revealed that the facility had completed the 100 % in-service of reporting of residents change in condition.	F 157		
F 309 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on record reviews, physician and staff interviews, the facility failed to provide appropriate pain management which caused one of one sampled resident (Resident #1) to have pain related to a fractured right hip for 3 days. The findings included: Resident #1 was admitted to the facility on 5/4/2016 with diagnoses of Alzheimer's disease, degenerative disease of nervous system, difficulty in walking, anxiety disorder, muscle weakness, hyperlipidemia and hypertension. The quarterly Minimum Data Set (MDS) dated 5/16/2016 revealed the resident had long and short term	F 309	Past noncompliance: no plan of correction required.	8/12/16

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memory problems, decision making skills were moderately impaired and he needed limited assistance with 2 persons with bed mobility and transfer.
Resident #1's care plan dated 6/13/2016 documented the resident was at risk for falls. The care plan documented following interventions: "Assist resident to negotiate barriers, assist the resident with transfers and ensure the environment is free of clutter as possible." The resident care plan also indicated the resident required occasional assistance to maintain maximum function of self-sufficiency for transferring. The care plan documented the following interventions: "Transfer independent at times, may need 2 person assist due to behaviors, monitor for safety awareness."
Further review of the care plan revealed the resident was not care planned for pain management.
Review of the MAR (Medication Administration Record) for the month of July 2016 revealed the resident was prescribed pain medication PRN (as needed medication) Motrin 800 mg (milligram) for pain. Further review of MAR revealed the pain medication was administered to the resident only 2 times. The resident was given medication for pain on 7/15/2016 at 8:00 AM and 7/17/2016 at 8:00 PM.
Review of the injury of unknown origin report dated 7/19/2016 documented "Resident noted to have a bruise to right hip, got an x- ray noted to have fracture to right femur."
NA (Nurse Aide) #9's statement dated 7/20/2016 documented "I took care of the resident on Friday 7/15/2016. There were no incidents. I didn't see any bruise on the resident's body. He didn't appear to be in any pain."
NA #1's statement dated 7/20/2016 documented

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"Friday 11-7 shift 7/15/2016 during care on Resident # 1 he showed no sign of pain."
NA #6's statement dated 7/20/2016 documented "On Saturday 7/16/2016 I worked on the resident's unit and the resident was in his recliner the whole day and complaining of knee pain. We did stand him once to change him. On Sunday 7/17/2016 he was in bed the whole day."
NA #5's statement dated 7/19/2016 documented "Saturday 7/16/2016 , I came in 3:00 PM the resident had a sitter and a Nurse Aide when I left at 7:00 PM, the other Nurse Aide came on at 7: 00 PM but was later asked to be the sitter. I noticed the resident was holding his knee and said he was hurting. Nurse was notified, later that evening the resident wouldn't turn to be changed. Sunday I came in he was hurting bad, I asked the sitter why he is holding his right side. I came on Monday I was told he had bruises on his right."
NA #7's statement date 7/20/2016 documented "7/16/2016 I came in 11: 00 PM resident was in his chair and the other Nurse Aide said she was waiting for the Nurse to bring him some pain medication. She said the resident cannot walk or get up out of the chair, so I said I will help walk him to his bed and we did and he was in a lot of pain. On 7/16/2016 I came in at 3:00 PM he was in bed I stay until 7: 00 AM and he was in bed the all-time. His pain was bad we then tried to change him with another Nurse Aide."
During the interview on 7/28/2016 at 1:40 PM, Nurse # 1 who was assigned to work with the resident on the second shift on Saturday 7/16/2016 reported that the resident was sitting in his recliner and the Nurse Aide reported to her that the resident was in pain. She added that she gave the resident the prn (as needed) medication and reported the resident's pain to the 11-7 shift nurse.

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During the interview on 7/28/2016 at 3:08 PM, NA # 4 reported she was assigned to work with Resident # 1 on 7/16/2016 on third shift. She reported that the resident was in excruciating pain at about 11 PM. NA # 4 added that she reported the concern to the nurse. She also reported that on Sunday 7/17/2016 morning, the resident was in so much pain and she did not reposition the resident. NA # 4 added she had to rip the resident's pull up in order to provide the incontinence care

NA #1's statement dated 7/18/2016 documented "On Sunday night 11-7 shift 7/17/2016 during the care on Resident #1 the resident yelled out with pain. I stopped care and ask resident what's wrong where he was hurting, I noticed when turning him from the right side he shouted. I asked resident again show me where it hurts."

