### Statement of Deficiencies and Plan of Correction

**POC #2**

**Soddy-Daisy Health Care Center**

**Summary Statement of Deficiencies**

- **ID PREFIX TAG**
- **F 000 Initial Comments**

Complaint Investigation #29487, #30005, #30025, and #30037 were completed on July 10, 2012, at Soddy-Daisy Health Care Center. No deficiencies were cited related to Complaint Investigation #29487, #30005, and #30037 under 42 CFR PART 484, Requirements for Long Term Care. Deficiencies were cited related to Complaint Investigation #30025, 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

**ID PREFIX TAG**
- **F 157**
  - **Ss-G**

A facility must immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either a threatening condition or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(a)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

**Provider's Plan of Correction**

This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.

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**Soratory Director's or Provider/Supplier Representative's Signature**

Date: 7-27-12

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(y) deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that for safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are subject to a 30 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 subject to a 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required in continued participation.
The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of facility investigation, review of facility nursing shift reports, review of facility policy, observation, and interview, the facility failed to notify the attending Physician and/or Resident's Responsible Party of a fall, and a fracture of the left distal femur (broken left thigh bone near the knee) for one (#1) of eleven residents reviewed. The facility's failure to notify the attending physician of resident #1's fall resulted in a delay of identifying and treating the fracture of the left distal femur (Actual Harm).

The findings included:
Resident #1 was admitted to the facility on May 15, 2008, with diagnoses including Osteoarthritis, Osteoporosis, History of Cardiovascular Accident (Stroke), and Diabetes Mellitus Type II.

Medical record review of a Physician's Progress Note dated June 23, 2008, revealed a physician evaluation due to "pain management" and "dizziness. Continued review revealed, "...appears somewhat confused... (resident) reports fall... no record of any fall in nursing notes... pain in both legs... pt (patient) with NODM (Non-Insulin Dependent Diabetes Mellitus), History of OA.

1. A full body assessment was completed on Resident #1 on 6/26/12 by the Nursing Supervisor. At that time it was noted the resident had increased pain, left leg swelling, and bruising. Physician and Responsible Party were notified on 6/26/12 by Nursing Supervisor. New orders were received to administer pain medication and transfer to emergency room for evaluation.

Pain medication was administered on 6/26/12 by Nursing Supervisor prior to transport. The resident was transferred via ambulance to the Emergency Department on 6/26/12 by the Nursing Supervisor. Resident #1 returned to facility on 6/27/12 with assessment completed, new orders received and noted, and care plan interventions updated by the Nursing Supervisor, MDS Coordinator, and Staff Development Coordinator.

Physician and family were notified of return to facility on 6/27/12 by the Nursing Supervisor and Admission Coordinator. The physician completed an examination of Resident #1 on 6/27/12. LPN #1 is no longer employed by the facility.
Continued From page 2
(Osteoarthritis), Psychoses, ? (questionable) PMR (Polymyalgia Rheumatica-muscle pain and stiffness)...alo numbness in feet...” Continued review revealed diagnoses including suspected Vertigo (inner ear) and Osteoarthritis, a treatment plan was developed including adding Medizine for 14 days as needed.

Medical record review of a Physician’s Telephone Order dated June 23, 2012, revealed an order for Medizine 12.5 milligrams, three times daily, as needed for dizziness, for fourteen days.

Medical record review of a Nurse’s Note dated June 23, 2012, at 2:41 p.m., revealed the Physician evaluated the resident due to complaints of dizziness.

Medical record review of a Nurse’s Note dated June 26, 2012, at 2:34 a.m., revealed, “Changin 4 for 12:45 a.m. This nurse (Registered Nurse (RN) #1) called to eval (evaluate) resident d/l (due to) increased pain and Lt. (left) upper leg swelling. Resident cries out in severe pain when leg is touched or with any movement. This nurse in to check resident Lt. leg swelling and old yellowish green bruises noted to left knee. Resident is unable to move (residents’ leg) and cries when staff attempts to move (residents’ leg). This nurse asked resident what happened and (resident) stated “I felt in the bathroom and they had to get me up.” Resident has not been getting up...as per (residents) normal. Called... (Physician) at 1:00 a.m., and new order to send to the ER (emergency room) for eval of Lt. leg. Also order noted to give Morphine (for moderate to severe pain) 5 mg (milligrams) SQ (subcutaneous-under the skin)...2:30 a.m.

2. Full Body Skin assessments were completed on 100% of residents on 6/26/12 thru 6/27/12 by the Treatment Nurse. No residents were identified as having been affected. All alert and oriented residents were interviewed regarding any potential issues or concerns on 6/27/12 by the Medical Records Director. No residents were identified as having been affected. An audit was completed of 100% of all events for the last 6 months for notification of Physician and Responsible Party on 7/13/12 by the Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator. No residents were identified as having been affected.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDERS/SUPPLIERS/CLA IDENTIFICATION NUMBER</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 157</td>
<td>449408</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

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**NAME OF PROVIDER OR SUPPLIER**

SODDY-DAISY HEALTH CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

701 SEQUOYAH ROAD
SODDY-DAISY, TN 37379

**F 157**

Continued From page 3

"Ambulance service here to transport resident to (hospital) ER..."

Continued review of the Nurse's Notes dated June 26, 2012, at 2:42 a.m., revealed, LPN #2 assessed resident’s left leg, "...Old bruising and swelling of the left leg and knee noted. Resident c/o pain to left leg. Supervisor (RN #1) notified."

Medical record review of a (hospital) radiology report of the left hip, dated June 26, 2012, revealed the resident had a comminuted (splintered or crushed) displaced left distal one-third femoral fracture (a traumatic break in the bone above the knee in which the two ends of the fractured bone are separated and out of their normal positions.

Medical record review of a Nurse's Note dated June 27, 2012, revealed the resident returned to the facility from the hospital on June 27, 2012, at 1:25 p.m. with diagnoses including a left femur fracture and was non-weight bearing on the left leg.

