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	345229	A. BUILDING _____ B. WING _____	C 08/08/2019

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PEAK RESOURCES - SHELBY	**1101 NORTH MORGAN STREET SHELBY, NC 28150**

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 8/7/19 to 8/8/19. A total of 8 allegations were investigated and all of them were unsubstantiated. There was one citation as a result of the complaint investigation. Event ID# OFT311	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		9/4/19

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

Electronically Signed | 08/28/2019

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F 580	Continued From page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff, family member and physician interviews, and record review, the facility failed to notify the Orthopedic doctor and the Responsible Party (RP) of drainage coming out of a cast for 1 of 1 resident reviewed for notification of significant change (Resident #1). Findings included: A review of Resident #1's medical record revealed she was originally admitted to the facility on 6/30/17 and had a history of right knee replacement approximately 10 years ago. A review of a document titled Report of Consultation from Ortho dated 4/23/19 revealed a diagnosis of periprosthetic right distal femur fracture (broken bone around the implants of a	F 580	F580 Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. Resident #1 There was no adverse effect to the resident due to the resident's responsible party not being notified of the knee wound drainage. Residents with potential: All residents identified with a change in	

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F 580	Continued From page 2 knee replacement) with the following recommendations: hinged knee brace locked in extension, no weight-bearing to right lower extremity, elevated leg rest if in wheelchair but recommend bedrest, check skin around brace for pressure sores. A review of a document titled Report of Consultation from Ortho dated 5/9/19 revealed the following recommendations: right lower extremity immobilized in new brace/cast, no weight-bearing to right lower extremity, do not remove brace, follow-up in 4 weeks. A review of the Annual Minimum Data Set (MDS) Assessment dated 5/14/19 revealed Resident #1 was severely cognitively impaired and required extensive physical assistance with all Activities of Daily Living (ADL). A review of a document titled Report of Consultation from Ortho dated 6/18/19 revealed a diagnosis of non-operable periprosthetic right distal femur fracture with the following recommendations: knee immobilizer, elevate in pillows prn (as needed) and follow-up in 2 months. A review of a document titled Report of Consultation from Dermatology dated 7/8/19 revealed a diagnosis of Scabies (partially treated) with recommendations that included repeating the treatment regimen in 1 week. A review of the facility's Infection Control Policy on Scabies which was last revised on July 2019 revealed the following statement: Residents should remain on Contact Precautions until 24 hours after last treatment.	F 580	condition have been reviewed for proper notification of physician and resident representative, unless otherwise instructed by resident. This was accomplished by the administrator the DON and the LPN-In-Charge and completed on 8/28/19. This included a review of the residents progress notes and physician orders starting 7/24/19 looking for changes in condition and to ensure the MD and residents representative were notified of any change. All residents with a change in condition had the appropriate notification i.e.: physician and resident representative. The Regional nurses reviewed the policy for Change in the Residents Condition. The policy was updated to include but is not limited to: The nurse will notify the resident's attending physician or on-call physician when there has been . A significant change in the resident's physical/emotional/mental condition; A need to alter the resident's medical treatment significantly; Instructions to notify the physician of changes in the resident's condition. Unless otherwise instructed by the resident, the nurse will notify the resident's next-of-kin or representative when: There is a significant change in the	

