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	345297	A. BUILDING _____ B. WING _____	C 06/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTIA VILLAGE-SNF	2200 ELM DRIVE LAURINBURG, NC 28352

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 06/16/20 through 06/19/20. Event ID# C1L811. 1 of the 1 complaint allegations was not substantiated.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff and consultant interviews the facility failed to assess resident cognition and resident mood in a quarterly Minimum Data Set (MDS) assessment for 1 of 1 residents (Resident #1) whose MDS was reviewed. Findings included: Resident #1 was admitted to the facility on 09/30/09 and had diagnoses of Alzheimer's disease, anxiety disorder and schizophrenia. The quarterly MDS dated 05/26/20 revealed her cognition had not been assessed in section C, and her mood had not been assessed in section D. For C0100 "Should a brief interview for metal status be conducted?" there was no code documented and the interview was blank. For C0600 "Should the staff assessment for metal status be conducted?" there was no code documented and the assessment was blank. For D0100 "Should resident mood interview be conducted?" there was no code documented and the interview was blank. For D0500 "Staff	F 638	F638 – Quarterly Assessment at Least Every 3 Months Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. The quarterly MDS assessment for Resident #1 dated 05/26/20 was completed on 6/17/20 by Karen Davis, RN and submitted on 06/17/20 by Amy Covington, RN. A 100% audit of MDS assessments with an ARD within the past 90 days was completed by the Director of Nursing on 6/19/20 to ensure all assessments were completed accurately and timely. Any issues identified, were corrected	6/19/20

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

Electronically Signed | 07/08/2020

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F 638	Continued From page 1 assessment of resident mood" the assessment was blank. In an interview on 06/16/20 at 4:46 PM the Social Worker (SW) stated that she was responsible for completing sections C and D. She indicated she had planned to go back and complete the quarterly MDS but had forgotten and the sections were missed. The SW stated that the MDS Coordinator had just returned to work, and that a contracted MDS Consultant had been working for the facility for about one month prior to her return. In a telephone interview on 06/16/20 at 5:06 PM the contracted MDS Consultant confirmed that Resident #1's quarterly MDS should have been completed. She stated that she asked the SW several times for the information and was told by the SW she would get it to her, but she never did. The Consultant indicated that the MDS could not be completed without the information from the SW. The contracted MDS Consultant stated that she did not go to the Director of Nursing (DON) or the Administrator to inform them that the MDS could not be completed or to ask for assistance in getting the SW to provide her with the information to complete the quarterly MDS. In a telephone interview on 06/17/20 at 1:21 PM the facility MDS Coordinator stated that the contracted MDS Consultant had sent her a list of what had not been completed while she was out on leave. She confirmed that she read the list and was aware that Resident #1's MDS had not been completed. The MDS Coordinator stated that it was her understanding that the contracted MDS Consultant would complete any outstanding work prior to resident assessment reference dates (ARD) of 06/12/20 even though the MDS	F 638	immediately. On 6/18/20, the Director of Nursing completed an in-service with all IDT members that are involved in completing MDS sections, including the MDS Coordinator, Certified Dietary Manager, Social Worker, Activities Coordinator, and Rehab Manager. This in-service included completing all MDS sections in a timely manner based on RAI guidelines and ensuring all MDS assessments are submitted timely based on RAI guidelines. The MDS Coordinator and Director of Nursing must be notified if any IDT member has knowledge that they will be unable to complete their section of the MDS timely. The Director of Nursing and Associate Director must be notified of any late completions and submissions. All newly hired staff and contracted staff that will be required to complete sections of the MDS will receive this education during orientation. The Director of Nursing and/or the MDS Coordinator will audit all MDS assessments and submissions weekly for 12 weeks to ensure all MDS assessments are being completed accurately and submitted timely according to RAI guidelines. Any identified issues will be corrected immediately upon discovery and the Director of Nursing will ensure the Associate Director is notified for corrective action. The results of this audit will be brought to and reviewed by the Director of Nursing	

