STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28256

(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 000	INITIAL COMMENTS On 03/06/17 the Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section began a complaint investigation at the facility. In order for the State Survey Agency to obtain all needed staff interviews to complete the investigation the survey's exit date was extended to 3/14/17. Event ID# QH0Z11. On 03/29/17 an amended Statement of Deficiencies was provided to the facility because the State Agency made revisions to tags F-157 and F-309. Event ID# QH0Z11.	F 000		
F 157 SS=G	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (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	F 157		4/14/17

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

Electronically Signed | 03/31/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 (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- (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). This REQUIREMENT is not met as evidenced by: Based on interviews with the physician, nurse practitioner and staff, and review of the medical record, the facility failed to notify the physician of a resident's fall which required surgical repair for a hip fracture for 1 of 4 sampled residents reviewed for physician notification (Resident #5). The findings included: Resident #5 was admitted to the facility on 05/29/13. Diagnoses included seizure disorder, mental disorder, mood affective disorder,	F 157	1. Resident #5 was transferred to the hospital and discharged from the facility on 2/24/17. 2. From 3/30/17-4/4/17, the Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) completed a quality monitoring of residents who sustained a fall from 2/28/17-3/28/17 to validate that the residents' physician and/or nurse practitioner (NP) was notified at the time of the fall. No discrepancies were	

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F 157	Continued From page 2 dementia, left knee deformity, history of falling and multiple old skeletal fractures. Review of Resident #5's annual Minimum Data Set (MDS) and Care Area Assessment dated 5/3/16 and quarterly MDS dated 1/19/17 assessed the resident with moderately impaired cognition, required supervision of one staff person with bed mobility, transfers and activities of daily living (ADL) and had no limitations with range of motion (ROM). A care plan updated 1/19/17, included to notify the physician (MD) of changes in condition. Review of two of the facility's reports, incident occurrence and Situation, Background, Appearance and Review/Notify (SBAR), both dated 1/20/17, recorded Resident #5 was noted with confusion, combative, lying on floor in front of her bathroom door, clothes wet with urine, call bell in reach, but not in use, confused, and looking for a family member. The SBAR documented that there was no sign/symptom (s/s) of injury, that the nurse practitioner (NP) was notified on 1/20/17 at 1:45 PM and gave verbal telephone orders and a message was left for the responsible party. Review of a MD progress note dated 01/23/17, revealed Resident #5 was assessed by the MD regarding a change in mental status (MS) from Friday, 1/20/17. The MD reviewed/assessed the labs ordered on 1/20/17 - 1/22/17 by the NP and assessed Resident #5. The progress note documented Resident #5 was seated at bedside with no acute distress, MS back to baseline, minimally verbal, lab results were negative for a urinary tract infection (UTI), chest xray (CXR) and dehydration, however, Resident #5 had an	F 157	identified. 3. By 4/7/17, the DCS and/or ADCS reeducated licensed nurses on regulation 483.10(g)(14) regarding notification of changes and Consulate Policies and Procedures N-105 “Change in Resident Condition”. Education included the expectation of the licensed nurse to promptly notify the residents’ physician and/or NP after a fall and to communicate and document the residents’ clinical assessment including but, not limited to, vital signs, range of motion (ROM) and neurological changes and pain. Newly hired licensed nurses will be educated upon hire. The licensed nurse are to promptly notify the residents’ physician and/or NP after a fall and will communicate the residents’ clinical assessment including but, not limited to, vital signs, range of motion (ROM)and neurological changes. Notification to be documented on the SBAR (Situation Background Appearance and Review) and physician and/or NP recommendations implemented as indicated. The DCS/Nurse Supervisor will review resident falls with the IDT (Interdisciplinary Team) during the morning stand-up meeting Mondays-Fridays and weekly during the Falls Committee Meeting to ensure compliance with timely physician and/or NP notification of residents who fall. 4. The DCS/Registered Nurse Supervisor will conduct Quality Assurance Monitoring of 3 residents’ medical records to ensure that the residents’ physician and/or NP was promptly notified after a	