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F 580	Continued From page 3 A review of a Progress Note dated 7/15/19 at 7:48 AM by Nurse #1 revealed "CNA (Certified Nursing Assistant) called the nurse into the room stating that the resident had something draining from her right leg. This nurse assessed resident's capillary refills and they returned within less than 3 seconds. This nurse assessed resident's hard cast area as good as I could and noted a tip of an opening. Unable to measure area. Placing the resident in the MD (Medical Doctor) board so she can see the Ortho team. DON (Director of Nursing) in and noticed area. Stated to put her down for the Ortho team to open the cast so we can visualize what was going on. Resident with no current c/o (complaints of) pain or discomfort at this time." A review of an Event Report completed on 7/15/19 at 8:02 AM by Nurse #1 for Resident #1 revealed an unmeasurable open area was noted but wasn't fully assessed due to area being covered by a hard cast on Resident #1's right leg. Nurse #1 placed on Doctor board for immediate Ortho consult. Under Resident Representative notification, the following statement was reviewed: No answer from (family member) at this time of the morning. Further review of all Progress Notes in the Electronic Medical Record for Resident #1 from 7/15/19 to 7/22/19 revealed no indication that the Orthopedic doctor or the RP have been notified of a drainage coming out of Resident #1's right leg cast. On 8/7/19 at 10:10 AM, an interview conducted with Nurse #2 revealed she could not remember when the wound to Resident #1's right knee had	F 580	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 start a new form of treatment; A lesson plan was developed by the regional nurses regarding residents change in condition as well as policy updates. This in-service was initiated 8/8/19 provided to the licensed nursing staff by the Staff Development Nurse, the DON and other qualified RN's. This will be completed by 8/30/19 any licensed nurses on LOA, vacation or PRN will be in-serviced on the policy updates prior to returning to an assignment. In addition during the morning clinical meeting the progress notes and physician orders are reviewed for any change in condition and proper notification of physician and resident representative. At the Monday clinical meeting all changes in condition are reviewed from the weekend to ensure proper resident representative and physician notification. Monitoring: A review of the resident's progress notes and orders has been completed daily from 8/7/19 to 8/28/19 by the administrator, the DON and other clinical team members, to	

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F 580	Continued From page 4 started but she was told that Resident #1 could not go to the Ortho during that time because she was currently on contact precautions for Scabies. On 8/7/19 at 2:22 PM, an interview conducted with Nurse Aide (NA) #1 revealed that on the morning of 7/15/19, NA #1 noticed a reddish-brown fluid coming out of Resident #1's right leg cast and left a quarter-sized discolored spot on top of it. NA #1 notified Nurse #2 who told her that Resident #1 could not be seen by the Ortho Clinic because she was currently on contact precautions for Scabies. On 8/8/19 at 4:15 AM, a phone interview was conducted with Nurse #1. Nurse #1 stated that on 7/15/19, one of the NA told her about the drainage coming out of Resident #1's right leg cast. Nurse #1 stated when she lifted the top edge of Resident #1's cast, she saw a tip of an open area, but she couldn't see a lot because the leg was covered with the cast. Nurse #1 further stated she noticed a quarter-sized dark spot on the cast. Nurse #1 stated the DON was present at that time and checked it with her. The DON told her to go ahead and call the on-call Nurse Practitioner. Nurse #1 stated she called the on-call Nurse Practitioner and was told to obtain an "Emergency Consult with Ortho." Nurse #1 reported this off to Nurse #2 and Nurse #3. Nurse #1 also stated that she filled out an Event Report and tried to call the RP but was unable to get in touch with her that morning. On 8/8/19 at 8:55 AM, a phone interview with Resident #1's RP revealed she was not notified by the facility about the drainage coming from the cast on Resident #1's right leg. The RP stated she discovered the drainage when she came to	F 580	ascertain compliance with notification of change of condition. Ongoing review of the physician orders and progress notes will continue using the newly developed audit tool. The audit tool was developed to ensure the physician and the resident representative have been notified of any change in the resident condition. The audit tool consists of the following: 1. The Resident representative has been notified of the resident change of condition 2. The resident physician has been notified/ is aware of the residents change in condition 3. Appropriate clinical documentation is evident. 4. Appointment: there is evidence of communication with consulting physician The audit tool will be completed on 100% of resident with a change of condition over the next 12 weeks, ongoing audits will be determined by the prior 12 weeks of audits. QAPI: The results of the audits will be reviewed and analyzed by the Director of Nurses and presented at the monthly QAPI meetings for the next 6 months.	

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visit Resident #1 on 7/24/19. The RP further stated she visited daily, but she was always told by the nursing staff to step out of the room during resident care.