Review of a facility investigation dated June 26, 2012, at 8:30 a.m., completed by the Staff Development Coordinator (SDC) and Assistant Director of Nursing (ADON) revealed, "...RN Supervisor (RN #1) assessed resident dt increased pain, left leg swelling and bruising noted to left knee. MD (Medical Doctor) notified and resident sent to ER for evaluation and tx (treatment). Upon investigation it was found that on 6:00 p.m. to 6:00 a.m., shift on Friday June 22, 2012, a CNA (Certified Nursing Assistant #1) reported to charge nurse (LPN #1) that resident was found in the bathroom floor..." Continued

3. All Licensed Nurses were inserviced on Event Management, nursing assessment, neurological checks, pain assessment, pain monitoring, investigation and reporting, and notification of Physician and Responsible Party for resident changes in condition 7/12/12 thru 7/13/12 by the Director of Nursing and Staff Development Coordinator. All employees including Licensed Nurses, Certified Nursing Assistants, Dietary, Environmental Services, Plant Operations, Business Office, Social Services, and Administration were inserviced on Resident Rights, Abuse and Neglect including types, investigation, and reporting 7/12/12 thru 7/13/12 by the Director of Nursing, Administrator, Dietary Manager, Environmental Services Manager, and Rehabilitation Manager.
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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 157</td>
<td>Continued From page 4</td>
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<td>Review of the investigation revealed that the resident’s Physician was not notified of the resident’s fall on June 22, 2012, until June 26, 2012, at 1:00 a.m.; the resident’s Responsible Party was not notified until June 28, 2012, at 1:25 a.m.</td>
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<td>4. Audits will be conducted for changes in condition on all events regarding comprehensive pain review, notification of Physician and Responsible Party by the Director of Nursing, Assistant Director of Nursing, or Nursing Supervisor daily for 1 month, then 3 times weekly for 2 months and / or until 100% compliant. Audits will be conducted on all 24 hour shift to shift nursing reports for any change and Physician and Responsible Party notification daily for 1 month then 3 times weekly for 2 months and / or until 100% compliant. All findings will be reviewed and reported in the Quality Assurance Performance Improvement Committee meeting for three months and / or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records, and Environmental Department.</td>
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<td>Review of a written statement dated June 25-26, 2012, by RN #1 revealed RN #1 was notified by LPN #2 of resident’s increased pain and swelling of the left upper leg. RN #1’s statement revealed the resident’s left leg was swollen, with old yellow bruising. “Resident stated (resident) fell in...bathroom 2-3 (two to three) days ago...but no report of a fall...Physician) was here and checked resident on June 23, 2012...(Physician) note states that resident also reported to (Physician) that (resident) fell but there was no nurses’ notes to support resident’s c/o... (Physician) was called at 1:00 a.m., and wanted (resident) to go to the ER and that (resident’s) leg may be broken...” (Resident) started crying and stated “yes, it’s broken... I fell in my bathroom between the wall and the commode...” RN #1 asked the resident if someone helped (resident) up, and resident stated “it was two women,” RN #1 informed the resident of pain medication to be administered, and the resident “started crying” and stated “thank you.”</td>
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<td>Review of a written statement dated June 25, 2012, (beginning of June 25-26, 2012, night shift from 6:00 p.m.-6:00 a.m.) by LPN #2 revealed the resident’s left leg was painful and swollen above and around the knee.</td>
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<td>Review of a written statement (no date) by CNA #1, revealed on June 22, 2012, CNA #1 walked into the resident’s room and heard a banging</td>
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<td>Statement of Deficiencies and Plan of Correction</td>
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<td>Name of Provider or Supplier: Soddy-Daisy Health Care Center</td>
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<td>Street Address, City, State, Zip Code: 701 Sequoyah Road, Soddy-Daisy, TN 37379</td>
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<tr>
<th>(X4) ID Prefix TAG</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded By Full Regulatory Or LSC Identifying Information)</th>
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<td>F 157: Continued From page 5</td>
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- Noise. CNA #1 opened the resident's bathroom door, found the resident sitting on the bathroom floor, banging the garbage can on the floor. "I ran and got the nurse (LPN #1), we picked (resident) up and then put (resident) in the bed."

- Review of a written statement (no date) by LPN #1, revealed, "About 6:20 p.m., (no date) assisted (resident) to BR (bathroom)...call light on. When assisting (resident) back to wc (wheelchair) (resident's) left leg went outward when wc was moved. (Weight) put on it. I was on (R) (right) side of pt. During the transfer pt. stated "my leg popped" 6:25 p.m., after assisting pt back to bed removed pants to check leg saw a knot with edema (L) (left) leg above knee at back. Ask pt about knot stated "that has been there" No discoloration noted ROM (range of motion) intact...Assisted pt with personal care due to stress incontinence 7:30 p.m. Pt. up to BR per self in wc transferred self to and from bed with no assistance. Cont (continued) taking self to BR with no assistance till (until) 6:00 a.m...."

- Medical record review revealed no documentation the resident fell on June 22, 2012. Continued review revealed no documentation the physician and/or the Responsible Party was notified of the resident falling on June 22, 2012, until June 26, 2012.

F 157

Continued From page 6

Review of the facility "Protocol: Post Fall" (no date), revealed, "1. Assess the resident and implement appropriate measure to provide immediate care. Neurological checks to be done for all unwitnessed falls...2. Nursing to complete...a. Fall Tracking Form. b. Incident Report, to include vital signs, with lying and standing blood pressure. Incident Report and accident/event management protocol to be completed per nurse...c. FSI- Fall Scene Investigation Report (used to identify the root cause analysis). d. Change of status review. e. Resident Event Documentation...f. Pain Assessment...g. Discuss findings...with the resident and the Responsible Party...

Review of the facility policy "Accidents and Incidents-Investigating and Reporting" dated October 01, 2011, revealed, "Policy: All accidents or incidents involving residents...occurring at our facilities must be investigated and reported to the Administrator. Purpose: To ensure the safety of all residents...General Guidelines: 1. Reporting of Accidents/Incidents: a...must be reported to the department supervisor as soon as the accident/incident is discovered...b. An Incident Report Form must be completed for all reported accidents or incidents. d. The nurse supervisor/charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided...3. Medical Attention...e. If the incident involves a resident, immediately contact the physician and responsible party of the incident...

Observation of the resident in the presence of the SDC, in the resident's room, on June 27, 2012, at 9:20 p.m., confirmed the resident was lying on the...
**Soddy-Daisy Health Care Center**