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F 157	Continued From page 3 elevated white blood cell count (Leukocytosis), and a low Dilantin level with possible seizure activity on 1/20/17. The plan was to order additional labs, discontinue the intravenous fluids (IVF) ordered by the NP, continue the antibiotic (Levaquin) ordered by the NP until repeated labs returned and refer Resident #5 for a neurology (neuro) consult. The progress note did not indicate notification of, or an assessment specific to a fall on Friday, 1/20/17. Review of the SBAR and hospital transfer summary, both dated 1/24/17, revealed that on 1/24/17, Resident #5 was transferred to the emergency room after Resident #5 called 911 and requested to have the emergency medical staff (EMS) take her to her family. Review of a hospital consultation report dated 1/25/17 recorded Resident #5 expressed seizure activity, and a fall, with mild left hip pain. An Xray completed during the hospital course revealed a displaced left femoral neck fracture that was repaired surgically at the hospital. An interview on 3/6/17 at 2:15 PM with nurse aide (NA) #1 revealed she worked with Resident #5 routinely on the 7A-3P shift. NA #1 described Resident #5 as alert/oriented, normally cooperative with care, not typically combative, independent with ADL, and required set up help only. NA #1 stated that she found Resident #5 on the floor in her room on 1/20/17, she did not recall the time nor the position of the resident's legs, and told Nurse #1. NA #1 stated Resident #5 was combative when Nurse #1 attempted to take the resident's vital signs (VS). NA #1 stated Resident #5 was combative, swinging at staff, when she and NA #1 used a gait belt to assist	F 157	fall at a frequency of 3 times a week for 4 weeks, 1 time a week for 8 weeks, then monthly . Schedule for QI monitoring will be modified based on findings. The results of QI monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or designee. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action if necessary to maintain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director, and at least three other members.	

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Resident #5 off the floor to her wheel chair (wc). NA #1 stated Resident #5 did not complain of pain and did not notice bruising/swelling/redness to her skin at the time of the fall, during the transfer to her wc or when NA #1 assisted Resident #5 to get dressed later in the shift.

An interview on 3/6/17 at 2:35 PM with NA #2 revealed she was in orientation on 1/20/17 when NA #1 asked for her assistance on the 7A - 3P shift to transfer Resident #5 from the floor to her wc after a fall. NA #2 stated she observed Resident #5 seated on the floor with her legs in front of her in a pool of urine. NA #2 stated Resident #5 expressed she did not want help getting off the floor and that the resident was not cooperative initially, but then cooperated with staff to transfer to her wc. NA #2 stated Resident #5 did not express pain and no signs of injury was observed. NA #2 stated that was her first and only time caring for Resident #5.

An interview on 3/6/17 at 3:20 PM with Nurse #1 revealed she was the treatment nurse for the facility, but on 1/20/17 she worked as a charge nurse on the floor providing medications to residents on the 7A - 3P shift. Nurse #1 stated on 1/20/17, she was the assigned nurse for Resident #5 and that the resident was in bed wearing her night clothes prior to her fall; Resident #5 had refused assistance with morning care and staff planned to return to offer assistance again. Nurse #1 stated NA #1 advised her that Resident #5 was on the floor in her room around 11:30 AM on 1/20/17. When Nurse #1 arrived to the resident's room, she found the resident on the floor on her back, her legs were in front of her, she was kicking/grabbing at staff, kicking in all directions and moving arms/hands in all directions. Nurse

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#1 stated Resident #5 did not complain of pain, but that Nurse #1 was unable to complete a full body assessment, assess ROM or obtain VS because Resident #5 was not cooperative. Nurse #1 stated she assumed Resident #5's ROM was fine because she moved her arms/legs in all directions when Resident #5 was combative and "This was not like her." Nurse #1 stated she called the NP and advised of the resident's change in MS, but not of the fall, nor did she advise the Unit Manager (UM), write a nurse's note (NN), record the fall on the 24 hour nursing communication report or in the MD communication book. She noted the reason was that she was not feeling well on Friday, 1/20/17, left her shift early and did not know who replaced her. Nurse #1 stated that when she spoke to the NP on the phone, she received verbal orders from the NP to obtain labs, a urinalysis, a CXR and start IVF. Nurse #1 stated when she returned to work on Monday, 1/23/17 she completed the incident report and SBAR, but that she did not work with Resident #5 after the fall on 1/20/17 nor before the Resident was discharged to the hospital on 1/25/17. Nurse #1 stated she was not aware that Resident #5 had a hip fracture. Nurse #1 stated she was counseled for not notifying the MD/NP of the fall, not documenting the fall in a NN/24 hour communication report/MD communication book and notifying the UM of the fall.

