STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	C 03/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 on record review and staff interviews, the facility failed to notify the doctor when complaints of pain were made after a fall had occurred for 1	F 157	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	4/10/17

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

Electronically Signed | 04/10/2017

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F 157	Continued From page 1 of 3 sampled residents, Resident #1. An x-ray completed after the fall revealed the resident had sustained a right hip fracture. The findings include: Resident #1 was originally admitted to the facility on 11/29/16, with diagnoses including, Dementia, Alzheimer's Disease with late onset, Muscle Weakness, Difficulty Walking and Displaced fracture of base of neck of right femur, and subsequent encounter for closed fracture with routine healing. According to an Admission Minimum Data Set (MDS) dated 12/6/16, Resident #1 was moderately cognitively impaired. In the area of bed mobility and transfers, he required extensive assistance, two person physical assistance. In the area of dressing, eating and personal hygiene, Resident #1 required total assistance. Resident #1's care plan dated 12/12/16 addressed increased risk for falls related to deconditioning (loss of muscle tone or loss of function) with actual fall. The interventions included to monitor and document for pain x 72 hours post fall follow up and to report pain, bruising, change in mental status or agitation to the physician. During an interview on 3/19/17 at 3:05 AM, the Third Shift Nurse Supervisor revealed she was on another hall Christmas morning and she came back toward the nurse's station toward the medication cart. She revealed a Nursing Assistant told her Resident #1 was on the floor outside his door. She stated there was a lot going on at the time. The Third Shift Nurse Supervisor stated she assessed Resident #1 and he did not exhibit any signs of pain. She recalled the resident was alert and there was no grimacing.	F 157	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 157 A corrective action for affected resident: For resident # 1, on 12/28/2016 when the resident was assessed by the hall nurse to have pain in the right hip and leg, the resident was medicated with PRN pain medication and the on-call MD was notified. The MD gave an order on 12/28/2016 to complete a pelvis and right hip x-ray. X-ray results were received back on 12/29/2016 positive for an acute impacted sub capital fracture of the right femur neck. The MD was notified of fracture on 12/29/16. The resident was sent to the hospital ER on 12/29/2016 and admitted. On 12/30/16, MD was notified that the investigation into the injury revealed an unreported fall. All current residents experiencing pain have the potential to be affected by the alleged deficient practice. Beginning on 04/07/2017 all current residents were assessed for indications of pain or injury by the hall nurses under the direction of the Director of Nursing. These were completed on 4/10/17. The pain assessment included interviewing all	

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F 157	Continued From page 2 She stated she did not see anything to keep from moving him. The Third Shift Nurse Supervisor revealed she brought Resident #1 to the front of the nursing station in a special chair to watch him more closely. She stated she forgot to write up everything that morning, to report the fall to the next shift, and to contact the family and doctor. She revealed she went home at the end of her shift and forgot about it. The Third Shift Nurse Supervisor continued by stating Resident #1 complained of pain two or three days later and she found out later there was a possibility of a small fracture. The Third Shift Nurse Supervisor recalled prior to Resident #1's fall, she gave him medication when he became agitated. She stated when she came back to work Monday (12/26/16) or Tuesday (12/27/16) night after the fall, he started complaining of pain. The Third Shift Nurse Supervisor did not explain why she did not call the doctor when Resident #1 started complaining of pain on 12/26/16 or 12/27/16 after the resident had fallen. In reference to reporting the fall to the doctor, the Third Shift Nurse Supervisor stated if there were no injuries after a fall, she would fax the doctor and if there was an injury she would get an order to send the resident out to the emergency room. She stated she did not fax the doctor the night of Resident #1's fall because it slipped her mind. The Third Shift Nurse Supervisor said a lot was going on, such as a lot of people needing care at one time. During an interview on 3/19/17 at 2:47 PM, Staff Nurse #1 revealed she worked on first shift with Resident #1 every day during the week and he denied pain, prior to 12/28/16. She stated the Nursing Assistant was doing her rounds on 12/28/16 and told her Resident #1 was complaining of pain. She stated Resident #1 did	F 157	current interviewable patients to ask if they are currently experiencing pain. If they are in pain then an assessment was completed that included the location of the pain, severity of the pain, characteristics of the pain, range of motion for extremity pain and whether or not it is chronic or acute. For cognitively impaired residents, the PAIN AD pain scale was completed. This pain scale numerically ranks pain signs and symptoms such as breathing, negative vocalizations, facial expressions, body language, and consolability to determine a 1-10 pain scale for the patient. If pain was identified, then an assessment was completed that included the location of the pain, severity of the pain, characteristics of the pain, range of motion for extremity pain and whether or not it is chronic (based on history) or acute. For chronic pain, as needed pain medications were administered by the nurse. A follow up 30-45 minutes after administration was completed to ensure pain was resolved. If not resolved then additional pain medications were administered according to orders or if additional pain medications were not ordered by the physician, they were contacted immediately for additional pain management orders. For acute pain, the Director of Nursing was notified and as needed pain medications were administered (if ordered). If the patient did not have an order for pain medications the MD was contacted immediately to get pain medication and other pain related orders.	