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F 638	Continued From page 2 Coordinator was back at work. The MDS Coordinator stated that she informed the contracted MDS Consultant she would remind the SW to complete Resident #1's quarterly MDS. The MDS Coordinator stated that a resident's MDS needed to be completed on time so it could be signed off and transmitted to the appropriate agency. In a telephone interview on 06/19/20 at 10:43 AM the Director of Nursing (DON) stated that the contracted MDS Consultant should have notified her or the Administrator when the SW failed to complete her sections of Resident #1's quarterly MDS. She indicated that if they had known, they could have spoken to the SW and the MDS would have been completed on time.	F 638	Services to the monthly Quality Assessment Performance Improvement Committee Meeting for a minimum of three consecutive meetings. Any issues, trends or concerns identified will be addressed and the plan will be updated to ensure continued compliance.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Family Nurse Practitioner (FNP), and Physician interviews the facility staff failed to raise the footrest on a resident's recliner as directed on the Care Plan and failed to transfer a resident using the required mechanical lift as listed on the Resident Care Guide for 1 of 1 residents (Resident #1) reviewed for accidents. Staff manually transferred	F 689	F689 □ Free of Accident Hazards/Supervision/Devices Resident #1 was sent to the hospital on 06/02/20 for evaluation and treatment. Each Nurse Mentor completed an audit of 100% of skilled nursing resident□s care	7/8/20

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Resident #1 to her recliner chair, and she had an unobserved fall from the chair which was not in the elevated position. As a result of the fall, Resident #1 experienced swelling to her right knee and leg pain. An x-ray showed that Resident #1 had a distal femur fracture. The facility staff also failed to report that the resident fell and to have the resident assessed by a nurse prior to moving her.

Findings included:

Resident #1 was admitted to the facility on 09/30/09 and had diagnoses of osteoporosis, Alzheimer's disease and Alzheimer's dementia.

The Falls Risk Assessment dated 05/24/20 revealed that Resident #1 was always disoriented. Resident #1's cognitive status had deteriorated, and she had no falls in the past three months. Resident #1 had severely impaired vision, was chair bound, and was unable to ambulate. Resident #1 was at high risk for falls.

The Care Plan which was updated on 05/25/20 showed that Resident #1 was at risk for falls. Interventions included the use of a mechanical lift for transfers and that Resident #1 not be left in the recliner unsupervised unless the feet were elevated. The Care Plan also revealed that Resident #1 was a total assist for transfers and that two people were needed for transfers with the mechanical lift.

The quarterly Minimum Data Set (MDS) dated 05/26/20 revealed Resident #1 had short- and long-term memory problems and was severely impaired in skills for daily decision making. Resident #1 was totally dependent on the

guides and care plans to ensure the appropriate method of transfer were listed on the care guide, care plan, and triggered to the kiosk. No other residents audited were found to be impacted. This audit was completed on 06/24/20.

The Director of Nursing completed an audit of 100% of skilled nursing resident□s care guides and care plans to ensure appropriate fall interventions were listed on the care guide, care plan, and triggered to the kiosk. No other residents audited were found to be impacted. This audit was completed on 7/8/20.

On 06/03/20, the Staff Development Coordinator began in-servicing 100% of licensed nursing staff regarding resident lifting and transferring. This in-service included following of resident care guides and reporting of incidents. This in-service was completed on 06/17/20. No staff will be allowed to work until they have received the in-service. All newly hired staff will receive this education during orientation.

On 07/02/20, each Nurse Mentor implemented staff huddles at each change of shift, for their respective households utilizing a daily shift huddle form. The goal of these huddles is to collect and share relevant information about residents and will be attended by off-going and on-coming nurses, medication aides, and nursing assistants. Staff huddles will require a signature attendance sheet and staff will

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physical assistance of two people for transfers.

The Resident Care Guide that was in effect on 05/31/20 revealed that Resident #1 was at risk for falls. Resident #1 was to be transferred using a mechanical lift with two people.

The Clinical Notes Report dated 06/01/20 at 10:21 AM and 1:04 PM revealed no entries mentioning Resident #1's knee swelling. These were the only two notes for 06/01/20.

The Clinical Notes Report dated 06/03/20 at 7:31 PM showed a Late entry note for 06/01/20 that was written by Nurse #1. The note specified that on 06/01/20 Nursing Assistant (NA) #1 reported swelling and pain to Resident #1's right knee to Nurse #1 when she put the recliner down to assist Resident #1 with lunch. There was minimal swelling and no bruising.

The Clinical Notes Report dated 06/02/20 at 12:11 PM revealed that Resident #1 had right knee swelling and was lying with her legs elevated. Pain was noted when her right leg was moved.