An interview on 3/6/17 at 4:00 PM with Nurse #2 revealed she worked as needed on the 7A - 3P and 3P - 11P shifts and had previously worked with Resident #5. Nurse #2 stated she worked with Resident #5 on Tuesday, 1/24/17 on the 3P - 11P shift, the day Resident #5 was transferred to the hospital. Nurse #2 stated during the shift on

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1/24/17, Resident #5 was noted self propelling in her wc, making multiple attempts to contact a family member via phone, cursing at staff and refusing staff's assistance with incontinence care. Nurse #2 stated this behavior was unusual for Resident #5 and unsuccessful attempts were made to assess the resident for s/s of pain/change in condition due to non-compliance. Nurse #2 stated Resident #5 took her medications without incident, denied pain when asked and that the resident eventually agreed to receive incontinence care. Nurse #2 stated that around 8:30 PM Resident #5 was witnessed to call 911 and requested EMS to take her to see a family member. Nurse #2 stated EMS arrived around 9:00 PM, assisted Resident #5 with a transfer from her wc to the stretcher and that during this transfer, Resident #5 complained of knee pain which was a routine complaint, but the first time she complained of pain that shift. Nurse #2 stated she was not aware that Resident #5 sustained a fall on 1/20/17 and that Nurse #2 did not assess Resident #5 for any s/s of injury post fall.

An interview on 3/6/17 at 4:50 PM with the MD via phone revealed she assessed Resident #5 in the facility on Monday, 1/23/17 for altered mental status (AMS). The MD stated at the time of her assessment on 1/23/17, she was not aware that Resident #5 sustained a fall on 1/20/17. The MD stated that labs were ordered by the NP because of a change in MS and possible seizure activity, not because of a fall. The MD stated that Resident #5 did not show s/s of distress or pain, but that she did not specifically assess the resident for hip pain. The MD stated she was made aware of the hip fracture after Resident #5 was transferred to the hospital on 1/24/17

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because the hospital contacted the facility to request assistance with contacting the family for authorization to surgically repair the resident's hip. The MD stated that the hip fracture quite possibly resulted from the resident's fall in the facility on 1/20/17 and that she would have expected MD/NP notification of a fall when a resident experienced a change in MS and subsequent fracture or documentation in the MD communication book for the MD/NP to follow up at the next onsite visit, if the fall did not result in injury.

An interview on 3/6/17 at 5:30 PM with UM #1 revealed she was in the facility on 1/20/17 on the 7A - 3P shift when Resident #5 fell. UM #1 stated Nurse #1 was the hall nurse that day/shift and left shift early because she was not feeling well. UM #1 stated she took over the medication cart that day, but Nurse #1 did not notify her of the resident's fall, did not notify the NP, did not complete a NN, incident report, document the fall on the 24 hour report or in the MD communication book. UM #1 stated she was not notified of the resident's fall on 1/20/17, the day it occurred. UM #1 stated she was made aware of the fall when she reviewed the SBAR on Monday, 1/23/17, but that the MD was not notified of the fall until 1/25/17 when the hospital contacted the facility and notified that Resident #5 required surgical repair of a hip fracture from a fall.

An interview on 3/6/17 at 5:50 PM with the director of nursing (DON) revealed that she was made aware on Monday, 1/23/17 that Resident #5 fell on Friday 1/20/17. The DON stated that Nurse #1 was the assigned nurse for Resident #5 on Friday, 1/20/17, but she failed to notify the MD/NP, UM/oncoming nurse of the fall for

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continued monitoring. The DON stated that nursing staff were only made aware of the resident's AMS/confusion. The DON stated that she conducted an investigation regarding Resident #5's fall and that Nurse #1 was counseled regarding the expectation to document adverse events in the MD communication book and to report adverse events to staff. The DON stated that when a resident fell, she expected the nurse responsible for the resident to communicate the fall by documenting in the 24 hour reporting book, complete an incident report, document the fall on the SBAR and in the MD communication book. The DON stated that if the fall resulted in obvious physical injury, the MD/NP would be called, otherwise the fall would be documented in the MD communication book.

A telephone interview was conducted on 3/13/17 at 3:29 PM with the NP. The NP stated she received a phone call from the facility on Friday, 1/20/17 and was made aware of a change in MS/confusion regarding Resident #5, but that she was not informed that Resident #5 fell. The NP stated she suspected that Resident #5 had an elevated Dilantin level and possible infection and gave verbal orders for labs, and obtain a urinalysis/CXR immediately. The NP stated that had she been made aware that Resident #5's altered MS occurred after a fall, she would have asked about the resident's VS, neuro checks, pain, deformities, and would have likely sent her to the hospital for further evaluation of the increased confusion. The NP stated that she expects to be notified of a resident's fall especially if the resident experiences a change in MS. The NP further stated that it was possible Resident #5's fracture occurred as a result of the fall, "To say otherwise would be inaccurate."