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F 157	Continued From page 3 not talk much and each time she picked up his right side he grabbed her hand as if he was hurting. She stated she turned him over and he guarded his right side. She revealed his family was in the room with him when he indicated he was hurting. Staff Nurse #1 revealed she gave Resident #1 Tylenol for pain and called the doctor on call at 4:29 PM. She revealed she did not know Resident #1 had fallen. She stated she looked for information regarding a fall and she did not see anything about him having a fall. During an interview on 3/20/17 at 2:13 PM, the Director of Nursing (DON) revealed an investigation probably was not done when the fall happened because the Third Shift Nurse Supervisor went home. The DON revealed the Third Shift Nurse Supervisor was careless in not calling Resident #1's family and not doing an incident report. The DON revealed she could not find a nurse's note written on 12/25/16 regarding the fall and she did not see an incident report or a fax to the doctor or a phone call to the family. She emphasized for a fall with an injury, the procedure was to call the DON, Administrator, family and doctor and for a fall without injury, make notifications and put something in place to prevent the fall from happening again such as putting a mattress beside the bed or bringing the resident up to the nurse's station. The DON revealed on 12/28/17 an X-ray was done and on 12/29/16 it was determined Resident #1 had a fracture. Resident #1 had surgery, due to the fracture for right hip repair on 12/30/16. The DON revealed after it was discovered through interviews that Resident #1 had a fall and fracture, she revealed the doctor and Resident #1's family were notified on 12/30/16 at 10:25 AM. During an interview on 3/21/17 at 12:00 PM, the	F 157	Once pain medications were administered a follow up 30-45 minutes after administration was completed to ensure that the pain was resolved. If not resolved, the MD was notified immediately for additional orders and interventions. If the acute pain involved an extremity, the MD was immediately notified of the findings. Systemic changes made were: In-service education began on 04/07/2017 by the Staff Development Coordinator for all RNs, LPNs, Med Aides, and NA□s FT, PT, and PRN. The in-service topics included: assessment and notification of the physician of new or unresolved pain. The Director of Nursing will ensure that any employee who has not received this training by 04/10/2017 will not be allowed to work until the training is completed. (See Education Attachment) The RN on call is the Director of Nursing if the staffing on-call is a LPN. The facility specific in-service was sent to Hospice Providers and Agency Staff whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training by 04/10/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 157	Continued From page 4 Administrator stated on the day Resident #1 was X-rayed and it was determined he had a fracture on 12/29/16, they started interviewing staff. She revealed once they started interviewing staff they found out Resident #1 had fallen. She revealed the Third Shift Nurse Supervisor did not call her to let her know when Resident #1 had fallen. During an interview on 3/21/17 at 1:03PM, the Administrator stated it was her expectation that when a resident had a fall incident, the nurse must immediately notify the resident's family and doctor.	F 157	all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing, Staff Development Coordinator, or designee will monitor this issue using the Clinical Quality Assurance Survey Tool Incident Review and MD Notification Tool (see attachment). The monitoring will include observing five resident□s for indicators of pain after a fall, pain management, and timely MD notification. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224		4/10/17

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F 224	Continued From page 5	F 224		

This REQUIREMENT is not met as evidenced by:
Based on record reviews, staff interviews and MD interview, the facility was negligent for failing to notify the doctor that a resident had a fall and complained of pain after the fall, and failed to notify oncoming shift nurses of the fall which resulted in injury for 1 (Resident #1) of 3 sampled residents reviewed for falls. An x-ray completed after the fall revealed a right hip fracture and the resident was admitted to the hospital to undergo surgery.