The Clinical Notes Report dated 06/03/20 at 7:24 PM showed a Late entry note for 06/02/20 that was written by Nurse Mentor #1. The note specified that Nurse Mentor #1 was notified of Resident #1's right knee swelling by Nurse #1 on 06/02/20 at approximately 9:00 AM. Resident #1 had been scheduled to see the medical provider and Nurse Mentor #1 had spoken to the FNP at 3:43 PM when she ordered an x-ray and labs. At 7:20 PM the results of the x-ray revealed a fracture and the provider was notified. Resident #1 was sent to the Emergency Department (ED).

communicate any occurrences during the shift. Nurse Mentors will be responsible for reviewing daily huddle sheets for identification of concerns.

The Staff Development Coordinator, MDS Coordinator, or the Director of Nursing will conduct observational audits to ensure resident care planned interventions are in place and residents are transferred according to their care plan. The observational audit will be completed for 10 residents per week for four weeks, then five residents weekly for four weeks, then five resident per month for two months. Any identified issues, including improper transfers will be immediately corrected prior to the transfer and re-education will be completed and documented. The issue will then be reported to the Director of Nursing and Associate Director immediately for corrective action.

Nurse Mentors for each household will attend two staff huddles per week in their respective household to ensure appropriate communication and utilization of the shift huddle form is occurring at shift change, with specific emphasis on any new care planned interventions for falls, transfer and lift needs. These audits will occur twice per week for 12 weeks.

The results of both these audits will be brought to and reviewed by the Director of Nursing Services and Nurse Mentors to the monthly Quality Assessment Performance Improvement Committee

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F 689	Continued From page 5 Staff were interviewed and it was discovered that Resident #1 had fallen out of a recliner on 06/01/20 and the fall was not reported by the NAs involved. In a telephone interview on 06/17/20 at 2:15 PM NA #2 confirmed that she was assigned to Resident #1 on the 11:00 PM-7:00 AM shift which began on 05/31/20. NA #2 stated she started working that night on another assignment and had been pulled to work on the Light House hall about 45 minutes into the shift. She indicated that the report she received from NA #3 for her new assignment was that everyone was fine and no information about the resident's care was provided. She stated she did not receive any report from the nurse. NA #2 stated that it was only the second time she had cared for Resident #1. She indicated that when it was time to shower Resident #1, she and NA #3 lifted her out of bed without using the mechanical lift and she took her to the shower room. She indicated after Resident #1 was showered she returned to the room and she and NA #3 lifted her into the recliner without using the mechanical lift. NA #3 left the room. Resident #1 was barefoot and resting in the recliner with the foot of the recliner in the down position. NA #2 stated she turned away and walked about four steps to get an item for Resident #1's arms and when she turned around Resident #1 was sitting on the floor with her back against the recliner and her legs straight out in front of her. NA #2 indicated Resident #1 did not appear to be in pain although there was a small amount of blood on her lip. She stated she ran to get NA #3 to help her with Resident #1. NA #2 indicated that she came back into the resident's room with NA #3 following behind her. She stated that NA #3 closed the door and asked	F 689	Meeting for a minimum of three consecutive meetings. Any issues, trends or concerns identified will be addressed and the plan will be updated to ensure continued compliance.	

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her if she had informed the nurse yet. When NA #2 told her no, NA #3 told her "good, don't." NA #2 stated that she and NA #3 lifted Resident #1 off the floor by placing their arms under Resident #1's arms and holding the back of her pants. They did not use the mechanical lift. NA #2 stated that Resident #1's feet were not lifted off the floor and were dragged when they lifted her off the floor, and that once in the recliner Resident #1's legs were raised. NA #2 indicated she stayed until the end of her shift and gave report to the oncoming NA but did not inform her that Resident #1 had fallen from the recliner onto the floor. NA #2 stated that she knew she should have used the mechanical lift to transfer Resident #1 and that she should have reported the fall to the nurse but that she was scared. She indicated she had just been through orientation and received training on the facility no lift policy. She indicated that Resident #1's right knee was a little swollen before the fall but that she had not reported this to the nurse either. She stated that the information on how to care for each resident was on the Kardex in the computer kiosk on the hall. She indicated that she had no time to look at the information prior to taking on her assignment so just cared for the residents the same way she did when she was orienting with another NA on that hall and the mechanical lift had not been used for Resident #1.