NA #3's statement dated 7/19/2016 documented "On Saturday 7/16/2016 I came in to do 1 on 1 on the resident and got report from another Nurse Aide that I would not have too much problems with the resident. The resident stayed in his chair the entire time and he didn't really seem to be in to too much pain except for when he would attempt to get up. I saw no reason to report the pain since I had already been told he was in pain I figured it had already been reported."

NA #4's statement dated 7/19/2016 documented "When caring for the resident on Saturday July 16th 2016 11-7 shift I noticed that he was experiencing a vast amount of pain when changing him. It was extremely unbearable for him to move or for me to move him. Reported it to the ADON (Assistant Director of Nursing)."

Nurse #2's statement with no date documented "note for 7/17/16, Sunday: resident was in bed with eyes closed most of the day, received in report that resident has right knee joint pain and

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that resident also has arthritis and receives pain medication for it."
Nurse #1's statement dated 7/18/2016 documented "This writer on 7/18/2016 was walking the hall with 7-3 nurse on spark unit when 7-3 Nurse Aide approached this writer and 7-3 Nurse. Nurse Aide stated, 11-7 Nurse Aide stated this resident has been having hip pain all night. 7-3 Nurse Aide stated resident had bruise on right hip and asked if this writer had been notified. This writer stated she had not been notified of any bruise or hip pain. The 11-7 Nurse Aide at 7:20 AM only stated to this writer that resident's knee had been bothering him again."
Nurse's note dated 7/18/2016 at 3:36 PM documented "Resident remains on one to one monitoring. Resident has complaints of pain to right hip and right knee. Pain medication administered per order. Pain is still present. The writer assessed slight bruising to right upper hip. The writer notified the doctor of the residents condition-orders received for resident to receive an x-ray and prn (as needed) ice."
Review of the incident report completed by the DON (director of nursing) dated 7/18/2016 documented "Received report from oncoming day shift Nurse Aide on 7/18/16 that the resident had a bruise to upper right hip. Resident noted to have pain to right side knee and hip and favored his right side while in bed, resident remained in bed, leg stabilized moaned, did not want to be repositioned." Under immediate action taken subheading the report indicated "Pain medication provided, MD (Medical Doctor) called, X-ray ordered, Responsible party were called on 7/18/16." The injury of unknown origin first appeared with the resident's complaint of pain on 7/16/2016 during third shift.
During the interview on 7/28/2016 at 2:29 PM, the

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(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
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Dietary aide #1 who was a sitter for Resident #1 on 7/18/2016 reported the resident was in so much pain on Monday 7/18/2016 at dinner time. She added the resident was not able to sit in upright position to eat his dinner. Dietary aide #1 further reported she expressed her concern to the nurse aide who was assigned to the resident about the resident's pain.

During the interview with Nurse #3 on 7/28/2016 at 3:20 PM, She reported she was assigned to work with the resident on 7/18/2016 second shift. Nurse #3 stated it was reported to her on 7/18/2016 by the first shift nurse that the resident had been refusing to get out of bed for 2 days. She added the first shift nurse reported to her that she had gotten an order for an x- ray but she did not know if it had been done since she had been in training for the last 2 hours. She decided to call the x- ray company later in the evening when she noticed they had not showed up to take the resident's x- ray. Nurse #3 added when she received the result after the x-ray was taken, she called 911 to transport the resident to the emergency room at about midnight.

Review of the x-ray report dated 7/18/2016 indicated "there is acute trans cervical fracture of the right femur. No dislocation or subluxation. The visualized bony structures appear unremarkable."

Nurse's note dated 7/20/2016 documented "Resident noted to be out of facility in hospital due to right hip fracture with follow up with interventions upon return, MD (Medical Director) and RP (Responsible Party) aware."