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A telephone interview was conducted on 3/13/17 at 4:03 PM with Nurse #3, assigned to care for Resident #5 on the 11P - 7A shift on 1/20/17. The interview revealed she did not recall specifically which days/shifts she cared for Resident #5, but that she was not aware that Resident #5 fell nor did she assess Resident #5 for s/s of injury post fall.

A telephone interview on 3/13/17 at 4:09 PM with Nurse #4 revealed she normally worked with Resident #5 on the 3P - 11P shift, but on Saturday 1/21/17 and Sunday 1/22/17, she was the assigned nurse on the 11P - 7A shift. She stated she was also the assigned nurse for Resident #5 on Monday, 1/23/17, 3P - 11P shift. Nurse #4 stated Resident #5's baseline was alert/oriented to self with some confusion, made her needs known, and at times she cursed at staff and refused medications. Nurse #4 stated "I worked with her all weekend (1/21/17 and 1/22/17), and on Monday (1/23/17), but I was not aware of the fall." Nurse #4 stated Resident #5 did not complain of leg/hip pain, ambulated in her room short distances as was her typical practice, but was noted to stay in bed on 1/21/17 - 1/22/17 more than usual and complained that she was tired. Nurse #4 stated this was not unusual behavior for the resident. Nurse #4 stated that if a fall had occurred on a previous shift, and she was notified, she would continue to monitor post fall with neuro checks/VS and ask the resident about pain post fall for several days.

A telephone interview on 3/14/17 at 12:31 PM with Nurse #5 revealed she was the assigned nurse for Resident #5 on Monday, 1/23/17 on the 7A - 3P shift. Nurse #5 stated Resident #5's

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F 157	Continued From page 10 baseline was alert/oriented, had episodes of bipolar disorder, was independent with ADL after being set-up, received scheduled pain medication, occasionally requested as needed (PRN) pain medication and ambulated short distances in her room. Nurse #5 stated she was not aware that Resident #5 fell on Friday, 1/20/17 and did not assess the resident for s/s of injury post fall. A telephone interview occurred on 3/14/17 at 12:49 PM with Nurse #6 and revealed she worked with Resident #5 on the 7A - 3P and the 3P - 11P shifts on Saturday 1/21/17. Nurse #6 stated that Resident #5 was typically alert with confusion and independent with her ADL. Nurse #5 stated that on Saturday, 1/21/17 Resident #5 had increased confusion, was being treated for a change in MS/UTI, complained of generalized pain and was medicated with PRN pain meds with effective results. Nurse #6 stated she was not aware Resident #5 fell and she did not assess the resident for s/s of injury post fall. Attempts to reach the nurse assigned to care for Resident #5 on Friday, 1/20/17, 3P - 11P shift, Sunday, 1/22/17, 3P - 11P shift, and multiple nurse aides were unsuccessful.	F 157		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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	F 309		4/14/17

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F 309	Continued From page 11 well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews with the physician, nurse practitioner and staff, and review of the medical record, the facility failed to assess a resident's vital signs, neurological changes and range of motion after a fall that required surgical repair for a hip fracture for 1 of 4 sampled residents reviewed for a change in condition (Resident #5). The findings included:	F 309	1. Resident #5 was transferred to the hospital and discharged from the facility on 2/24/17. 2. From 3/30/17-4/4/17, the Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) completed a quality monitoring of residents who sustained a fall from 2/28/17-3/28/17 to validate that the licensed nurse completed and	