In a telephone interview on 06/18/20 at 9:27 AM NA #3 confirmed that she worked with NA #2 on the 11:00 PM-7:00 AM shift on 05/31/20 but was not assigned to Resident #1. She stated that she informed NA #2 that Resident #1 needed to be showered and to use a mechanical lift for the transfer. NA #3 stated that NA #2 never came to ask her for assistance in transferring Resident #1

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for her shower or to place her in the recliner following the shower and she did not assist with those transfers. She indicated that NA #2 did come to ask for assistance in dressing Resident #1 and that she cared for about three other residents and then took the mechanical lift to Resident #1's room and knocked on the door. When she opened the door, she saw Resident #1 on the floor next to the bed with blood on her lip. NA #3 stated that NA #2 said that Resident #1 had slid down and kept asking if she was going to be in trouble. NA #3 stated that she panicked when she saw the blood and just wanted to get Resident #1 off the floor, so she and NA #2 lifted the resident off the floor and placed her in the recliner. NA #3 admitted that she should have used the mechanical lift to get Resident #1 up off the floor, but she had not. She indicated she told NA #2 to tell the nurse and that NA #2 left the room. NA #3 stated that she left Resident #1 in the recliner and went to finish caring for the residents on her own assignment. She gave report to the oncoming NAs at change of shift, but she did not report Resident #1's fall to anyone.

In a telephone interview on 06/17/20 at 5:17 PM Nurse #2, who worked on 05/31/20 on the 7:00 PM-7:00 AM shift and was responsible for caring for Resident #1, stated that neither NA #2 nor NA #3 had informed her that Resident #1 had fallen early that morning. She stated that if she had been informed of the fall, she would have assessed Resident #1 and assisted the NAs with putting her back in the bed or recliner using the mechanical lift. She indicated she would have notified the medical provider of the fall and carried out any orders they gave. She indicated that Resident #1 should have been transferred using a mechanical lift and that she had been

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available to assist with transfers if needed but had not been asked. Nurse #2 indicated that she had seen NA #2 transport Resident #1 to the shower room and back but had not witnessed the actual transfers. She stated that the NAs knew what each resident needed because it was the responsibility of the nurse to make sure that they knew what care to provide. Nurse #2 stated she had not given any type of report to NA #2 because she had worked on that assignment before and knew what the residents needed. Nurse #2 then stated that she "might" have mentioned something to NA #2 but was not sure. She stated other than report from the nurse, there would be no other way for the NAs to know what to do for the residents unless "maybe" there was something when they did their charting.

In a telephone interview on 06/18/20 at 10:08 AM NA #1 confirmed that she worked with Resident #1 on the 7:00 AM-3:00 PM shift on 06/01/20. NA #1 stated that she did not receive report from NA #2, but that NA #3 had told her that Resident #1 had been bathed. Neither NA had reported to her that Resident #1 had experienced a fall. She indicated that after she fed Resident #1 lunch and placed the recliner foot up, Resident #1 said "oh my leg." NA #1 indicated that she thought the comment was because of the repositioning of Resident #1's legs in the recliner. NA #1 stated that when she went to transfer Resident #1 into the bed from the recliner using the mechanical lift she said "oh my leg" again. NA #1 undressed Resident #1's lower body at that time and saw the swelling of the right knee. She reported the swelling to Nurse #1. NA #1 stated that prior to that day there had been no swelling in the knee and there had been no complaints of knee pain.

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In an interview on 06/16/20 at 3:17 PM NA #4 stated she had worked with Resident #1 on 06/01/20 on the 3:00 PM-11:00 PM shift and had been informed by Nurse #1 about Resident #1's knee swelling, but not about a fall as it had not been reported at that time.

In a telephone interview on 06/17/20 at 1:38 PM NA #5 confirmed that she had worked with Resident #1 on 06/01/20 on the 11:00 PM-7:00 AM shift. She indicated she saw the swelling to Resident #1's knee and reported it to Nurse #3 who came and assessed the knee. NA #5 stated she repositioned Resident #1 every two hours and did not see any bruising to the knee. NA #5 indicated that Resident #1 did not appear to be in pain.

