STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	C 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 000	INITIAL COMMENTS A complaint survey was conducted from 05/30/18 through 06/01/18. Past-noncompliance was identified at: CFR 483.25 at tag F684 at a scope and severity (G) Non-noncompliance began on 05/18/18. The facility came back in compliance effective 05/24/18.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff, resident and family interview the facility failed to assess and treat 1 of 1 resident's with falls resulting in injury Resident #1. Findings included: Resident #1 was readmitted to the facility on 5/1/18 with diagnosis of hypertension, anxiety disorder, gastro-esophageal reflux disease, major depressive disorder, cellulitis, unspecified osteoarthritis, and atherosclerotic heart disease. Review of the minimum data set assessment 5/8/18 revealed that the resident's short and long term memory were ok. She was coded as needing limited one person assistance for bed	F 684	Past noncompliance: no plan of correction required.	6/20/18

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

Electronically Signed | 06/20/2018

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mobility, limited assistance with set up help only for transfer and supervision with one person assistance for toileting.
Review of nurses note 5/18/18 8:30 AM stated, "Found resident on floor. Assisted to bedside commode then to bed. Resident reports severe pain to right leg and that she hit her head. Notified Dr. and resident's daughter." Nurses note 5/18/18 9:11 AM stated, "At approximately 8:20 found resident on floor near doorway. Complaints of right leg pain and headache. MD notified, daughter notified, Orders obtained."
Electronic medical record note 5/18/18 at 14:06 stated, Resident fell this morning and has had change in mental status she did not want medication.
Medical record review of the medication administration record revealed an order 5/18/18 which stated, "Right hip/thigh 1 view status post fall and severe pain."
Review of the facility investigation revealed a signed statement by the nurse on duty (no date) on 5/18/18 which stated, "At 8:20 nursing assistant (NA) stated that she heard a "thud". We both entered the resident's (Resident #1) room (door was closed) and found resident on the floor, lying on her right side. Resident stated that she had hit her head and she was going to the bathroom. She also complained of pain to right thigh. NA and I lifted resident off of floor and to the bedside commode. After resident finished voiding we assisted her to bed. Resident would not straighten her right leg to be able to assess the leg lengths. Neurovascular checks to right leg were within normal limits; pedal pulses were good and resident could wiggle her toes. At 0835 Dr. was paged. Call was returned and orders for right hip x-rays were received. Approximately 0840 the daughter, _____ was called and

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notified that resident fell and orders for x-rays were given." The note further stated that at approximately 12:30 family member arrived and was concerned about the residents change in mental status and wanted resident to be evaluated by a physician. At approximately 1305 emergency services transported the resident to the hospital.

Review of hospital records dated 5/19/18 stated, "Reports she fell today when she was half-asleep getting out of bed and fell on the floor. She had tripped over something." Hospital records stated the resident had a comminuted intertrochanteric hip fracture with major fragments fixed in near anatomic alignment.

Review of a statement written by the nursing assistant 5/22/18 stated, "On Friday May 18 while picking up the breakfast trays I, (name), heard a loud thump and then proceeded to check my patients for a fall. When I opened the door to room ___the patient was laying on her right side by the door. I went and got the nurse (name). Nurse then asked the patient was she hurt; and if she hit her head. The patient responded with her right leg felt broke and yes she hit her head. She then asked her what she was trying to do when she fell. The patient responded with I was trying to go the bathroom. The patient then said she still had to use the bathroom. Nurse asked if she could stand and the patient said no. We then go the bed side commode and placed it behind the patient, then stood her and moved the commode underneath her and sit her down on it. When the patient finished using the bathroom we then placed her walker behind her, then stood her, moved the commode, then moved the walker underneath her, then we sat her on the walker, rolled the patient to the bed then helped transfer her to the bed. After we straightened her in bed

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Nurse left to go and call the doctor and the family of the patient. I then proceeded to check her vitals.
Review of the facility investigation revealed a notarized statement from the physician 5/24/18 which stated, "On May 18, 2018 at approximately 8:20 am, the resident (#1) experienced an incident and accident which resulted in a fall and sustained an injury. This injury included a fracture resulting in complaints of pain."
During interview with a family member on 5/30/18 at 5:02 PM she reported that the facility called her at 8:15 AM and told her that her that the resident fell and they would have mobile x-ray come over. She stated she arrived at 1:00 PM and her Mom had been laying there for 5 hours or so. The family member stated that the resident looked passed out.
During interview with Resident #1 on 5/30/18 at 7:02 PM she stated that her daughter told her she was laying there for 5 hours. She said she did not remember and that she hit her head. She said the next thing she knew she was at the hospital and they told her she had a broken hip.
Interview with a nurse on 5/30/18 at 8:56 PM revealed that around 8 AM about 10 minutes after she and the nursing assistant left the resident's room they heard a thud. The resident was on the floor. The resident reported that she was going to the bathroom. The resident complained of pain at that time. The nurse stated they helped the resident up to use the bedside commode and she would not straighten her leg. The nurse said she checked the resident's neurovascular vital signs, checking capillary refill and that the resident was able to move her foot. When she returned to the resident's room around 10 AM, she was asleep and the nurse did not feel like she needed to wake her up to give her pain medication. The