On 8/8/19 at 10:15 AM, an interview conducted with Nurse #3 revealed she got a note on her desk from Nurse #1 on 7/15/19 about Resident #1 requiring Emergency Consult with the Orthopedic doctor. Nurse #3 discussed this with 2 other nurses at the morning meeting, and it was decided as a group that Resident #1 was currently on contact precautions at that time, and therefore, could not be transported out of the facility. Nurse #3 further stated that she did not check the facility's policy regarding Scabies and did not realize that Resident #1 could have come off contact precautions during that week because her last treatment for Scabies was on 7/15/19. Nurse #3 also stated that she had assumed the RP had known about the drainage because she had talked to her on 7/23/19 about setting up an appointment with the Orthopedic doctor for Resident #1, but Nurse #3 did not discuss the presence of drainage from Resident #1's cast with the RP.

Continuation of the interview with NA #1 on 8/7/19 at 2:22 PM revealed that on 7/22/19, she noticed an increase in the drainage coming out of Resident #1's right leg cast. NA #1 also stated that there was foul odor from Resident #1's right leg cast. NA #1 further stated she placed a towel on top of Resident #1's cast to keep the top sheet from getting wet from the drainage. NA #1 notified Nurse #2 who told her that she was aware of it and that she was trying to get Resident #1 to see the Orthopedic doctor.

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Continuation of the phone interview with the RP on 8/8/19 at 8:55 AM revealed that when she visited Resident #1 on 7/24/19, she uncovered Resident #1 and saw a towel placed on top of Resident #1's cast. The RP lifted the towel and noted a large amount of brownish drainage on the towel and it looked like the drainage came out of Resident #1's cast. The RP spoke with the DON who stated that Resident #1 had a tiny abscess at the tip of the cast. The RP insisted that Resident #1 needed to be seen by the Orthopedic doctor because it was hard to assess the extent of the wound with the cast being in place on Resident #1's right leg. The RP further stated that she called the Ortho Clinic on 7/24/19 twice to get an appointment set up for Resident #1 on the same day.

A review of the Notes from the Ortho Clinic dated 7/24/19 revealed the following: Drainage was bloody and saturated the bandage. The cast was removed from Resident #1's right lower extremity due to wetness and bad odor. The type of cast/splint removed was a knee immobilizer with cast tape around top and bottom of brace. The cast material and knee immobilizer were removed, and the wound was cleaned and dressed. The DON was notified that the Orthopedic doctor wanted to send Resident #1 to the hospital for further treatment.

On 8/8/19 at 10:25 AM, a phone interview with the Orthopedic doctor was conducted. The Orthopedic doctor stated that he expected to be notified of the drainage that came out of Resident #1's right leg cast but he did not think the outcome would have been different if he had been notified of it sooner when the drainage was first noted. The Orthopedic doctor further stated

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that the wound on Resident #1's knee developed from the inside out because she had a fracture that was inoperable. He said that on 4/23/19 when the fracture was first diagnosed, he offered Resident #1's RP treatment options from which the RP chose to have it treated conservatively. The Orthopedic doctor further stated Resident #1 was sent out to the hospital directly from the Ortho Clinic on 7/24/19 because of her other complex medical conditions.

On 8/8/19 at 11:34 AM, an interview conducted with the DON revealed that she did not find out about the drainage from Resident #1's right leg cast until a couple of days later after it was first noted. The DON stated she did know why Nurse #1 had made the statement that the DON was aware of it on 7/15/19. The DON stated there was a quarter-sized reddened area under the cast, but it was hard to see if it was open or not. The DON further stated that she thought the Orthopedic doctor had already been called and they were waiting for Resident #1's appointment. The DON stated she just found out that the Orthopedic doctor had not been called prior to 7/23/19. She further stated that on 7/24/19, she talked to the RP and told her that Resident #1 had a little open area under the cast, but the RP insisted that Resident #1 be sent out to the Ortho Clinic on that day. The DON stated that she expected the nursing staff to notify the RP of significant changes and was not aware that the RP has not been notified of the drainage before 7/24/19. She also stated that Resident #1 could have come off contact precautions during that week so there was no reason why she couldn't go to the Ortho Clinic.

On 8/8/19 at 1:41 PM, an interview with the

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F 580	Continued From page 8 Administrator was conducted with the Regional Nurse Consultant present. The Administrator stated that it was her expectation that the facility doctor and the RP be notified of any significant changes regarding Resident #1. The Administrator further stated that the Orthopedic doctor should have been notified of the drainage coming out of Resident #1's right leg cast as soon as possible.	F 580		