In an interview on 06/16/20 at 2:56 PM Nurse #1 indicated she worked on 06/01/20 on the 7:00 AM-7:00 PM shift. She indicated that NA #1 had informed her around lunch time that Resident #1 had a swollen knee and complained of pain to the knee. Nurse #1 stated she assessed Resident #1 and noted only slight to minimal swelling of the right knee. She indicated she asked NA #1 to remove the support stockings and to elevate Resident #1's legs. Resident #1 was due for scheduled pain medicine, so she provided the medication to the resident with good result. Nurse #1 stated that later in the shift Resident #1's knee looked about the same and that she informed the oncoming nurse (Nurse #3) of the swelling. She stated that when she worked on 06/02/20, the swelling in Resident #1's knee had increased. Nurse #1 stated that she informed Nurse Mentor #1 that Resident #1 needed to be seen by the medical provider. She indicated that at that time there was no bruising to Resident

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#1's right knee. Nurse #1 indicated that Resident #1 was kept in bed with her leg elevated and was repositioned every two hours. She indicated that during repositioning, Resident #1 complained of pain to the right leg. Nurse #1 stated that the FNP had been in in the afternoon to examine Resident #1 and had ordered an x-ray of the right knee due to the swelling and faint bruising that was now seen on Resident #1's right knee. She indicated that about 7:00 PM she received a call from Nurse Mentor #1 and was told to send Resident #1 to the ED.

In an interview on 06/16/20 at 2:06 PM Nurse Mentor #1 stated she spoke with Nurse #1 on 06/02/20. Nurse #1 informed her that Resident #1 had a swollen right knee. Resident #1 was placed on the list to be seen by the provider. There was no bruising or injury that Nurse #1 was aware of at that time. In the afternoon the FNP reported that there was bruising and swelling to Resident #1's right knee and an x-ray and labs were ordered. Nurse Mentor #1 indicated that she initiated an investigation and began to call staff who had worked with Resident #1 over the last few days. She was informed by NA #1 that she had noticed the swelling to Resident #1's right knee on 06/01/20 about midday and had reported the swelling to Nurse #1. Nurse Mentor #1 indicated that Nurse #1 had assessed the knee on 06/01/20 and had informed the second shift NA to leave Resident #1 in bed. She stated that she continued calling staff and spoke with NA #2 who told her that she was unaware of anything happening to Resident #1. Nurse Mentor #1 indicated that NA #2 stated that when she had transferred Resident #1 into a shower chair in the early morning of 06/01/20, Resident #1 had verbalized a yelping sound but that was all.

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SCOTIA VILLAGE-SNF	2200 ELM DRIVE LAURINBURG, NC 28352

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Nurse Mentor #1 stated that when the Radiology Report was received on 06/02/20 and revealed a fracture, she notified the FNP and received an order to send Resident #1 to the ED. Nurse Mentor #1 stated that NA #2 called her back a little while later and related that after showering Resident #1, the resident was transferred into a recliner in the resident's room. Nurse Mentor #1 indicated that NA #2 told her that she turned away from the resident and Resident #1 fell onto the floor. NA #2 went to get NA #3, and they picked Resident #1 up off the floor and placed the resident back in the recliner without informing Nurse #2 of the fall. NA #2 informed Nurse Mentor #1 that she was told by NA #3 not to tell the nurse about Resident #1's fall. Nurse Mentor #1 stated she called the Director of Nursing (DON) and informed her of NA #2's statement.

In an interview on 06/16/20 at 2:17 PM the DON indicated that after she became aware of NA #2's statement, she checked the schedule and saw that NA #3 was scheduled to work 11:00 PM-7:00 AM on 06/02/20. She stated she contacted NA #3 via telephone and instructed her not to come to work that night, but to come to the facility in the morning of 06/03/20 for an interview. NA #2 was not scheduled to work on 06/02/20 and was also asked to come to the facility for an interview on 06/03/20. The DON indicated that during her interview NA #2 was upset, tearful, and avoided eye contact. NA #2 verified that she had worked with Resident #1 on the 11:00 PM-7:00 AM shift that began on 05/31/20. NA #2 told the DON that after she showered Resident #1, she placed the resident in a recliner using a mechanical lift. NA #2 told the DON that the foot rest of the recliner was down and that she turned away from Resident #1 and heard a thud. She looked back

