STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 06/17/2024

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DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 06/17/24. Event ID# 6X9J11. The following intakes were investigated: NC00218056. One (1) of 1 complaint allegation did not result in deficiency.	F 000		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow up on x-ray results for 1 of 1 resident reviewed for providing care according to professional standards (Resident #1). The findings included: Review of progress note dated 06/07/24 completed by Nurse #1 revealed Resident #1 voiced left hip pain stating something popped when she was turned by Nurse Aides (NAs) providing incontinence care. The note further revealed the on-call provider was contacted and gave an order for an x-ray to be completed of Resident #1's left hip.	F 777	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 07/01/2024

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Review of Resident #1's orders revealed on 06/07/24 the on-call provider ordered an x-ray of the residents left hip.

Review of progress note date 06/08/24 completed by Nurse #1 revealed the facility received a call from the mobile x-ray company stating a repeat left hip x-ray would need to be completed as the films from last evening were unclear and rejected by the radiologist.

Review of the x-ray results completed on 06/08/24 revealed Resident #1 sustained a left mildly displaced femoral neck fracture (upper part of the thigh bone). The note further revealed diffused osteopenia is present. The results were sent electronically to the facility at 7:16 PM the same day.

An interview with Nurse Aide (NA) #1 on 06/17/24 at 2:05 PM revealed on 06/07/24 during 1st shift she and another NA went to change Resident #1. NA #1 indicated Resident #1 often refused care but allowed the NAs to give incontinence care. NA #1 stated when the NAs rolled the resident on her side the resident stated she felt a "pop" and that her hip hurt. NA #1 indicated they immediately went and got Nurse #1 to assess the resident.

An interview with NA #2 on 06/17/24 at 1:45 PM revealed she cared for Resident #1 on 06/08/24 (7:00 AM- 3:00 PM) and 06/09/24 7 AM-3 PM and 11:00 PM- 7:00 AM). NA #2 further revealed Resident #1 did not complain or show any signs of pain during her shifts. NA #2 indicated Resident #1 often refused care and was often confused.

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An interview with NA #3 on 06/17/24 at 2:45 PM revealed she had cared for Resident #1 on 06/08/24 (11:00 PM- 7:00 AM) and the resident did not complain or show any signs of pain. NA #3 indicated Resident #1 often refused care and often seems confused.

A phone interview conducted with Nurse #1 on 06/17/24 at 10:55 AM revealed she had cared for Resident #1 on 06/07/24 and 06/08/24 during day shift 7:00 AM to 7:00 PM. Nurse #1 further revealed on 06/07/24 two NAs had cared for Resident #1 and reported to the nurse that Resident #1 had complained of pain in her left hip. Nurse #1 indicated she assessed Resident #1 and found no irregularities of the left hip but contacted the on-call provider due to the resident complaining of pain and a mobile x-ray was ordered. Nurse #1 stated Resident #1's x-ray was obtained after the Nurses shift ended at 7:00 PM. Nurse #1 revealed on 06/08/24 she was notified Resident #1's x-rays completed on 06/07/24 were inconclusive, and x-ray were obtained again on 06/08/24. Nurse #1 stated she communicated to Nurse #2 at shift change that Resident #1 had received a follow up x-ray and results were pending.

A phone interview conducted with Nurse #2 revealed she cared for Resident #1 on 06/08/24 from 7:00 PM to 7:00 AM. Nurse #2 further revealed Nurse #1 communicated to her at shift change that Resident #1 had an x-ray completed and results were pending. Nurse #2 stated she failed to follow up and look for the x-ray results in the system. Nurse #2 indicated she had also failed to communicate to the next Nurse #3 on shift that Resident #1 had received an x-ray and results were pending. Nurse #2 revealed she had

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been educated to communicate resident information and to follow up on orders but had failed to do so on 06/08/24.

Review of progress note dated 06/10/24 completed by the Director of Nursing (DON) revealed upon findings Resident #1's x-ray showed a mild displaced, impacted left femoral neck fracture. The note further revealed the Medical Director (MD) was notified and Resident #1 was ordered to be sent to the hospital for evaluation and treatment.

Review of orthopedic consult note from the hospital dated 06/10/24 revealed Resident #1 had a closed left hip fracture. The note further revealed the fracture was a fragility fracture with osteoporosis.

Review of hospital progress notes revealed Resident #1 was admitted on 06/10/24 with left hip pain. The note further revealed resident #1 sustained a closed left hip fracture. On 06/11/24 Resident #1 received hip arthroplasty to the left hip. Resident #1 was discharged back to the facility on 06/13/24.