The findings included:

Resident #1 was originally admitted to the facility on 11/29/16, with diagnoses including, Dementia, Alzheimer's Disease with late onset, Muscle Weakness, Difficulty Walking and Displaced fracture of base of neck of right femur, and subsequent encounter for closed fracture with routine healing.

According to an Admission Minimum Data Set (MDS) dated 12/6/16, Resident #1 was moderately cognitively impaired. In the area of bed mobility and transfers, he required extensive assistance, two person physical assistance. In the area of dressing, eating and personal hygiene, Resident #1 required total assistance. Resident #1's care plan dated 12/12/16 addressed increased risk for falls related to deconditioning (loss of muscle tone or loss of function) with actual fall. The interventions included to monitor and document for pain for 72

F 224
A corrective action for affected resident: For resident # 1, on 12/28/2016 when the resident was assessed by the hall nurse to have pain in the right hip and leg, the resident was medicated with PRN pain medication and the on-call MD was notified. The MD gave an order on 12/28/2016 to complete a pelvis and right hip x-ray. X-ray results were received back on 12/29/2016 positive for an acute impacted sub capital fracture of the right femur neck. The MD was notified of fracture on 12/29/16. The resident was sent to the hospital ER on 12/29/2016 and admitted. On 12/30/16, the MD was notified that the investigation into the origin of injury revealed an unreported fall

All current residents who have had a fall have the potential to be affected by the alleged deficient practice.

Beginning on 04/06/2017 all current residents were interviewed or assessed based on their cognitive status, for a falls history or indicators that a fall may have occurred. The Social Worker interviewed all alert and oriented residents for any falls that may have occurred over the past 30 days. If falls were reported by the resident, it was then compared to the resident□s medical records to ensure a

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F 224	Continued From page 6 hours post fall follow up and to report pain, bruising, change in mental status or agitation to the physician. During an interview on 3/19/17 at 3:05 AM, the Third Shift Nurse Supervisor revealed she was on another hall Christmas morning and she came back toward the nurse's station toward the medication cart. She revealed a Nursing Assistant told her Resident #1 was on the floor outside his door. She stated there was a lot going on at the time. The Third Shift Nurse Supervisor stated she assessed Resident #1 and he did not exhibit any signs of pain. She recalled the resident was alert and there was no grimacing. She stated she did not see anything to keep from moving him. The Third Shift Nurse Supervisor revealed she brought Resident #1 to the front of the nursing station in a special chair to watch him closer. She stated she forgot to write up everything that morning, to report the fall to the next shift and to contact the family and doctor. She revealed she went home at the end of her shift and forgot about it. The Third Shift Nurse Supervisor continued, Resident #1 complained of pain two or three days later and she found out later there was a possibility of a small fracture. The Third Shift Nurse Supervisor recalled prior to Resident #1's fall, she gave him medication when he became agitated. She stated when she came back to work Monday (12/26/16) or Tuesday (12/27/16) night after the fall, he started complaining of pain. The Third Shift Nurse Supervisor did not explain why she did not call the doctor when Resident #1 started complaining of pain on 12/26/16 or 12/27/16 after the resident had fallen. In reference to reporting the fall to the doctor, the	F 224	falls assessment was completed along with MD and responsible party notifications. This was completed by 04/07/2017. For cognitively impaired residents, the hall nurses under the direction of the Director of Nursing completed a head to toe assessment for injuries of unknown origin. In addition to this, various nursing staff across all three shifts were interviewed to identify any unreported falls over the past 30 days. This was accomplished by printing a list of falls for the last 30 days. The Director of Nursing reviewed the list of falls with staff for identification of any possible unreported falls that they may be aware of. If any falls were identified as unreported, the resident was immediately assessed for injury, the MD and responsible party notified, and an incident report completed. This process was completed on 04/10/2017. Systemic changes made were: In-service education began on 04/07/2017 by the Staff Development Coordinator for all RNs, LPNs, Med Aides, and NA□s FT, PT, and PRN. The in-service topics included: Incident reporting and required notifications, shift report, completion of an incident report, and falls assessment. The Director of Nursing will ensure that any employee who has not received this training by 04/10/2017 will not be allowed to work until the training is completed. (See Education attachment). The facility specific in-service was sent to	