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<th>ID PREFIX</th>
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<th>Summary Statement of Deficiencies</th>
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<th>Provider's Plan of Correction</th>
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<td>F 157</td>
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<td>Continued from page 7 bed, with an immobilizer on the resident's left lower extremity, extending from the mid-thigh to the upper ankle. Yellow bruising extended laterally, above the immobilizer. Continued observation of the resident, in the resident's room, on July 10, 2012, confirmed the immobilizer was present on the resident's left lower extremity; with continued observation confirming the resident had one large yellow bruise on the lateral left thigh, measuring 12.5 inches by 11.0 inches. Within the yellow bruising were three separate purple bruises; (1) the upper lateral measured 4.5 inches by 4.5 inches, (2) the mid-lateral measured 5.0 inches by 3.0 inches, and (3) the lower lateral measured 3.0 inches by 1.5 inches. Interview with the SDC on June 27, 2012, at 4:30 p.m., in the conference room, confirmed upon arriving to work at the facility on June 28, 2012, at approximately 5:45 a.m., RN #1 gave report to the SDC. RN #1 reported on June 26, 2012, sometime around midnight (could not recall the exact time), the resident had increased complaints of pain with swelling in the left thigh; the resident alleged to have fallen and was assisted up by two females. The Physician was notified (sometime around midnight on June 26, 2012) and ordered the resident to be sent to the ER for an evaluation. An x-ray of the left hip was completed on June 28, 2012, at the hospital, and confirmed the resident had a left femoral fracture. The resident's chart was retrieved and reviewed; the Physician's Progress Note dated June 23, 2012, was reviewed, which included complaints of dizziness and allegations of a fall. No incident report had been completed; and the resident's...</td>
<td>F 157</td>
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<td>Cross-referenced to the appropriate deficiency</td>
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Interview with LPN #1, in the presence of the Administrator, on June 27, 2012, at 5:45 p.m., in the conference room, confirmed LPN #1 intentionally gave false and misleading information during the facility's investigation of the resident's left femoral fracture. LPN #1 confirmed the resident did have an unwitnessed fall on June 22, 2012, and at approximately 6:20 p.m., CNA #1 notified LPN #1 the resident was on the floor in the bathroom. LPN #1 and CNA #1 went to the resident's room to assist the resident up from the floor. LPN #1 confirmed the resident was sitting on the buttocks, with the knees bent upward. As the resident was assisted up, the resident complained of pain in the right foot, and LPN #1 heard the resident's left leg pop. When the surveyor asked if pain medication had been administered or if the Physician was notified, LPN #1 confirmed, "No...I didn't give any pain medication...No, I didn't call the Doctor or the resident's Responsible Party (family)...I know better...I knew better...I knew what to do, I just didn't do it..." Continued interview confirmed the physician was not notified of the resident's fall, complaint of pain, or of the left leg popping. LPN #1 confirmed when the SDC called (LPN #1) on June 26, 2012, and asked about the resident's left femoral fracture, "I intentionally deceived (SDC); I lied to (SDC) and (Administrator)...The written statement I gave to (Administrator) was false...I knew it was untruthful...I did not call the Physician and did not follow the facility's policies and procedures...I knew what to do...the resident was in the floor and I didn't do what I was supposed to do...I failed to follow the protocol and it's the patient that suffered."
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 157 Continued From page 9</td>
<td>Interview with CNA #1, on June 27, 2012, at 8:30 p.m., via telephone, confirmed the resident fell on June 22, 2012, after supper (unsure of exact time). CNA #1 went into the resident's room and heard a noise coming from the bathroom. Upon entering the bathroom, CNA #1 confirmed the resident was sitting on the bathroom floor, with the right leg extended outward and the left leg bent up under (resident's) bottom (buttocks). CNA #1 went and got LPN #1 and they went back into the resident's bathroom, got the resident up and into a wheelchair, then put the resident to bed. CNA #1 confirmed the resident verbalized complaints of knee pain, but the resident did not identify which knee was hurting. Continued interview with CNA #1 confirmed LPN #1 did not assess the resident, &quot;Once the resident was in bed, we (CNA #1 and LPN #1) left (resident's) room together.&quot;</td>
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Interview with the resident's attending Physician (Medical Director) on June 27, 2012, at 7:35 p.m., in the conference room, confirmed on June 23, 2012, the resident told the Physician, (resident) had fallen (did not state when). The Physician evaluated the resident, saw no edema or discoloration; the resident complained of back and bilateral (both) leg pain. The Physician confirmed the resident had chronic pain secondary to generalized Arthritis. Upon the resident reporting the fall, the Physician confirmed to review the resident's chart and there was no documentation of a fall. Continued interview confirmed the Physician was not notified of any fall occurring recently, or on June 22, 2012. The Physician confirmed, "I expect to be notified of all falls...If I had gotten this information..."
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier Number:** 445406

**Name of Provider or Supplier:** SODDY-DAISY HEALTH CARE CENTER

**Address:** 781 SEQUOYAH ROAD

**City, State, Zip Code:** SODDY-DAISY, TN 37379

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| Continued From page 10 on the fall, I would have focused my examination on the (resident's) leg. Continued interview confirmed the facility's failure to notify the Physician of resident #1's fall resulted in a delay of identifying and treating the fracture of the left distal femur.

C/O #30025

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<th>D 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</th>
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<td></td>
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<td>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on medical record review, review of facility investigation, review of facility nursing shift reports, review of facility policy, observation, and interview, the facility failed to follow facility policies to provide the necessary services, and prevent neglect for one (#1) resident with a left femur fracture after a fall, of eleven residents reviewed. The facility's failure to follow policies and prevent neglect resulted in a three-day delay of treatment from an unreported fall with a fracture of the left distal femur (broken left thigh bone near the knee) and failed to provide pain management for one (#1) of eleven residents reviewed (Actual Ham).</td>
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1. A full body assessment was completed on Resident #1 on 6/26/12 by the Nursing Supervisor. At that time it was noted the resident had increased pain, left leg swelling, and bruising. Physician and Responsible Party were notified on 6/26/12 by Nursing Supervisor. New orders were received to administer pain medication and transfer to emergency room for evaluation. Pain medication was administered on 6/26/12 by Nursing Supervisor prior to transport. The resident was transferred via ambulance to the Emergency Department on 6/26/12 by the Nursing Supervisor.
Resident #1 was admitted to the facility on May 15, 2006, with diagnoses including Osteoarthritis, Osteoporosis, History of Cardiovascular Accident (Stroke), and Diabetes Mellitus Type II.

Medical record review of a Physician's Progress Note dated June 23, 2012, revealed a physician evaluation due to "pain management" and "c/o (complaint of) of dizziness." Continued review revealed, "...appears somewhat confused...(resident) reports fall...no record of any fall in nursing notes...pain in both legs...pt (patient) with NIDDM (Non-Insulin Dependent Diabetes Mellitus), History of OA (Osteoarthritis), Psychoses, ? (questionable) PMR (Polymyalgia Rheumatica-muscle pain and stiffness)...c/o numbness in feet..." Continued review revealed diagnoses including suspected Vertigo (inner ear) and Osteoarthritis; a treatment plan was developed including adding Meclizine for 14 days as needed.

Medical record review of a Physician's Telephone Order dated June 23, 2012, revealed an order for Meclizine 12.5 milligrams, three times daily, as needed for dizziness, for fourteen days.

Medical record review of a Nurse's Note dated June 23, 2012, at 2:41 p.m., revealed the Physician evaluated the resident due to complaints of dizziness.

Medical record review of a Nurse's Note dated June 28, 2012, at 2:34 a.m., revealed, "Charting for 12:45 a.m. This nurse (Registered Nurse

Resident #1 returned to facility on 6/27/12 with assessment completed, new orders received and noted, and care plan interventions updated by the Nursing Supervisor, MDS Coordinator, and Staff Development Coordinator. Physician and family were notified of return to facility on 6/27/12 by the Nursing Supervisor and Admission Coordinator. The physician completed an examination of Resident #1 on 6/27/12. LPN #1 is no longer employed by the facility.
Continued From page 12

(RN) #1 called to eval (evaluate) resident d/t
(due to) increased pain and Lt. (left) upper leg
swelling. Resident cries out in severe pain when
leg is touched or with any movement. This nurse
in to check resident Lt. leg swelling and old
yellowish green bruises noted to left knee.
Resident is unable to move (resident's) leg and
cries when staff attempts to move (residents) leg.
This nurse asked resident what happened and
(resident) stated "I fell in the bathroom and they
had to get me up." Resident has not been getting
up...as per (resident's) normal. Called...
(Physician) at 1:00 a.m., and new order to send
to the ER (emergency room) for eval of Lt. leg.
Also order noted to give Morphine (for moderate
to severe pain) 5 mg (milligrams) SQ
(subcutaneous-under the skin)...2:30 a.m.,
Ambulance service here to transport resident to
(hospital) ER..."