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F 309	Continued From page 12 Resident #5 was admitted to the facility on 05/29/13. Diagnoses included seizure disorder, mental disorder, mood affective disorder, dementia, left knee deformity, history of falling and multiple old skeletal fractures. Review of Resident #5's annual Minimum Data Set (MDS) and Care Area Assessment (CAAs) dated 5/3/16 and quarterly MDS dated 1/19/17 assessed Resident #5 with clear speech, able to understand and be understood, moderately impaired cognition, required supervision of one staff person with bed mobility, transfers and activities of daily living (ADL), no limitations in range of motion (ROM) received scheduled pain medication, no complaints of pain in the previous 5 days and no falls. The CAAs plan was to care plan Resident #5 for chronic pain and her history of falls. Review of Resident #5's care plan, updated 1/19/17, identified a risk for alteration in pain and falls related to chronic pain (bilateral lower extremities, bilateral knees, shoulder and lower back), history of seizure activity/falls, multiple skeletal fractures, confusion/dementia, poor safety awareness, non-compliance and daily use of antidepressants. Interventions included to monitor for signs/symptoms (s/s) of pain, changes in mood/appetite, administer scheduled pain medication as ordered, anticipate/assess need for pain relief or complaints of pain, and notify the physician (MD) of changes in condition. Review of two of the facility's reports, incident occurrence and Situation, Background, Appearance and Review/Notify (SBAR), both dated 1/20/17, recorded Resident #5 was noted with confusion, combative, lying on floor in front	F 309	documented a resident assessment to include; vital signs, range of motion (ROM) and neurological changes. No discrepancies were identified. 3. By 4/7/17, the DCS and/or ADCS reeducated licensed nurses on regulation 483.24, 483.25(k)(l) regarding providing care/services for highest well being and Consulate Policies and Procedures N-105 “Change in Resident Condition” and “Fall Toolkit”. Education included the expectation of the licensed nurse to complete and document a thorough clinical assessment of a resident who falls including but, not limited to, vital signs, range of motion (ROM) and neurological changes. Newly hired licensed nurses will be educated upon hire. The licensed nurse are to complete and document a comprehensive clinical assessment of a resident who falls including but, not limited to, vital signs, range of motion (ROM)and neurological changes and pain. The clinical assessment will be documented on the SBAR (Situation Background Appearance and Review) and communicated on the 24-Hour report for further follow-up as necessary. The DCS/Nurse Supervisor to review resident falls with the IDT (Interdisciplinary Team)during the Morning Stand-up Meeting, Mondays-Fridays and weekly during the Falls Committee Meeting to ensure a comprehensive assessment was completed for residents who fall to provide care for highest well being and Care Plan updated as indicated 4. The DCS/Registered Nurse Supervisor to conduct Quality Assurance	

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F 309	Continued From page 13 of her bathroom door, clothes wet with urine, call bell in reach, but not in use, confused, and looking for a family member. The SBAR documented that there was no s/s of injury, that the nurse practitioner (NP) was notified on 1/20/17 at 1:45 PM and gave verbal telephone orders and a message was left for the responsible party. Neither report documented an assessment of vital signs (VS) (blood pressure, pulse, respirations, temperature), pain, neurological (neuro) evaluation or ROM. Further review of the medical record revealed there was no documentation in the resident's nurse's notes (NN) regarding a fall on 1/20/17 or an assessment of the resident's neuro changes or ROM related to a fall. VS were documented for the 11P - 7A shift on 1/21/17 through the 3P - 11P shift on 1/24/17. VS on 1/21/17 were documented as 98.9 (temperature), 98 (pulse), 18 (Respirations), 124/90 (blood pressure). Review of MD telephone orders revealed that Resident #5 had the following new orders after a fall on 1/20/17 which were ordered by the NP: ·1/20/17 - Chest Xray (CXR), STAT (immediately), Dilantin level (a blood test that measures a risk for seizure activity), CBC (complete blood count) with differential (a comprehensive blood analysis), CMP (comprehensive metabolic panel), and urinalysis, STAT ·1/21/17 - Start Levaquin (antibiotic) (ABT) 500 mg daily for 10 days as a prophylactic response to a possible upper respiratory infection (URI) or urinary tract infection (UTI) ·1/22/17 - Start intravenous fluids (IVF) of 1 liter of a 0.9% solution of normal saline at 70 cubic centimeters per hour	F 309	Monitoring of 3 residents' medical records to ensure that residents who fall have a comprehensive assessment completed and documented at a frequency of 3 times a week for 4 weeks, 1 time a week for 8 weeks, then monthly. Schedule for QI monitoring to be modified based on findings. The results of QI monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or designee. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action if necessary to maintain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director, and at least three other members.	