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nurse said she called and got an order for an x-ray but they had not arrived after several hours. The residents' daughter arrived and said she wanted her to be seen (by MD). The nurse stated that the resident said she hit her head but she did not see or feel any kind of bump. She did neuro checks by asking her orientation questions.
Interview with the Director of Nurses (DON) at 9 PM on 5/30/18 revealed that the nurse was terminated because she felt like the nurse did not do her job the way she should have. She stated the nurse should have assessed the resident and noticed her hip was out of line. She never should have moved her. She should have called emergency services. Per the DON the nurse's statement said she didn't assess the resident. She stated that both she and the administrator were in the facility and were never notified of the fall or complaints of pain.
Interview on 5/31/18 at 1:51 PM with the nursing assistant on duty at the time of the incident revealed that she was doing breakfast trays when she heard a thud. She checked Resident #1's room and she was at the door on the floor with the wound vacuum attached to her leg. The resident said she was going to the bathroom. The nurse said can you stand and the resident said "no, my leg is broken." We stood her and I slid the bedside commode under her because she said she had to go to the bathroom. She said her leg was hurting. She said she had never had a broken bone in her life. After she finished using the commode the resident was assisted back to bed. The nurse asked her if she hit her head and the resident said yes. The NA stated that she did the resident's vital signs after she was back in bed. She stated she left the room to go get vital sign equipment. The NA further stated that the resident was so confused she didn't know the

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wound vacuum was on. She had been confused for a couple of mornings; just out of it. She reported that she thought the resident was checked for a urinary tract infection a few days ago. The NA said the resident was hard to wake up that morning. The NA said that the resident did not ring the bell that morning. She said she tried to get her up to eat but she was out of it. She went back in Resident #1's room to put her back on the commode again and the resident was in pain. She kept ring the bell because she was in pain and said her leg was broken. She stated the resident was out of it and confused. She said she told the nurse the resident was in pain.

Review of the facility's plan of correction revealed the following:

"The nurse who was responsible for the care for the care of the resident at the time of the fall was in-serviced and suspended pending investigation on 5/18/18. After investigation, the nurse's employment was terminated on May 24, 2018 and the nurse was reported to the North Carolina Board of Nursing on May 24, 2018. The nursing assistant that assisted with moving the resident was in-serviced and disciplined upon her return to work on 5/22/18. The resident was sent to the hospital on 5/18/18 and has not returned to the facility, thus, no other corrective action can be taken for this resident."

"A root cause analysis was completed and it was determined (the nurse) singularly acted and violated the standards of care regarding assessment and documentation after a fall, assessment of pain and timely pain intervention, and movement of a resident after a fall with injury."

"Any resident with a fall has the potential to be affected by this practice. Incidents 30 days back

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from the fall were reviewed to determine if assessments and documentation were complete, complaints of pain were appropriately addressed, if suspicion of significant injury was reported to Senior Staff, and if transport to the hospital was reported to senior staff."
Licensed nurses were in-serviced regarding assessment and documentation after a fall, Senior Staff notification of incidents with suspicion of significant injury, not moving a resident unless absolutely necessary if a fractured is suspected, and pain assessment and timely intervention for pain. The Certified Nursing Assistants were in-serviced regarding reporting signs and symptoms of pain and following up with nurse and/or Senior Staff if no intervention from nurse or if signs and symptoms of pain persist. Their in-service also included what to do if a nurse request a CAN (certified nursing assistant) to help move a resident after a fall and the CNA suspects significant injury. "
"As a systemic change, the unit manager/supervisor will check the progress notes throughout their shift to see if there are any indications of incidents." If there is an indication of a fall, the unit manager/supervisor will review the documentation to ensure the assessment is complete and document, if a pain assessment had been completed and treated as necessary, and if there is any indication of significant injury. If there is indication of significant injury, it will be determined if a Senior Staff member was notified, and will follow up with the nurse as necessary."
"Ongoing monitoring will be performed by the Director of Nursing or designee utilizing the fall audit tool to ensure continued compliance. The auditing will occur daily until 100% compliance is maintained for two consecutive months. All results will be brought to the Quality Assurance

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F 684	Continued From page 7 Committee for review and recommendations. The Director of Nursing is responsible for implementing the plan of correction and will be in compliance by May 24, 2018. The in-service topics and the staff sign in sheets were reviewed on May 30, 2018. A review of the facility fall audit look back and ongoing monitoring sheets with documented review of falls which occurred after May 24th was also reviewed.	F 684		