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F 224	Continued From page 7 Third Shift Nurse Supervisor stated if there were no injuries, she would fax the doctor and if there was an injury she would get an order to send the resident out to the emergency room. She stated she did not fax the doctor the night of Resident #1's fall because it slipped her mind. The Third Shift Nurse Supervisor said a lot was going on, such as a lot of people needing care at one time. She stated the fall did not come back to her until she found out the resident had a fracture. Review of Nursing notes for 12/26/16 and 12/27/16 revealed there was no pain medication documented as given. During an interview on 3/19/17 at 2:47 PM, Staff Nurse #1 revealed she worked on first shift with Resident #1 every day during the week and he denied pain, prior to 12/28/16. She stated the Nursing Assistant was doing her rounds on 12/28/16 and told her Resident #1 was complaining of pain. She stated Resident #1 did not talk much and each time she picked up his right side he grabbed her hand as if he was hurting. She stated she turned him over and he guarded his right side. She revealed his family was in the room with him when he indicated he was hurting. Staff Nurse #1 revealed she gave Resident #1 Tylenol for pain and called the doctor on call at 4:29 PM. She revealed she did not know Resident #1 had fallen. She stated she looked for information regarding a fall and she did not see anything about him having a fall. During an interview on 3/20/17 at 2:13 PM, the Director of Nursing (DON) revealed an investigation probably was not done when the fall happened because the Third Shift Nurse Supervisor went home. The DON stated the Third Shift Nurse Supervisor was neglectful in not	F 224	Hospice Providers and Agency Staff whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training by 04/10/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing, Staff Development Coordinator, or designee will monitor this issue using the Clinical Quality Assurance Survey Tool Incident Review and MD Notification Tool (see attachment). The monitoring will include auditing five resident□s residents weekly for timely fall reporting, fall and pain assessment procedures, and shift reporting. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support	

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F 224	Continued From page 8 calling Resident #1's family and not doing an incident report. The DON revealed she could not find a nurse's note written on 12/25/16 regarding the fall and she did not see an incident report or a fax to the doctor or a phone call to the family. She emphasized for a fall with an injury, the procedure was to call the DON, Administrator, family and doctor and for a fall without injury, make notifications and put something in place to prevent the fall from happening again such as putting a mattress beside the bed or bringing the resident up to the nurse's station. The DON revealed on 12/28/17 an X-ray was done and on 12/29/16 it was determined Resident #1 had a fracture. Resident #1 had surgery, due to the fracture for right hip repair on 12/30/16. The DON revealed after it was discovered through interviews that Resident #1 had a fall and fracture, she revealed the doctor and Resident #1's family were notified on 12/30/16 at 10:25 AM. During an interview on 3/20/17 at 2:55 PM, the facility Physician revealed due Resident #1's declining condition he was not as active and his pain perception was questionable because of his cognition and he was nonverbal. He revealed facility staff were very good about notifying him about resident conditions and concerns. The Physician further stated if the facility neglected to notify the physician it would be because of over work and not from lack of care. During an interview on 3/21/17 at 12:00 PM, the Administrator stated on the day Resident #1 was X-rayed and it was determined he had a fracture on 12/29/16, they started interviewing staff. She revealed once they started interviewing staff they found out Resident #1 had fallen. She revealed	F 224	Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 224	Continued From page 9 the Third Shift Nurse Supervisor did not call her to let her know when Resident #1 had fallen. During an interview on 3/21/17 at 1:03PM, the Administrator stated it was her expectation that when a resident had a fall incident, the nurse must immediately notify the resident's family and doctor.	F 224		
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 and staff interviews, the facility failed to communicate a fall to oncoming staff and failed to continue to assess for injury after every shift for the first 72 hours, which resulted in the resident complaining of pain and receiving an x-ray noting a fractured hip four days after the resident's fall for 1 of 3 sampled residents reviewed for falls (Resident #1). The findings included: Resident #1 was originally admitted to the facility on 11/29/16, with diagnoses including, Dementia, Alzheimer's Disease with late onset, Muscle Weakness, Difficulty Walking and Displaced fracture of base of neck of right femur,	F 309	F 309 A corrective action for affected resident: For resident # 1, on 12/28/2016 when the resident was assessed by the hall nurse to have pain in the right hip and leg, the resident was medicated with PRN pain medication and the on-call MD was notified. The MD gave an order on 12/28/2016 to complete a pelvis and right hip x-ray. X-ray results were received back on 12/29/2016 positive for an acute impacted sub capital fracture of the right femur neck. The MD was notified of fracture on 12/29/16. The resident was sent to the hospital ER on 12/29/2016 and admitted. On 12/30/16, MD was notified	4/10/17