An interview conducted with the Nurse Practitioner (NP) on 06/17/24 at 10:35 AM revealed Resident #1 had rheumatoid arthritis, was immobile for 5 plus years, had contractures, and took several immunosuppressant drugs that caused Resident #1's bones to be brittle with low density. The NP further revealed Resident #1 was on palliative care due to her diagnoses and pain management. The NP indicated she would have expected nursing staff

to receive x-ray results and contacted a provider.

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The NP stated even though the facility delayed sending Resident #1 the resident had no negative outcome.

An interview conducted with the Director of Nursing (DON) on 06/17/24 at 11:30 AM revealed she was not in the building until 06/10/24 when she found Resident #1's x-rays had not been found in the system by nursing staff. The DON further revealed she had educated Nursing staff to always follow up with residents if they had been sent or if any results were pending. The DON indicated results are sent to the charting system that Nursing staff can obtain. The DON stated nursing staff failed to communicate and follow up on Resident #1's x-rays results. The facility received Resident #1's x-ray results on 06/08/24 but failed to review them until 06/10/24.

The facility provided the following corrective action plan with a completion date of 6/11/24.

Allegation background:
On 6/7/24 Nurse Aide #1 certified nurse aide, and Nurse Aide #4 certified nurse aide were providing care to Resident #1.
- They heard a pop during care, staff reported the change in condition to Nurse #1.
- Nurse went to resident's room to assess resident and notified the on-call provider and obtained an order for an X-ray.
- Nurse informed resident's family member of the change in condition and new orders for x-ray.
- Resident #1 is a 73-year-old female who is a long-term resident in the facility.
- She has a diagnosis of rheumatoid arthritis, heart failure, obesity, and long-term use of steroids related to arthritis.
- She has been bed bound for several years.

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X-ray results resulted on 6/8/24 at 7:16 PM, results were not reported to the provider until 6/10/24.

Timeline:
- 6/7/24 Contracted imaging provider came to the facility and obtained x-rays on the resident
- 6/8/24 at 6:15 PM contracted imaging provider notified the facility nurse that x ray results were unclear and rejected by the radiologist and they would be back to re-take the x ray.
- 6/8/24 at 6:49 PM contracted imaging provider was back in the facility and obtained repeat x-ray.
- 6/8/24 at 7:16 PM x-ray results were sent to the facility.
- 6/10/24 at 10:00 AM resident was reviewed in clinical morning meeting with Director of Nursing and identified a positive X-ray for femur fracture.
- 6/10/24 at 10:54 AM Assistant Director of nursing notified Medical Director of the positive results with new orders to send resident to hospital for further evaluation. Resident #1's family member was notified of the positive results from x-ray and new orders to send to hospital. Resident #1 was assessed by the hospital and sent for surgery to repair the fracture.

Upon discovery of the occurrence, facility implemented the following quality insurance measures:
- 6/10/24 Medical Director was notified of positive x-ray results and resident was transferred to the hospital for evaluation and treatment.
- She was admitted to the hospital and on 6/11/24 underwent left hip hemi arthroplasty.
- Orthopedic provider diagnosed resident with a fragility fracture of the femur related to osteoporosis.
- She was readmitted to the facility on 6/13/24.

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Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
- On 6/10/24 the Director of Nursing or designee reviewed all x ray results for the past seven days to ensure the results were called into the provider.
- No other issues were identified.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
All licensed nurses including agency staff were educated 6/10/24 on timely notification to the provider for positive x-ray results. The system failure was a lack of understanding of the new electronic medical records system and nurse was not aware to check portal for diagnostic results. Nurses including agency staff were re-educated by DON/Designee on proper communication between nurses and shifts and where to look for these reports. Nurses including agency staff were re-educated by DON/Designee to check for results every shift. Licensed Nurses including agency staff were also educated by DON/designee that if diagnostic results were pending, that they are to report to on coming shift and the oncoming shift was to check portal for results. The education was provided in-person and via phone with all Licensed nurses including agency with understanding of education confirmed by nurses reiterating the content of the education. All newly hired licensed nurses to receive education during orientation.

To monitor and maintain ongoing compliance
- Beginning 6/16/24 the Director of Nursing or designee will review 3 resident charts per week

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for timely notification of positive diagnostic results to the provider.
- Audits will continue for 8 weeks. Results of the audit will be reported to the QAPI committee by the Director of Nursing or designee. If concerns are identified with audits, the IDT team will meet to make adjustments to the QAPI.

Alleged date of completion for the corrective action plan is 6/11/24.

The corrective action plan was validated on 06/27/24 as evidenced by staff interviews, review of education sign sign in sheets and audits. Staff education was initiated on (6/10/24) regarding timely notification to provider for positive Xray results. Licensed nursing staff from multiple shifts were interviewed and stated they were educated to check the portal of the electronic medical records for diagnostic results every shift and pending diagnostic results were to be reported to the oncoming shift and oncoming shift was to check the portal for results.

The completion date of 6/11/24 was validated.