Continued review of the Nurse's Notes dated
June 26, 2012, at 2:42 a.m., revealed, LPN #2
assessed resident's left leg. "...Old bruising and
swelling of the left leg and knee noted. Resident
c/o pain to left leg, Supervisor (RN #1) notified.

Medical record review of a hospital radiology
report of the left hip, dated June 26, 2012,
revealed the resident had a comminuted
(splintered or crushed) displaced left distal
one-third femoral fracture (a traumatic break in
the bone above the knee in which the two ends of
the fractured bone are separated and out of their
normal positions).

Medical record review of a Nurse's Note dated
June 27, 2012, revealed the resident returned to
the facility from the hospital on June 27, 2012, at

2. Full Body Skin assessments
were completed on 100% of
residents on 6/26/12 thru 6/27/12
by the Treatment Nurse. No
residents were identified as having
been affected. All alert and
oriented residents were
interviewed regarding any
potential issues or concerns on
6/27/12 by the Medical Records
Director. No residents were
identified as having been affected.
An audit was completed of 100%
of all events for the last 6 months
for notification ofPhysician and
Responsible Party on 7/13/12 by
the Director of Nursing, Assistant
Director of Nursing, and Staff
Development Coordinator. No
residents were identified as having
been affected.
Continued From page 13:
1:25 p.m. with diagnoses including a left femur fracture and was non-weight bearing on the left leg.

Review of a facility investigation dated June 26, 2012, at 8:30 a.m., completed by the Staff Development Coordinator (SDC) and Assistant Director of Nursing (ADON) revealed, "...RN Supervisor (RN #1) assessed resident d/t increased pain, left leg swelling and bruising noted to left knee. MD (Medical Doctor) notified and resident sent to ER for evaluation and tx (treatment). Upon investigation it was found that on 6:00 p.m. to 6:00 a.m., shift on Friday June 22, 2012, a CNA (Certified Nursing Assistant) reported to charge nurse (LPN #1) that resident was found in the bathroom floor..." Continued review of the investigation revealed the resident's physician was not notified of the resident's fall on June 22, 2012, until June 26, 2012, at 1:00 a.m.

Review of a written statement dated June 26-28, 2012, by RN #1 revealed RN #1 was notified by LPN #2 of resident's increased pain and swelling of the left upper leg. RN #1's statement revealed the resident's left leg was swollen, with old yellow bruising. "Resident stated (resident) fell in...bathroom 2-3 (two to three) days ago...but no report of a fall... (Physician) was here and checked resident on June 23, 2012...Physician's note states that resident also reported to (Physician) that (resident) fell but there was no nurses' notes to support resident's o/a... (Physician) was called at 1:00 a.m. and wanted (resident) to go to the ER and that (resident)'s leg may be broken..." (Resident) started crying and stated "yes, it's broken...I fell in my bathroom between the wall and the commode..." RN #1
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>F 224</td>
<td>Continued From page 14</td>
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<td>asked the resident if someone helped (resident) up, and resident stated &quot;it was two women.&quot; RN #1 informed the resident of pain medication to be administered, and the resident &quot;started crying&quot; and stated &quot;thank you.&quot;</td>
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<td>Review of a written statement dated June 25, 2012, (beginning of June 25-26, 2012, night shift from 6:00 p.m.-6:00 a.m.) by LPN #2 revealed the resident's left leg was painful and swollen above and around the knee.</td>
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<td>Review of a written statement (no date) by CNA #1, revealed June 22, 2012, CNA #4 walked into the resident's room and heard a banging noise. CNA #1 opened the resident's bathroom door, found the resident sitting on the bathroom floor, banging the garbage can on the floor. &quot;I ran and got the nurse (LPN #1), we picked (resident) up and then put (resident) in the bed.&quot;</td>
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<td>Review of a written statement (no date) by LPN #1, revealed, &quot;About 6:20 p.m., (no date) assisted (resident) to BR (bathroom)...call light on. When assisting (resident) back to w/c (wheelchair) (resident's) left leg went outward when w/t (weight) put on it. I was on (R) (right) side of pt. During the transfer pt. stated &quot;my leg popped&quot; 6:25 p.m., after assisting pt back to bed removed pants to check leg saw a knot with edema (L) (left) leg above knee at back. Ask pt about knot stated &quot;that has been there.&quot; No discoloration noted ROM (range of motion) intact...Assisted pt with personal care due to stress incontinence. 7:30 p.m. Pt. up to BR per self in w/o transferred self to end from bed with no assistance. Cont (continued) taking self to BR with no assistance till (until) 8:00 a.m...&quot;</td>
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4. Audits will be conducted for changes in condition on all events regarding comprehensive pain review, notification of Physician and Responsible Party by the Director of Nursing, Assistant Director of Nursing, or Nursing Supervisor daily for 1 month, then 3 times weekly for 2 months and/or until 100% compliant. Audits will be conducted on the 24 hour shift to shift nursing reports for any change and Physician and Responsible Party notification daily for 1 month then 3 times weekly for 2 months and/or until 100% complaint. Random daily full body skin assessments will be completed on 4 residents for one month then three times weekly for 2 months and/or until 100% compliant by the Treatment Nurse, Nursing Supervisor, or Charge Nurse. Random daily interviews will be completed on 4 residents for one month then three times weekly for 2 months and/or until 100% compliant by Medical Records Director, Director of Nursing, Assistant Director of Nursing, Supervisor, or Staff Development Coordinator.
F 224 Continued From page 15

Medical record review revealed no documentation the resident fell on June 22, 2012. Continued review revealed no documentation of the resident being assessed for injury or change in condition (no vital signs, no pain assessment, no neurological assessment, and no body systems assessment) on June 22, 2012. Continued review revealed no documentation the physician was notified of the resident falling on June 22, 2012, until June 26, 2012.


Review of the facility "Protocol: Post Fall" (no date), revealed, "1. Assess the resident and implement appropriate measures to provide immediate care. Neurological checks to be done for all witnessed falls... 2. Nursing to complete... a. Fall Tracking Form. b. Incident Report, to include vital signs, position, and standing blood pressure. Incident Report and accident/event management protocol to be completed per nurse... c. FSI-Fall Scene Investigation Report (used to identify the root cause analysis). d. Change of status review. e. Resident Event Documentation... f. Pain Management... g. Discuss findings... with the resident and family..."