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F 309	Continued From page 10 subsequent encounter for closed fracture with routine healing and Adult Failure to thrive. According to an Admission Minimum Data Set (MDS) dated 12/6/16, Resident #1 was moderately cognitively impaired. In the area of bed mobility and transfers, he required extensive assistance with two person physical assistance. In the area of dressing, eating and personal hygiene, he required total assistance. Review of Resident #1's care plan dated 12/12/16 addressed increased risk for falls related to deconditioning with actual fall. The goal was to minimize risk for falls through current interventions x 90 days. The interventions included to monitor and document x 72 hours post fall follow up. Signs/symptoms: pain, bruising, change in mental status, change in condition or new onset, confusion, sleepiness, inability to maintain posture, agitation, report to doctor any of above signs/symptoms. Observe for possible side effects of medications that may affect balance and gait and report to nurse if change in condition or gait. Determine cause of falls. Educate family caregiver due to causes. During an interview on 3/19/17 at 3:20 AM, Nursing Assistant #1 (NA#1) stated about 2:00 AM on a weekend (12/25/16) she was providing care to a resident in another room. She recalled she heard a noise and found Resident #1 on the floor. NA#1 stated Resident #1 was lying on the floor and he had fallen outside of his door. She stated Resident #1's room was one room up from the room where she was providing care to another resident. NA#1 explained Resident #1's room was at the lower end of a particular hall. She stated the resident did not appear to be in pain. She said he was not yelling or anything. NA#1 revealed she went to get the Third Shift	F 309	that the investigation into origin of the injury revealed an unreported fall. All current residents who have had a fall have the potential to be affected by the alleged deficient practice. Beginning on 04/06/2017 all current residents were interviewed or assessed based on their cognitive status, for a falls history or indicators that a fall may have occurred. The Social Worker interviewed all alert and oriented residents for any falls that may have occurred over the past 30 days. If falls were reported by the resident, it was then compared to the resident□s medical records to ensure a falls assessment was completed along with MD and responsible party notifications. This was completed by 04/07/2017. For cognitively impaired residents, the hall nurses under the direction of the Director of Nursing completed a head to toe assessment for injuries of unknown origin. In addition to this, various nursing staff across all three shifts were interviewed to identify any unreported falls over the past 30 days. This was accomplished by printing a list of falls for the last 30 days. The Director of Nursing reviewed the list of falls with staff for identification of any possible unreported falls that they may be aware of. If any falls were identified as unreported, the resident was immediately assessed for injury, the MD and responsible party notified, and an incident report completed. This process was completed on 04/10/2017.	