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·1/22/17 - Start Dilantin 100 mg capsule, give 300 mg now and continue same dose of Dilantin 300 mg at bedtime for a Dilantin level of 8.1 (Low); may insert Mid Line or PICC (peripherally inserted central catheter) Line

Review of a MD progress note dated 01/23/17, revealed Resident #5 was assessed by the MD regarding altered mental status (AMS) from Friday, 1/20/17. The MD reviewed/assessed the labs ordered on 1/20/17 - 1/22/17 by the NP and assessed Resident #5. The progress note documented Resident #5 was seated at bedside with no acute distress, MS back to baseline, minimally verbal, urinalysis/CXR/dehydration negative, elevated white blood cell count (Leukocytosis), and a low Dilantin level with possible seizure activity on 1/20/17. The plan was to order additional labs (CBC, BMP (basic metabolic panel), discontinue the IVF, continue the ABT (Levaquin) until repeated labs returned and refer for a neuro consult. The progress note did not indicate notification of, or an assessment specific to a fall on Friday, 1/20/17.

A nurse's progress note dated 1/23/17 at 12 midnight recorded Resident #5 was medicated due to complaints of pain to her legs with effective results.

A nurse's progress note and SBAR dated 1/24/17 at 9:00 PM recorded that Resident #5 denied pain when asked and was noted going up/down the hall repeatedly stating to call her family and saying, "I don't want to die here." The progress note/SBAR documented that the oncall NP was notified and an unsuccessful attempt was made to notify the family. Resident #5 was noted to call 911 requesting emergency medical staff (EMS) to

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take her to her family. EMS arrived at 9:30 PM for transport and Resident #5 was noted to complain of knee pain during transfer from her wheel chair (wc) to the stretcher.

Review of the SBAR and hospital transfer summary, both dated 1/24/17, revealed that on 1/24/17, Resident #5 was transferred to the emergency room after Resident #5 called 911 and requested to have the emergency medical staff (EMS) take her to her family.

Review of a hospital consultation report dated 1/25/17 recorded Resident #5 expressed seizure activity, and a fall, with mild left hip pain. An Xray completed during the hospital course revealed a displaced left femoral neck fracture repaired surgically at the hospital.

An interview on 3/6/17 at 2:15 PM with nurse aide (NA) #1 revealed she worked with Resident #5 routinely on the 7A-3P shift. NA #1 described Resident #5 as alert and oriented, normally cooperative with care, not typically combative, independent with ADL, and required set up help only. NA #1 stated that she found Resident #5 on the floor in her room on 1/20/17, she did not recall the time nor the positron of the resident's legs, and told Nurse #1. NA #1 stated Resident #5 was combative when Nurse #1 attempted to take the resident's VS. NA #1 stated Resident #5 was combative, swinging at staff, when she and NA #1 used a gait belt to assist Resident #5 off the floor to her wc. NA #1 stated Resident #5 did not complain of pain and did not notice bruising/swelling/redness to her skin at the time of the fall, during the transfer to her wc or when NA #1 assisted Resident #5 to get dressed later in the shift.

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An interview on 3/6/17 at 2:35 PM with NA #2 revealed she was in orientation on 1/20/17 when NA #1 asked for her assistance on the 7A - 3P shift to transfer Resident #5 from the floor to her wc after a fall. NA #2 stated she observed Resident #5 seated on the floor with her legs in front of her in a pool of urine. NA #2 stated Resident #5 expressed she did not want help getting off the floor and that the resident was not cooperative initially, but then cooperated with staff to transfer to her wc. NA #2 stated Resident #5 did not express pain and no signs of injury was observed. NA #2 stated that was her first and only time caring for Resident #5.

An interview on 3/6/17 at 3:20 PM with Nurse #1 revealed she was the treatment nurse for the facility, but on 1/20/17 she worked as a charge nurse on the floor providing medications to residents on the 7A - 3P shift. Nurse #1 stated on 1/20/17, she was the nurse assigned to Resident #5 and Resident #5 was in bed wearing her night clothes prior to her fall; Resident #5 had refused assistance with morning care and staff planned to return to offer assistance again. Nurse #1 stated NA #1 advised her that Resident #5 was on the floor in her room around 11:30 AM on 1/20/17. When Nurse #1 arrived to the resident's room, she found the resident on the floor on her back, her legs were in front of her, she was kicking/grabbing at staff, kicking in all directions and moving arms/hands in all directions. Nurse #1 stated Resident #5 did not complain of pain, but that she was unable to complete a full body assessment, assess her ROM or obtain VS because Resident #5 was not cooperative. Nurse #1 stated she assumed Resident #5's ROM was fine because she moved her arms/legs in all