Random daily Comprehensive Pain Reviews will be completed on 4 residents for one month then three times weekly for 2 months and / or until 100% compliant by the Director of Nursing, Assistant Director of Nursing, Supervisor, Charge Nurse, Treatment Nurse, Quality Assurance Director, or Staff Development Coordinator. All findings will be reviewed and reported in the Quality Assurance Performance Improvement Committee meetings for three months and / or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records, and Environmental Department.
F 224. Continued From page 16

Immediately. Do not wait for blood pressure to stabilize. If not, place in chair and obtain blood pressure. 4. Do neurochecks for all unwitnessed falls...7. Nursing to complete...Fall Tracking Form; Incident Report, to include vital signs, with lying and standing blood pressure...Incident Report and Accident/Event Management Protocol to be completed per nurse...; FSI-Fall Scene Investigation Report...; Pain Assessment..."

Review of the facility policy "Accidents and Incidents-Investigating and Reporting" dated October 01, 2011, revealed, "Policy: All accidents or incidents involving residents...occurring at our facilities must be investigated and reported to the Administrator. Purpose: To ensure the safety of all residents...General Guidelines: 1. Reporting of Accidents/Incidents: a...must be reported to the department supervisor as soon as the accident/incident is discovered...b. An Incident Report Form must be completed for all reported accidents or incidents. d. The nurse supervisor/charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided...3. Medical Attention:...e. If the incident involves a resident, immediately contact the physician and responsible party of the incident...Steps in the Procedure: 1. The Incident Report...a. The nurse supervisor/charge nurse and/or the department director or supervisor shall...3. Use information obtained during the investigation to complete the Incident Report Form; and 4. Complete the assessment of the resident...complete the information required and give a full description of the occurrence. Record time of incident, and describe exactly what occurred or was observed...
F 224 Continued From page 17

Review of the facility policy "Charting and Documentation: Nurse's Notes" pages one through three, revealed, "Policy: To maintain a complete account of the resident's care...Purpose: To ensure that all services provided to the resident or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. General Guidelines...3. All incidents, accidents, or changes in the resident's condition must be recorded..."

Review of the facility policy "Pain Management" (no date), revealed, "Policy...Any resident who experiences pain will be reviewed and a plan will be established to treat his or her pain...Purpose(s): 1. To ensure the physical and psychological well being of the resident. 2. To maintain optimum functional ability. Guiding Principles: In the long-term care setting, the comfort and well-being of the individual resident should always be paramount (of chief concern or importance). This principle is the foundation for effective management of pain. Adequate pain management should be sought in each case. Individualized care...ensures that pain management is tailored to each resident's needs, circumstances, conditions, and risk factors. Members of the interdisciplinary care team have a responsibility to advocate for resident comfort...Procedure(s):...b. Process 1. Pain will be reviewed/scored using a numeric 0-10 (zero to ten) scale. Alternate scales may be used...The type of scale used, if different than policy, must be documented...3. Every resident will be regularly and systematically reviewed for pain...b. With any change in resident condition...new onset..."
F 224 Continued From page 18

complaints of pain...To maintain a complete account of the resident’s care...Purpose: To ensure that all services provided to the resident or any changes in the resident’s medical or mental condition, shall be documented in the resident’s medical record. General Guidelines:...3. All incidents, accidents, or changes in the resident’s condition must be recorded...”

Observation of the resident in the presence of the SDC, in the resident’s room, on June 27, 2012, at 9:20 p.m., confirmed the resident was lying on the bed, very confused and verbalized a nonsensical conversation with the surveyor. The SDC confirmed the resident was not typically confused to this degree. Continued observation confirmed an immobilizer was on the resident’s left lower extremity, extending from the mid-thigh to the upper ankle. Yellow bruising extended laterally, above the immobilizer. The resident expressed complaints of pain “Oh, oh, oh...that hurts...” with the slightest touch and/or movement during care per nursing staff.

Continued observation of the resident, in the resident’s room, on July 10, 2012, confirmed the immobilizer was present on the resident’s left lower extremity; with continued observation confirming the resident had one large yellow bruise on the lateral left thigh, measuring 12.5 inches by 11.0 inches. Within the yellow bruising were three separate purple bruises: (1) the upper lateral measured 4.5 inches by 4.5 inches, (2) the mid-lateral measured 5.0 inches by 3.0 inches, and (3) the lower lateral measured 3.0 inches by 1.5 inches.
Interview with the SDC on June 27, 2012, at 4:30 p.m., in the conference room, confirmed upon arriving to work at the facility on June 26, 2012, at approximately 5:45 a.m., RN #1 gave report to the SDC. RN #1 reported on June 26, 2012, sometime around midnight (could not recall the exact time), the resident had increased complaints of pain with swelling in the left thigh; the resident alleged to have fallen and was assisted up by two females. The physician was notified (sometime around midnight) and ordered the resident to be sent to the ER for an evaluation. An X-ray of the left hip was completed on June 26, 2012, at the hospital, and confirmed the resident had a left femoral fracture. The SDC confirmed, on June 26, 2012, at approximately 8:45 a.m., to report RN #1’s findings regarding the resident in the facility’s morning clinical meeting. An investigation was initiated immediately, to determine the cause of the fracture. The resident’s chart was retrieved and reviewed; the physician’s note dated June 23, 2012, was reviewed, which included complaints of dizziness and allegations of a fall. No Incident Report had been completed; and the resident’s chart revealed no documentation of a fall.

Nursing assignment schedules from June 21-25, 2012, were reviewed and interviews began. The SDC’s interview with CNA #1 revealed CNA #1 found the resident on the floor banging on a garbage can on June 22, 2012, after supper. CNA #1 left the resident’s room and immediately notified LPN #1 for assistance; together, CNA #1 and LPN #1 went back to the resident’s room, got the resident out of the floor, and put the resident in the bed. The SDC called LPN #1 after
**F 224** Continued From page 20

completing the interview with CNA #1. The SDC asked LPN #1 "Do you know anything that may have happened to (resident)?" LPN #1 denied knowing anything. The SDC continued questioning "Are you sure you don't know anything that happened to the resident on Friday or Saturday night (June 22 or 23, 2012)?" LPN #1 revealed to remember providing assistance to (resident), who "began to go down and LPN #1 caught (resident) and put (resident) in the wheelchair." The SDC confirmed this was the only information provided or revealed by LPN #1.

