F 157 483.10(b)(11) NOTIFY OF CHANGES

SS= D (INJURY/DECLINE/ROOM, ETC)

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 resulted 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 life threatening conditions 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 § 483.16(e)(2), or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

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:

Complaint investigation for TN00028507

Acceptable for 2/13/12

LAWRENCE STRATTON
Laboratory Director or Provider/Supervisor Representative

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discoverable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discoverable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
F 157  Continued From page 1

Based on medical record review and interview, it was determined the facility failed to notify the resident’s responsible party of the diagnosis of a fracture after a fall and the transfer of the resident to the hospital. The facility failed to notify the resident’s responsible party of a transfer to the emergency room due to elevated blood pressure for 1 of 19 (Resident #19) sampled residents.

The findings include:


During an interview in the 400 hall private dining room on 1/9/12 at 1:55 PM, Nurse #8 was asked about Resident #19. Nurse #8 stated, “I talked to the family and told them we were getting an x-ray, and if there was a problem, I would call back. I always call the family when I send someone to the hospital.” The nurse agreed that she did not specifically remember calling the family and had not documented notification of the x-ray results.

Completion Date: 1/31/12

re-inserviced and audits will continue until substantial compliance is met. The DON, ADON, and Unit Manager will report their findings to the Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinators, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Admissions Coordinator, Maintenance Supervisor, and Activities Coordinator.
F 157: Continued From page 2 and transfer.

Further review of the nurses notes dated 6/11/11 documented, "Sent to ER R/T BP [blood pressure] being elevated per on call MD [medical doctor]. Returned with no new orders."

During an interview in the 400 hall private dining room on 1/9/12 at 2:10 PM, Nurse #9 was asked about Resident #19. Nurse #9 stated, "I cannot remember calling the family, but I always call when I send someone to the hospital." Nurse #9 agreed that there was no documentation in the nurses notes or in the daily skilled nurses notes to indicate that the family was notified of the transfer for the elevated blood pressure.

This deficiency was cited in relation to the complaint investigation initiated on 1/9/12 but not completed until the annual recertification survey of 1/19/12.