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F 309	Continued From page 11 Nurse Supervisor after she saw Resident #1 on the floor. She recalled after the Third Shift Nurse Supervisor checked out Resident #1 and he was ok, she helped to assist the resident to his chair. She stated it was the first time she had seen Resident #1 out of his bed by himself as she could recall. NA#1 revealed Resident #1 usually slept well during the night. During an interview on 3/19/17 at 3:05 AM, the Third Shift Nurse Supervisor revealed she was on another hall Christmas morning and she came back toward the nurse's station toward the medication cart. She revealed a Nursing Assistant told her Resident #1 was on the floor outside his door. She stated there was a lot going on at the time. The Third Shift Nurse Supervisor stated she assessed Resident #1 and he did not exhibit any signs of pain. She recalled the resident was alert and there was no grimacing. She stated she did not see anything to keep from moving him. The Third Shift Nurse Supervisor revealed she brought Resident #1 to the front of the nursing station in a special chair to watch him closer. She stated she forgot to write up everything that morning, including reporting the fall to the next shift and contacting the family and doctor. She stated she went home and forgot about it. She recalled no one saw any signs of pain until days later. The Third Shift Nurse Supervisor said Resident #1 complained of pain two or three days later and she found out later there was a possibility of a small fracture. The Third Shift Nurse Supervisor recalled prior to Resident #1's fall, she gave him medication when he became agitated. She stated when she came back Monday (12/26/16) or Tuesday (12/27/16) night after the fall, he started	F 309	Systemic changes made were: In-service education began on 04/07/2017 by the Staff Development Coordinator for all RNs, LPNs, Med Aides, and NA□s FT, PT, and PRN. The in-service topics included: Incident reporting and required notifications, shift report, completion of an incident report, falls assessment, and ongoing monitoring for 72 hours. The Director of Nursing will ensure that any employee who has not received this training by 04/10/2017 will not be allowed to work until the training is completed. (See Education Attachment). The facility specific in-service was sent to Hospice Providers and Agency Staff whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training by 04/10/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing, Staff Development Coordinator, or designee	

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F 309	Continued From page 12 complaining of pain. In reference to reporting the fall to the doctor, the Third Shift Nurse Supervisor stated if there were no injuries, she would fax the doctor and if there was an injury she would get an order to send the resident out. She stated she did not fax the doctor the night of Resident #1's fall because it slipped her mind. The Third Shift Nurse Supervisor said a lot was going on, such as a lot of people needing care at one time. She stated the fall did not come back to her until she found out the resident had a fracture. During an interview on 3/21/17 at 12:03 PM, NA#3 stated on 12/27/16, when she went in Resident #1's room to put the head of his bed down he moaned. She revealed when she went back in his room and repositioned him, he moaned like he did not want to be bothered. She stated she did know if he was in acute pain because he was a very thin man. NA#3 recalled she checked on Resident #1 quite a bit that night and she also had to change him. NA#3 revealed she did not contact a nurse because Resident #1 acted like he didn't feel good and he did not want to be bothered. During an interview on 3/19/17 at 2:55 PM, Nursing Assistant (NA#2) revealed when Resident #1 got up before she left on Christmas day he did not show any signs of pain. She stated she usually used the sit to stand lift to transfer Resident #1. She stated before they found out Resident #1 had a fracture, she revealed during toileting Resident #1 was able to stand up, with the aide of the sit to stand lift, and pull down his pants most of the time. NA#2 stated she was providing care to Resident #1 on 12/28/16 and she asked Staff Nurse #1 to come in the room with her. She said Resident #1 was	F 309	will monitor this issue using the Clinical Quality Assurance Survey Tool Incident Review and MD Notification Tool (see attachment). The monitoring will include auditing five resident□s residents for timely fall reporting, shift report, and 72 hour assessment procedures post fall. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 309	Continued From page 13	F 309		

grabbing her and he acted like he was hurting. She stated it was right before Resident #1's family came in his room, that they recognized he was hurting. NA #2 recalled Resident #1's family member wanted him out of bed the same day he indicated he was hurting. NA#2 recalled a family member wanted Resident #1 up in a chair after they found out he was in pain because they did not want him lying in bed all the time. She stated the family member got Resident #1 out of bed and he sat up for about a good hour and she put him back to bed. NA#2 revealed Staff Nurse #1 ordered an X-ray and that was when it was determined the resident had a fracture. NA#2 stated she worked with Resident #1 every day on first shift and he had not complained of pain before 12/28/16.

During an interview on 3/19/17 at 2:47 PM, Staff Nurse #1 revealed she worked on first shift with Resident #1 every day and he denied pain. She stated the Nursing Assistant was doing her rounds on 12/28/16 and told her Resident #1 was complaining of pain. She stated Resident #1 did not talk much and each time she picked up his right side he grabbed her hand as if he was hurting. She stated she turned him over and he guarded his right side. She revealed his family was in the room with him when he indicated he was hurting. Staff Nurse #1 revealed she gave Resident #1 Tylenol for pain and called the doctor on call. She revealed it was a week or two weeks prior to that period of time that she remembered he had fallen. Staff Nurse #1 stated every resident was checked every day routinely for pain. She revealed she did not know Resident #1 had fallen. She stated she looked for information regarding a fall and she did not see anything about him having a fall.