Interview with LPN #1, in the presence of the Administrator, on June 27, 2012, at 5:45 p.m., in the conference room, confirmed LPN #1 intentionally gave false and misleading information during the facility's investigation of the resident's left femoral fracture. LPN #1 confirmed the resident did have an unwitnessed fall on June 22, 2012, and at approximately 6:20 p.m., CNA #1 notified LPN #1 the resident was on the floor in the bathroom. LPN #1 and CNA #1 went to the resident's room to assist the resident up from the floor. LPN #1 confirmed the resident was sitting on the buttocks, with the knees bent upward. As the resident was assisted up, the resident complained of pain in the right foot, and LPN #1 heard the resident's left leg pop. When the surveyor asked if pain medication had been administered or if the Physician was notified, LPN #1 confirmed, "No...I didn’t give any pain medication...No, I didn’t call the Doctor...I know better...I knew better then...I knew what to do, I just didn’t do it..." Continued interview confirmed the Physician was not notified of the resident's fall, complaint of pain, or of the left leg popping. LPN #1 confirmed when the SDC called (LPN #1)
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:**
SODDY-DAISY HEALTHCARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
701 SEQUOYA ROAD
SODDY-DAISY, TN 37379

**DATE SURVEY COMPLETED:**
07/10/2012

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| F 224   |        |     | Continued From page 21 on June 26, 2012, and asked about the resident's left temporal fracture, "I intentionally deceived (SDC); I lied to (SDC) and (Administrator). The written statement I gave to (Administrator) was false. I knew it was untruthful. I did not call the Physician and did not follow the facility's policies and procedures. I knew what to do, ... the resident was in the floor and I didn't do what I was supposed to do...I failed to follow the protocol and it's the patient that suffered."

Interview with CNA #1, on June 27, 2012, at 8:30 p.m., via telephone, confirmed the resident fell on June 22, 2012, after supper (unsure of exact time). CNA #1 went into the resident's room and heard a noise coming from the bathroom. Upon entering the bathroom, CNA #1 confirmed the resident was sitting on the bathroom floor, with the right leg extended outward and the left leg bent up under (resident's) bottom (buttocks). CNA #1 went and got LPN #1 and they went back into the resident's bathroom, got the resident up and into a wheelchair, then put the resident to bed. CNA #1 confirmed the resident verbalized complaints of knee pain, but the resident did not identify which knee was hurting. Continued interview with CNA #1 confirmed LPN #1 did not assess the resident. "Once the resident was in bed, we (CNA #1 and LPN #1) left (resident's) room together."

Interview with the resident's attending Physician (Medical Director) on June 27, 2012, at 7:35 p.m., in the conference room confirmed, on June 23, 2012, the resident told the Physician, (resident) had fallen (did not state when). The Physician evaluated the resident, saw no edema or discoloration; the resident complained of back...
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<td>F 224</td>
<td>Continued From page 22 and bilateral (both) leg pain. The Physician confirmed the resident had chronic pain secondary to generalized Arthritis. Upon the resident reporting the fall, the Physician confirmed to review the resident's chart and there was no documentation of a fall. Continued interview confirmed the Physician was not notified of any fall occurring recently, or on June 22, 2012. The Physician confirmed, &quot;I expect to be notified of all falls...If I had gotten this information on the fall, I would have focused my examination on the (resident's) leg.&quot; The Physician confirmed the nurse's failure to follow facility policies and failure to provide pain management for resident #1 resulted in a delay of treatment and complaints of pain without treatment.</td>
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<td>Interview with the Administrator on June 27, 2012, at 9:00 p.m., and July 10, 2012, at 6:00 p.m., in the conference room, confirmed LPN #1 failed to follow facility policies, failed to report the resident's fall on June 22, 2012, failed to provide accurate information (both verbally and written) during a facility investigation to determine the cause of a resident with a fractured left femur, failed to provide the necessary services to prevent a three-day delay in treatment for a fall with a fractured left femur, and failed to provide pain management for the resident's complaint of pain. Continued interview confirmed LPN #1 was suspended on June 27, 2012, and remained on suspension until terminated on July 3, 2012. Continued interview confirmed the facility's failure resulted in neglect of resident #1.</td>
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| F 309     | SS-G| **483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**

Each resident must receive and the facility must provide the necessary and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility investigation, review of facility nursing shift reports, review of facility policy, observation, and interview, the facility failed to follow facility policies in a timely manner, resulting in a delay of treatment from a fall with a fracture of the left distal femur (broken left thigh bone near the knee) and failed to provide pain management for one (#1) of eleven residents reviewed. The facility's failure to follow policies and failure to provide pain management for resident #1 resulted in a delay of treatment and complaints of pain without treatment (Actual Harm).

The findings included:

Resident #1 was admitted to the facility on May 15, 2008, with diagnoses including Osteoarthrosis, Osteoporosis, History of Cardiovascular Accident (Stroke), and Diabetes Mellitus Type II.

Medical record review of a Physician's Progress Note dated June 23, 2012, (no time), revealed a physician evaluation for a routine visit and a
- **F 309**

  Continued from page 24:

  complaint of dizziness." Continued review revealed, "...appears somewhat confused... (resident) reports fall... no record of any fall in nursing notes... pain in both legs... pt (patient) with NIDDM (Non-Insulin Dependent Diabetes Mellitus), History of OA (Osteoarthritis), Psychoses, ? (questionable) PMR (Polymyalgia Rheumatica—muscle pain and stiffness)... clonus in feet." Continued review revealed diagnoses including suspected Vertigo (inner ear) and Osteoarthritis; a treatment plan was developed including adding Medicine for 14 days as needed.

  Medical record review of a Physician's Telephone Order dated June 23, 2012, revealed an order for Medication 12.5 milligrams, three times daily, as needed for dizziness, for fourteen days.

  Medical record review of a Nurse's Note dated June 23, 2012, at 2:41 p.m., revealed the Physician evaluated the resident due to complaints of dizziness.

  Medical record review of a Nurse's Note dated June 25, 2012, at 7:04 p.m., revealed, "In bed all day. C/O (complaining of) pain in the left knee..."

  Medical record review of a Nurse's Note dated June 26, 2012, at 2:34 a.m., revealed, "Charting for 12:45 a.m. This nurse (Registered Nurse [RN] #1) called to eval (evaluate) resident d/t (due to) increased pain and LL (left) upper leg swelling. Resident cries out in severe pain when leg is touched or with any movement. This nurse in to check resident LL leg swelling and old yellowish green bruises noted to left knee. Resident is unable to move (residents') leg and

2. Full Body Skin assessments were completed on 100% of residents on 6/26/12 thru 6/27/12 by the Treatment Nurse. No residents were identified as having been affected. All alert and oriented residents were interviewed regarding any potential issues or concerns on 6/27/12 by the Medical Records Director. No residents were identified as having been affected.

An audit was completed of 100% of all events for the last 6 months for notification of Physician and Responsible Party on 7/13/12 by the Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator. No residents were identified as having been affected. Comprehensive Pain Reviews were completed on 100% of all residents on 7/11/12 by the Assistant Director of Nursing, Treatment Nurse, Staff Development Coordinator, and QA Director. No residents were identified as having been affected.