Review of the Hospital discharge summary dated 7/28/2016 documented "The patient presented to the emergency department via EMS (Emergency Medical Services) from the nursing home secondary to a fall with subsequent right hip

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 07/28/2016

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fracture." The resident's discharge plan indicated: "Right hip fracture post mechanical fall. The patent is postoperative day # 6. The patient is awaiting rehabilitation placement."
During the interview on 7/28/2016 at 2:15 PM, the Physician reported that he was not notified about the change in the resident's level of pain until Monday 7/18 /2016 around 3pm. He added that the nurse should have notified him of the resident's pain on Saturday 7/16/2016 when they noticed that the resident continued to be in excruciating pain after attempting prn (as needed medication). Physician also added that the medication that was being given to the resident was not enough to stop the resident's pain since the pain was as a result of a fracture.
During the interview on 7/28/2016 at 3:40 PM, The Director of Nursing (DON) reported she was made aware of the resident's fracture on 7/18/2016. She stated the doctor was made aware of the x-ray results and the resident was sent out to the emergency room. She also acknowledged that the staff should have reported to the doctor on Saturday 7/16/2016 the change in the level of resident's pain than later on Monday. She also added the family should have been notified on Saturday of the change in the resident's pain when it was first noticed. The DON also reported she conducted an investigation to find the cause of the resident's fracture and she could not identify the cause. She reported she faxed to the state agency a 24 hour report on 7/19/2016 and 5 days report on 7/25/2016 reporting injury of unknown origin. She also reported she had completed a plan of correction to make sure the incident does not happen again.
The corrective action for past non-compliance dated 7/25/2016 included:

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Resident # 1 had a bruise of unknown origin on 7/18/2016, and x-ray showed a femur fracture of a left hip. Resident # 1 currently is discharged from facility to the hospital.
A 100% body assessment audit of all resident with Brief Interview for Mental Status (BIMS) score of less than 13 were checked and assessment completion date is 7/22/2016 by hall nurses. All resident with BIMS score of 13-15 were interviewed for possible abuse, neglect or injuries and the completion date is 7/22/2016 by the Social worker. Staff facilitator assistant, and/or administrator reviewed all clinic notes, entries, and 24 hour summaries for possible injuries, changes in conditions and increased pain occurrence for the last 30 days. The completion date is 7/19/2016 by Director of Nursing (DON).
Corrective action taken per policy.
100% in-servicing of all nurses will be provided by the staff facilitator on abuse, reporting abuse, types of abuse, changes in condition assessment and timely treatment which will include the doctor and responsible party notification, as well as documentation for changes in condition prior to reporting to duty. The staff will be unable to take the floor until the completion of the in-servicing.
100% in-service of all Nurse's Aide will be provided by the staff facilitator on abuse, reporting abuse, types of abuse, reporting changes in condition to chain of command, documentation for changes in condition in appropriate portals prior to reporting to duty and the staff will be unable to take the floor until completion of in-service. All newly hired staff will be in -serviced upon hire by staff facilitator. Face to face director of nursing meeting will be conducted with nurses and Nurse Aide. They will be discussing documentation, changes in condition, and resources for reporting any nursing

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F 309	Continued From page 15 concerns to the administrative staff if they do not feel their concerns or issues are not being addressed. The completion date for Nurses and Nurse Aides is 7/25/2016 and for the DON is 7/25/2016. Any employee unable to attend the meeting will be in-serviced prior to reporting to duty and will not be able to take the floor until completion of the in-service. Incident interventions and daily charting will be monitored by DON, ADON (Assistant Director of Nursing), and Supervisor nurse daily from Monday through Friday. The resident population which includes Resident # 1 upon return to the facility will be monitored indefinitely, using a 24 hour shift summary QI (Quality Improvement) tool. Concerns will be addressed immediately and retraining will be conducted for any identified areas of concern by Staff facilitator, DON, ADON, and/ or QI nurse. The completion date is 10/18/2016 This will be monitored by the executive committee weekly x 4 and monthly x 2, and concerns will be addressed appropriately. The completion date is 10/18/2016 As part of the validation process on 7/28/2016, the entire plan of correction was reviewed including re-education of staff .The named resident was not at the facility during the validation. Interviews of the nurse aides and nurses revealed they were aware of reporting of change in the residents' condition which included reporting to the physician of increase in the level of pain on residents and the family member. A review of the monitoring tools revealed that the facility had completed the 100 % in-service of reporting of residents change in condition.	F 309		