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Review of a mobile x-ray report dated, 12/28/16 and exam date, 12/29/16, read in part, "Examination: Right Hip, Pelvis, Clinical indication: Pain, pelvis. Findings: Acute traverse, impacted subcapital fracture neck right femur (thigh bone) is noted with mild right hip joint effusion. Impression: 1. Acute impacted subcapital fracture neck right femur (thigh bone)."

During an interview on 3/20/17 at 2:13 PM, the Director of Nursing (DON) revealed an investigation probably was not done when the fall happened because the Third Shift Nurse Supervisor was tired and went home. The DON revealed she could not find a nurse's note written on 12/25/16 regarding the fall and she did not see an incident report or a fax to the doctor or a phone call to the family. The DON said the Third Shift Nurse Supervisor did not follow policy. She emphasized for a fall with an injury, the procedure was to call the DON, Administrator, family and doctor and for a fall without injury, make notifications and put something in place to prevent the fall from happening again such as putting a mattress beside the bed or bringing the resident up to the nurses station. The DON revealed on 12/28/17 an X-ray was done and it was determined on 12/29/16 Resident #1 had a fracture. She stated they interviewed staff that worked with Resident #1 and a Nursing Assistant said he had crawled out onto the hallway. The DON revealed after it was discovered through interviews that Resident #1 had a fall and fracture, she stated the doctor and Resident #1's family were notified on 12/30/16 at 10:25 AM.

During an interview on 3/21/17 at 12:00 PM, the Administrator stated on the day Resident #1 was

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F 309	Continued From page 15 X-rayed and it was determined he had a fracture on 12/29/16, they started interviewing staff. She revealed once they started interviewing staff they found out Resident #1 had fallen. She revealed the Third Shift Nurse Supervisor did not call her to let her know when Resident #1 had fallen. During another interview on 3/21/17 at 1:03 PM, the Administrator revealed her expectation would be for the Nurse to complete fall report and notify them through the fall reporting system.	F 309		
F 514 SS=G	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document an assessment of a fall and also failed to document resident's complaints of pain and medication given for pain relief after a fall had occurred, for 1 of 3 sampled residents, Resident #1. An x-ray completed after the fall revealed the resident had sustained a right hip	F 514	F 514 A corrective action for affected resident: For resident # 1, on 12/28/2016 when the resident was assessed by the hall nurse to have pain in the right hip and leg, the resident was medicated with PRN pain medication and the on-call MD was	4/10/17

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F 514	Continued From page 16 fracture. The findings included: Resident #1 was originally admitted to the facility on 11/29/16, with diagnoses including, Dementia, Alzheimer's Disease with late onset, Muscle Weakness, Difficulty Walking and Displaced fracture of base of neck of right femur, and subsequent encounter for closed fracture with routine healing. During an interview on 3/19/17 at 3:05 AM, the Third Shift Nurse Supervisor revealed she was on another hall Christmas morning and she came back toward the nurse's station toward the medication cart. She revealed a Nursing Assistant told her Resident #1 was on the floor outside his door. The Third Shift Nurse Supervisor stated she assessed Resident #1 and he did not exhibit any signs of pain. She recalled the resident was alert and there was no grimacing. She stated she did not see anything to keep from moving him. She stated she forgot to write up everything that morning, to report the fall to the next shift, and to contact the family and doctor. She revealed she went home at the end of her shift and forgot about it. The Third Shift Nurse Supervisor continued by stating Resident #1 complained of pain two or three days later and she found out later there was a possibility of a small fracture. The Third Shift Nurse Supervisor recalled prior to Resident #1's fall, she gave him medication when he became agitated. She stated when she came back to work Monday (12/26/16) or Tuesday (12/27/16) night after the fall, he started complaining of pain. During an interview on 3/19/17 at 2:47 PM, Staff Nurse #1 revealed she worked on first shift with Resident #1 every day during the week and he	F 514	notified. The MD gave an order on 12/28/2016 to complete a pelvis and right hip x-ray. X-ray results were received back on 12/29/2016 positive for an acute impacted sub capital fracture of the right femur neck. The MD was notified of fracture and orders on 12/29/16. The resident was sent to the hospital ER on 12/29/2016 and admitted. On 12/30/16, the MD was notified that the investigation into the origin of injury revealed an unreported fall. All current residents who have had a fall have the potential to be affected by the alleged deficient practice. Beginning on 04/07/2017 all current residents were interviewed or assessed based on their cognitive status, for a falls history or indicators that a fall may have occurred. The Social Worker interviewed all alert and oriented residents for any falls that may have occurred over the past 30 days. If falls were reported by the resident, it was then compared to the resident□s medical records to ensure a falls assessment was completed along with MD and responsible party notifications. For cognitively impaired residents, the hall nurses under the direction of the Director of Nursing completed a head to toe assessment for injuries of unknown origin. If injuries were noted, an investigation as initiated. In addition to this, various nursing staff across all three shifts were interviewed to identify any unreported falls over the past 30 days. This was	