Full Risk Assessments were completed on 100% of all residents 6/26/12 thru 7/11/12 by the Assistant Director of Nursing and MDS Coordinators. No residents were identified as having been affected.
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cries when staff attempts to move (resident's) leg. This nurse asked resident what happened and (resident) stated "I fell in the bathroom and they had to get me up." Resident has not been getting up...as per (resident's) normal. Called...
(Physician) at 1:00 a.m., and new order to send to the ER (emergency room) for eval of Lt. leg. Also order noted to give Morphine (for moderate to severe pain) 5 mg (milligrams) SQ (subcutaneous-under the skin)...2:30 a.m., Ambulance service here to transport resident to (hospital) ER...

Continued review of the Nurse's Notes dated June 26, 2012, at 2:42 a.m., revealed, LPN #2 assessed resident's left leg, "Nurse on day shift reported to this nurse of increased pain...Old bruising and swelling of the left leg and knee noted. Resident c/o pain to left leg. Supervisor (RN #1) notified."

Medical record review of a (hospital) radiology report of the left hip, dated June 26, 2012, revealed the resident had a comminuted (splintered or crushed) displaced left distal one-third femoral fracture (a traumatic break in the bone above the knee in which the two ends of the fractured bone are separated and out of their normal positions).

Medical record review of a Nurse's Notes dated June 27, 2012, revealed the resident returned to the facility from the hospital on June 27, 2012, at 1:25 p.m. with diagnoses including a left femur fracture and was non-weight bearing on the left leg.

Review of a facility investigation dated June 26,

3. All Licensed Nurses were in-serviced on Event Management and nursing assessment, neurological checks, pain assessment, pain monitoring, investigation and reporting, notification of Physician and Responsible Party with resident changes 7/12/12 thru 7/13/12 by the Director of Nursing and Staff Development Coordinator. All Licensed Nurses were in-serviced on 24 hour shift to shift report, resident change on condition with Physician and Responsible Party notification on 7/23/12 by the Director of Nursing and Staff Development Coordinator. All employees including Licensed Nurses, Certified Nurses Assistants, Dietary, Environmental Services, Plant Operations, Business Office, Social Services, and Administration were in-serviced on Resident Rights, Abuse and Neglect including types, investigation, and reporting 7/12/12 thru 7/13/12 by the Director of Nursing, Administrator, Dietary Manager, Environmental Services Manager, and Rehabilitation Manager.
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<td>07/10/2012</td>
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<td>07/10/2012</td>
<td>2012, at 8:30 a.m., completed by the Staff Development Coordinator (SDC) and Assistant Director of Nursing (ADON) revealed, &quot;,...RN Supervisor (RN #1) assessed resident d/t increased pain, left leg swelling and bruising noted to left knee. MD (Medical Doctor) notified and resident sent to ER for evaluation and bx (treatment). Upon investigation it was found that on 8:00 p.m. to 5:00 a.m., shift on Friday June 22, 2012, a CNA (Certified Nursing Assistant) reported to charge nurse (LPN #1) that resident was found in the bathroom floor.&quot; Continued review of the investigation revealed the resident's Physician was not notified of the resident's fall on June 22, 2012, until June 26, 2012, at 1:00 a.m.; the resident's family was not notified until June 26, 2012, at 1:25 a.m.</td>
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| 07/10/2012 | Review of a written statement dated June 25-26, 2012, by RN #1 revealed RN #1 was notified by LPN #2 of resident's increased pain and swelling of the left upper leg. RN #1's statement revealed the resident's left leg was swollen, with old yellow bruising. "Resident stated (resident) fell in...bathroom 2-3 (two to three) days ago...but no report of a fall...(Physician) was here and checked resident on June 23, 2012... (Physician's) note states that resident also reported to (Physician) that (resident) fell but there was no nurses' notes to support resident's c/o... (Physician) was called at 1:00 a.m., and wanted (resident) to go to the ER and that (resident's) leg may be broken..." (Resident) started crying and stated "yes, it's broken...I fell in my bathroom between the wall and the commode..." RN #1 asked the resident if someone helped (resident) up, and resident stated "it was two women." RN #1 informed the resident of pain medication to be
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Continued from page 27
administered, and the resident "started crying" and stated "thank you."

Review of a written statement dated June 25, 2012, (beginning of June 25-26, 2012, night shift from 6:00 p.m.-8:00 a.m.) by LPN #2 revealed the resident's left leg was painful and swollen above and around the knee.

Review of a written statement (no date) by CNA #1, revealed on June 22, 2012, CNA #1 walked into the resident's room and heard a banging noise. CNA #1 opened the resident's bathroom door, found the resident sitting on the bathroom floor, banging the garbage can on the floor. "I ran and got the nurse (LPN #1), we picked (resident) up and then put (resident) in the bed."

Review of a written statement (no date) by LPN #1, revealed, "About 6:20 p.m., (no date) assisted (resident) to BR (bathroom)...call light on. When assisting (resident) back to wc (wheelchair) (resident's) left leg went outward when wt. (weight) put on it. I was on (R) (right) side of pt. During the transfer pt. stated "my leg popped" 6:25 p.m., after assisting pt back to bed removed pants to check leg saw a knot with edema (L) (left) leg above knee at back. Ask pt about knot stated "that has been there" No discoloration noted ROM (range of motion) intact...Assisted pt with personal care due to stress incontinence. 7:30 p.m. Pt up to BR per self in wc transferred self to and from bed with no assistance. Cont (continued) taking self to BR with no assistance till (until) 6:00 a.m."...

Medical record review revealed no documentation

Continued
**F 309** Continued From page 28

Review revealed no documentation of the resident being assessed for injury or change in condition (no vital signs, no pain assessment, no neurological assessment, and no body systems assessment) June 22, 2012; continued review revealed no documentation the Physician was notified of the resident falling on June 22, 2012, until June 28, 2012.


Review of the facility "Procedure: Post Fall" (no date), revealed: "...4. Do neurochecks for all unwitnessed falls...7. Nursing to complete...Fall Tracking Form; Incident Report, to include vital signs, with lying and standing blood pressure...Incident Report and Accident/Event Management Protocol to be completed per nurse...; Pain Assessment..."

Review of the facility policy "Accidents and Incidents-Investigating and Reporting" dated October 01, 2011, revealed, "Policy: All accidents or incidents involving residents...occuring at our facilities must be investigated and reported...as soon as the accident/incident is discovered...b. An Incident Report Form must be completed for all reported accidents or incidents. 3. Medical Attention:...e. If the incident involves a resident, immediately contact the physician and responsible party of the incident..."

Review of the facility policy "Pain Management" (no date), revealed, "Policy...Any resident who
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experiences pain will be reviewed and a plan will be established to treat his or her pain...Purpose(s): 1. To ensure the physical and psychological well being of the resident. Guiding Principles: Members of the interdisciplinary care team have a responsibility to advocate for resident comfort...Procedure(s):...B. Process 1. Pain will be reviewed/assessed using a numeric 0-10 (zero to ten) scale. Alternate scales may be used...The type of scale used, if different than policy, must be documented...3. Every resident will be regularly and systematically reviewed for pain...b. With any change in resident condition...new onset complaints of pain...To maintain a complete account of the resident's care...Purpose: To ensure that all services provided to the resident or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. General Guidelines:...3. All incidents, accidents, or changes in the resident's condition must be recorded..."