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directions when Resident #5 was combative and "This was not like her." Nurse #1 stated she called the NP and advised of the resident's AMS, but not of the fall, nor did she advise the Unit Manager (UM), write a NN, record the fall on the 24 hour nursing communication report or in the MD communication book. She noted the reason was that she was not feeling well on Friday, 1/20/17, left her shift early and did not know who replaced her. Nurse #1 stated that when she spoke to the NP on the phone, she received verbal orders from the NP to obtain labs, urinalysis, CXR and start PICC line with IVF. Nurse #1 stated when she returned to work on Monday, 1/23/17 she completed the incident report and SBAR, but that she did not work with Resident #5 on the days after the fall on 1/20/17 nor before the resident was discharged to the hospital on 1/24/17. Nurse #1 stated she was not aware that Resident #5 had a hip fracture. Nurse #1 stated she was counseled for not notifying the MD/NP of the fall, not documenting the fall in a NN/24 hour communication report/MD communication book and notifying the UM of the fall.

An interview on 3/6/17 at 4:00 PM with Nurse #2 revealed she worked as needed on the 7A - 3P and 3P - 11P shifts and had previously worked with Resident #5. Nurse #2 stated she worked with Resident #5 on Tuesday, 1/24/17 on the 3P - 11P shift, the day Resident #5 was transferred to the hospital. Nurse #2 stated during the shift on 1/24/17, Resident #5 was noted self propelling in her wc making multiple attempts to contact a family member via phone, cursing at staff and refusing staff's assistance with incontinence care. Nurse #2 stated this behavior was unusual for Resident #5 and unsuccessful attempts were

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made to assess the resident for pain and her AMS due to non-compliance. Nurse #2 stated Resident #5 took her medications without incident, denied pain when asked and that the resident eventually agreed to receive incontinence care. Nurse #2 stated that around 8:30 PM on 1/24/17 Resident #5 was witnessed to call 911 and requested EMS to take her to see a family member. Nurse #2 stated EMS arrived around 9:00 PM, assisted Resident #5 with a transfer from her wc to the stretcher and that during this transfer, Resident #5 complained of knee pain which was a routine complaint, but the first time she complained of pain that shift. Nurse #2 stated she was not aware that Resident #5 sustained a fall on 1/20/17 and that she had not assessed Resident #5 for any s/s of injury post fall.

An interview on 3/6/17 at 4:50 PM with the MD via phone revealed she assessed Resident #5 in the facility on Monday, 1/23/17 for AMS. The MD stated at the time of her assessment on 1/23/17, she was not aware that Resident #5 sustained a fall on 1/20/17. The MD stated that labs were ordered by the NP because of AMS and possible seizure activity, not because of a fall. The MD stated that Resident #5 did not show s/s of distress or pain, but that she did not specifically assess the resident for hip pain. The MD stated she was made aware of the hip fracture after Resident #5 was transferred to the hospital on 1/24/17 because the hospital contacted the facility to request assistance with contacting the family for authorization to surgically repair the resident's hip. The MD stated that the hip fracture quite possibly resulted from the resident's fall in the facility on 1/20/17.

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An interview on 3/6/17 at 5:30 PM with UM #1 revealed she was in the facility on 1/20/17 on the 7A - 3P shift when Resident #5 fell. UM #1 stated Nurse #1 was the hall nurse that day/shift and left shift early because she was not feeling well. UM #1 stated she took over the medication cart that day, but Nurse #1 did not notify her of the resident's fall, did not notify the NP, did not complete a NN, incident report, document the fall on the 24 hour report or in the MD communication book. UM #1 stated she was not notified of the resident's fall on 1/20/17, the day it occurred, and therefore Resident #5 was not assessed with VS, for pain, changes in skin integrity or in ROM post fall. UM #1 stated she was made aware of the fall when she reviewed the SBAR on Monday, 1/23/17, but that the MD was not notified of the fall until 1/25/17 when the hospital contacted the facility and notified that Resident #5 required surgical repair of a hip fracture. UM #1 stated the oncoming nursing staff were not made aware to monitor/assess Resident #5 post fall, over the weekend.