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F 514	Continued From page 17 denied pain, prior to 12/28/16. She stated the Nursing Assistant was doing her rounds on 12/28/16 and told her Resident #1 was complaining of pain. She stated Resident #1 did not talk much and each time she picked up his right side he grabbed her hand as if he was hurting. She stated she turned him over and he guarded his right side. She revealed his family was in the room with him when he indicated he was hurting. Staff Nurse #1 revealed she gave Resident #1 Tylenol for pain and called the doctor on call at 4:29 PM. She revealed she did not know Resident #1 had fallen. She stated she looked for information regarding a fall and she did not see anything about him having a fall. During an interview on 3/20/17 at 2:13 PM, the Director of Nursing (DON) revealed an investigation probably was not done when the fall happened because the Third Shift Nurse Supervisor went home. The DON revealed the Third Shift Nurse Supervisor was careless in not calling Resident #1's family and not doing an incident report. The DON revealed she could not find a nurse's note written on 12/25/16 regarding the fall and she did not see an incident report or a fax to the doctor or a phone call to the family. She emphasized for a fall with an injury, the procedure was to call the DON, Administrator, family and doctor and for a fall without injury, make notifications and put something in place to prevent the fall from happening again such as putting a mattress beside the bed or bringing the resident up to the nurse's station. The DON revealed on 12/28/17 an X-ray was done and on 12/29/16 it was determined Resident #1 had a fracture. Resident #1 had surgery, due to the fracture for right hip repair on 12/30/16. The DON revealed after it was discovered through interviews that Resident #1 had a fall and	F 514	accomplished by printing a list of falls for the last 30 days. The Director of Nursing reviewed the list of falls with staff for identification of any possible unreported falls that they may be aware of. If any falls were identified as unreported, the resident was immediately assessed for injury, the MD and responsible party notified, and an incident report completed. This process was completed on 04/10/2017. Systemic changes made were: In-service education began on 04/07/2017 by the Staff Development Coordinator for all RNs, LPNs, Med Aides, and NA□s FT, PT, and PRN. The in-service topics included: Incident reporting and required notifications, completion of an incident report, falls assessment, ongoing monitoring, pain assessment and documentation of interventions including administering PRN medications. The Director of Nursing will ensure that any employee who has not received this training by 04/10/2017 will not be allowed to work until the training is completed. (See Education attachment). The facility specific in-service was sent to Hospice Providers and Agency Staff whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training by 04/10/2017 will not be allowed to work until training has been completed.	

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F 514	Continued From page 18 fracture, she revealed the doctor and Resident #1's family were notified on 12/30/16 at 10:25 AM. During another interview on 3/21/17 at 1:03 PM, the Administrator revealed her expectation would be for the Nurse to complete fall report and notify them through the fall reporting system.	F 514	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing, Staff Development Coordinator, or designee will monitor this issue using the Clinical Quality Assurance Survey Tool Incident Review and MD Notification Tool (see attachment). The monitoring will include observing five resident□s for falls assessment, indicators of pain after a fall, pain management, documentation of PRN pain medications and timely MD notification. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	