Observation of the resident in the presence of the SDC, in the resident's room, on June 27, 2012, at 9:20 p.m., confirmed the resident was lying on the bed, very confused and verbalizing a nonsensical conversation with the surveyor. The SDC confirmed the resident was not typically confused to this degree. Continued observation confirmed an immobilizer was on the resident's left lower extremity, extending from the mid-thigh to the upper ankle. Yellow bruising extended laterally, above the immobilizer. The resident expressed complaints of pain "Oh, oh...that hurts..." with the slightest touch and/or movement during care per nursing staff.
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<th>F 309</th>
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<td>Continued observation of the resident, in the resident's room, on July 10, 2012, confirmed the immobilizer was present on the resident's left lower extremity; with continued observation confirming the resident had one large yellow bruise on the lateral left thigh, measuring 12.5 inches by 11.0 inches. Within the yellow bruising were three separate purple bruises: (1) the upper lateral measured 4.5 inches by 4.5 inches, (2) the mid-lateral measured 5.0 inches by 3.0 inches, and (3) the lower lateral measured 3.0 inches by 1.5 inches.</td>
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Interview with the SDC on June 27, 2012, at 4:30 p.m., in the conference room, confirmed upon arriving to work at the facility on June 28, 2012, at approximately 5:45 a.m., RN #1 gave report to the SDC. RN #1 reported on June 28, 2012, sometime around midnight (couldn't recall the exact time), the resident had increased complaints of pain with swelling in the left thigh; the resident alleged to have fallen and was assisted up by two females. The physician was notified (sometime around midnight) and ordered the resident to be sent to the ER for an evaluation. An x-ray of the left hip was completed on June 28, 2012, at the hospital, and confirmed the resident had a left femoral fracture. The SDC confirmed, on June 28, 2012, at approximately 8:45 a.m., to report RN #1's findings regarding the resident in the facility's morning clinical meeting. An investigation was initiated immediately, to determine the cause of the fracture. The resident's chart was retrieved and reviewed; the physician's note dated June 23, 2012, was reviewed, which included complaints of dizziness and allegations of a fall. No Incident Report had been completed; and the resident's...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

SODDY-DAISY HEALTH CARE CENTER

<table>
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<th>(X1) PROVIDER/SUPPLIER/CLA</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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NAME OF PROVIDER OR SUPPLIER

SODDY-DAISY HEALTH CARE CENTER

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<th>ID</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>DB Computation Date</th>
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</table>
| F 309   | F 309 | Continued From page 31, chart revealed no documentation of a fall. Nursing assignment schedules from June 21-25, 2012, were reviewed and interviews began. The SDC's interview with CNA #1 revealed CNA #1 found the resident on the floor banging on a garbage can on June 22, 2012, after supper; CNA #1 left the resident's room and immediately notified LPN #1 for assistance; together, CNA #1 and LPN #1 went back to the resident's room, got the resident out of the floor, and put the resident in the bed. The SDC called LPN #1 after completing the interview with CNA #1. The SDC asked LPN #1 "Do you know anything that may have happened to (resident)?" LPN #1 denied knowing anything. The SDC continued questioning "Are you sure you don't know anything that happened to the resident on Friday or Saturday night (June 22 or 23, 2012)?" LPN #1 revealed to remember providing assistance to (resident), who "began to go down and LPN #1 caught (resident) and put (resident) in the wheelchair." The SDC confirmed this was the only information provided or revealed by LPN #1. Interview with LPN #1, in the presence of the Administrator, on June 27, 2012, at 5:45 p.m., in the conference room, confirmed LPN #1 intentionally gave false and misleading information during the facility's investigation of the resident's left femoral fracture. LPN #1 confirmed the resident did have an unwitnessed fall on June 22, 2012, and at approximately 6:20 p.m., CNA #1 notified LPN #1 the resident was on the floor in the bathroom. LPN #1 and CNA #1 went to the resident's room to assist the resident up from the floor. LPN #1 confirmed the resident was sitting on the buttocks, with the knees bent upward. As the resident was assisted up, the resident...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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| F 309     | Continued from page 32 complained of pain in the right foot, and LPN #1 heard the resident's left leg pop. When the surveyor asked if pain medication had been administered or if the physician was notified, LPN #1 confirmed, "No...I didn't give any pain medication...No, I didn't call the Doctor...I know better...I knew better then...I knew what to do, I just didn't do it." Continued interview confirmed the physician was not notified of the resident's fall, complaint of pain, or of the left leg popping. LPN #1 confirmed when the SDC called (LPN #1) on June 25, 2012, and asked about the resident's left femoral fracture, "I intentionally deceived (SDC); I lied to (SDC) and (Administrator)...The written statement I gave to (Administrator) was false...I knew it was untruthful...I did not call the physician and did not follow the facility's policies and procedures...I knew what to do...the resident was in the floor and I didn't do what I was supposed to do...I failed to follow the protocol and it's the patient that suffered." Interview with CNA #1, on June 27, 2012, at 8:30 p.m., via telephone, confirmed the resident fell on June 22, 2012, after supper (unsure of exact time). CNA #1 went into the resident's room and heard a noise coming from the bathroom. Upon entering the bathroom, CNA #1 confirmed the resident was sitting on the bathroom floor, with the right leg extended outward and the left leg bent up under (resident's) bottom (buttocks). CNA #1 went and got LPN #1 and they went back into the resident's bathroom, got the resident up and into a wheelchair, then put the resident to bed. CNA #1 confirmed the resident verbalized complaints of knee pain, but the resident did not identify which knee was hurting. Continued interview with CNA #1 confirmed LPN #1 did not...
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assess the resident, "Once the resident was in bed, we (CNA #1 and LPN #1) left (resident’s)
room together."

Interview with the resident's attending Physician
(Medical Director) on June 27, 2012, at 7:35 p.m.,
in the conference room, confirmed on June 23,
2012, the resident told the Physician, (residents)
had fallen (did not state when). The Physician
evaluated the resident, saw no edema or
discoloration; the resident complained of back
and bilateral (both) leg pain. The Physician
confirmed the resident had chronic pain
secondary to generalized Arthritis. Upon the
resident reporting the fall, the Physician
confirmed to review the resident’s chart and there
was no documentation of a fall. Continued
Interview confirmed the Physician was not notified
of any fall occurring recently, or on June 22,
2012. The Physician confirmed, "Based upon the
fracture...it is most likely she fell onto her knee..."
The Physician confirmed, "I expect to be notified
of all falls...If I had gotten this information on the
fall, I would have focused my examination on the
(resident's) leg." The Physician confirmed the
nurse's failure to follow facility policies and failure
to provide pain management for resident #1
resulted in a delay of treatment and complaints of
pain without treatment.

C/O #30025