An interview on 3/6/17 at 5:50 PM with the director of nursing (DON) revealed that she was made aware on Monday, 1/23/17 that Resident #5 fell on Friday 1/20/17. The DON stated that Nurse #1 was the assigned nurse for Resident #5 on Friday, 1/20/17, but she failed to notify the MD/NP, UM/oncoming nurse of the fall for continued monitoring. The DON stated that nursing staff were only made aware of the resident's AMS/confusion. The DON stated that she conducted an investigation regarding Resident #5's fall and that Nurse #1 was counseled regarding the expectation to document adverse events in the MD communication book and to report adverse events to staff. The DON

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stated that when a resident fell, she expected the nurse responsible for the resident to communicate the fall by documenting in the 24 hour reporting book, complete an incident report, document the fall on the SBAR and in the MD communication book. The DON stated that if the fall resulted in obvious physical injury, the MD/NP would be called, otherwise the fall would be documented in the MD communication book. The DON also stated that for the next 72 hours, she expected nurses to monitor the resident for any s/s of bruises, changes in condition, changes in mobility, complaints of pain and conduct neuro checks/VS. If the nurse identified any changes, the DON expected the nurse to follow up with DON/MD.

A telephone interview was conducted on 3/13/17 at 3:29 PM with the NP. The NP stated she received a phone call from the facility on Friday, 1/20/17 and made aware of a change in MS/confusion regarding Resident #5, but that she was not informed that Resident #5 fell. The NP stated she suspected that Resident #5 had an elevated Dilantin level and possible infection and gave verbal orders for labs (Dilantin level, CBC with differential, CMP, urinalysis/CXR STAT). The NP stated that had she been made aware that Resident #5's AMS occurred after a fall, she would have asked about the resident's VS, neuro checks, pain, deformities, and would have likely sent her to the hospital for further evaluation of the increased confusion. The NP further stated that it was possible Resident #5's fracture occurred as a result of the fall, "To say otherwise would be inaccurate."

A telephone interview was conducted on 3/13/17 at 4:03 PM with Nurse #3, assigned to care for

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Resident #5 on the 11P - 7A shift on 1/20/17. The interview revealed she did not recall specifically which days/shifts she cared for Resident #5, but that she was not aware that Resident #5 fell nor did she assess Resident #5 post fall to look for injury, or check VS, conduct safety checks/neuro checks.

A telephone interview on 3/13/17 at 4:09 PM with Nurse #4 revealed she normally worked with Resident #5 on the 3P - 11P shift, but on Saturday 1/21/17 and Sunday 1/22/17, she was the assigned nurse on the 11P - 7A shift. She stated she was also the assigned nurse for Resident #5 on Monday, 1/24/17, 3P - 11P shift. Nurse #4 stated Resident #5's baseline was alert/oriented to self with some confusion, made her needs known, and at times she cursed at staff and refused medications. Nurse #4 stated "I worked with her all weekend (1/21/17 and 1/22/17), and on Monday (1/23/17), but I was not aware of the fall." Nurse #4 stated Resident #5 did not complain of leg/hip pain, ambulated in her room, but was noted to stay in bed on 1/21/17 - 1/22/17 more than usual and complained that she was tired. Nurse #4 stated this was not unusual behavior for the resident. Nurse #4 stated that if a fall had occurred on a previous shift, and she was notified, she would continue to monitor post fall with neuro checks/VS and ask the resident about pain post fall for several days.

A telephone interview on 3/14/17 at 12:31 PM with Nurse #5 revealed she was the assigned Nurse for Resident #5 on Monday, 1/23/17 on the 7A - 3P shift. Nurse #5 stated Resident #5's baseline was alert/oriented, had episodes of bipolar disorder, was independent with ADL after being set-up, received scheduled pain

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medication, occasionally requested pain medication as needed (PRN) and ambulated short distances in her room. Nurse #5 stated she was not aware that Resident #5 fell on Friday, 1/20/17. Nurse #5 stated the routine practice for a resident post fall was to assess the resident's VS, conduct neuro checks, assess for pain/injury for 72 hours post fall to see if any changes occurred.

A telephone interview occurred on 3/14/17 at 12:49 PM with Nurse #6 and revealed she worked with Resident #5 on the 7A - 3P and the 3P - 11P shifts on Saturday 1/21/17. Nurse #6 stated that Resident was typically alert with confusion and independent with her ADL. Nurse #5 stated that on Saturday, 1/21/17 Resident #5 had increased confusion, was being treated for AMS/UTI, complained of generalized pain and was medicated with PRN pain meds with effective results. Nurse #6 stated she was not aware Resident #5 fell and that she did not complete a post fall assessment which would have included assessments of pain, ROM, neuro checks and frequent monitoring.

Attempts to reach the nurse assigned to care for Resident #5 on Friday, 1/20/17, 3P - 11P shift, Sunday, 1/22/17, 3P - 11P shift, and multiple nurse aides were unsuccessful.