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and saw Resident #1 sitting on the floor with her back against the recliner and both legs straight out in front. NA #2 told the DON that she went to get NA #3 for help and that when NA #3 came into the room she asked NA #2 if she had told Nurse #2. When NA #2 stated that she had not informed the nurse, NA #3 told NA #2 "good, don't" and they lifted Resident #1 off the floor without using the mechanical lift into the recliner. NA #2 indicated to the DON that Resident #1 was singing and did not appear to be in pain. The DON stated that NA #2 indicated that she knew she should have reported the fall to the nurse. The DON indicated that NA #3 was belligerent, defensive and angry during her interview. She confirmed that she was not assigned to Resident #1 when the fall occurred and that she only assisted with getting Resident #1 off the floor and into the recliner. NA #3 denied that she assisted NA #2 with any mechanical lift transfers for Resident #1 during their shift. She told the DON that she knocked on Resident #1's closed door and when she opened it, she saw Resident #1 sitting on the floor. NA #3 indicated she instructed NA #2 to go and get the nurse and that NA #2 left the room. When NA #2 came back to the room, they lifted Resident #1 off the floor without using a mechanical lift and placed her in the recliner. The DON stated she had the two NAs perform a demonstration of how they lifted Resident #1 into the recliner. The NAs each placed a hand under her arms and lifted her into the chair. NA #3 related to the DON that she knew she should have reported the fall to the nurse but that she did not. NA #3 told the DON that she would never have told NA #2 not to tell the nurse about the fall. The DON stated that both NAs employment was terminated because they failed to properly transfer Resident #1 and

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failed to report the fall.

In an interview on 06/16/20 at 1:46 PM the Staff Development Coordinator (SDC) stated that NA #2 and NA #3 had recently been through orientation. She stated that she had done the orientation herself and knew that they both were aware that the facility was a no lift facility, that residents needed to be transferred according to the information on the Resident Care Guide, and that falls needed to be reported to the nurse right away. She indicated that everyone made mistakes but that they made the wrong choice when they decided not to use the mechanical lift to transfer Resident #1 and to not report the fall to the nurse.

The FNP Progress Note dated 06/02/20 revealed she had been requested to examine Resident #1 due to swelling in the right knee. The nurse had denied any recent injury but there was moderate swelling and bruising to the knee. There was pain when passive range of motion (movement) was performed on the knee. Resident #1 was unable to verbalize a possible incident or when the swelling had started. There was no acute distress and no wound was noted. Pulses were present in the right lower extremity. A knee x-ray was ordered.

The Radiology Report dated 06/02/20 showed that Resident #1 had a distal femoral supracondylar fracture with medial and posterior displacement (a straight across misaligned break in the thigh bone just above the knee) of indeterminate age (unable to tell by x-ray alone if the fracture was new or old). There was also diffuse osteopenia (a condition that causes the loss of bone mass causing bones to weaken)

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noted.

Multiple attempts to contact the Radiologist were unsuccessful.

In a telephone interview on 06/18/20 at 9:49 AM the FNP stated that she performed rounds on Tuesdays at the facility. She indicated she received a list of residents who needed to be seen and Resident #1's name was on the list because of right knee swelling. The FNP stated that when she examined Resident #1's right knee it appeared to be about three times larger than the left knee and had a slight discoloration. Resident #1 was non-ambulatory and could not verbalize what had happened to her knee. The FNP indicated there had been no report of any type of injury so she ordered an x-ray of the knee along with labs. She stated that when the x-ray showed a fracture, she ordered that Resident #1 be sent to the ED. Later she was informed that a NA had come forward and admitted that Resident #1 had fallen on 06/01/20 and the fall had not been reported. The FNP stated that from the severity of the break, she felt the fracture was from the fall and was not pathological (caused by an underlying disease).

In a telephone interview on 06/18/20 at 10:40 AM Resident #1's Physician stated that she was severely demented and could not tell anyone what happened. He indicated that he thought the break was traumatic rather than pathological in nature even with a diagnosis of osteoporosis. He indicated that he was aware that swelling to the knee had been reported and that later a NA had confessed that Resident #1 had fallen and that she had not reported it. The Physician stated that the NAs should have used a mechanical lift to

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F 689	Continued From page 15 transfer Resident #1 from the floor to the recliner after the fall. In a telephone interview on 06/19/20 at 10:43 AM the DON indicated that NA #2 and NA #3 should not have moved Resident #1 prior to reporting the fall to the nurse so an assessment could have been done to rule out injury. Once Resident #1 had been assessed they should have gotten the resident up according to the information in the Resident Care Guide which for this resident was with a mechanical lift with two people assisting. The DON indicated that transfer information was readily available in the care guide in the computer kiosk and both NAs knew how to access that information. The DON confirmed that both NAs had received training in orientation about reporting of incidents and transfers. Both NAs were terminated.	F 689		