STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676029	A. Building B. Wing	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observations, interviews, and record reviews the facility failed to provide for the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one (Resident #1, Resident #2, Resident #3) of five residents reviewed for call lights. The facility failed to ensure Resident #1, Resident #2, and Resident #3's call light was accessible. This failure placed the resident at risk of falling, further injury, and unnecessary pain from not being able to call for help. Findings included: Review of Resident 1#'s face sheet revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cystitis without hematuria (infection of your urinary bladder), muscle weakness, Type 2 diabetes mellitus (high blood sugar) with foot ulcer (slow healing wound), retention of urine (inability to empty the bladder), Stage 3 chronic kidney disease, dehydration, and repeated falls. Review of Resident #1's MDS, dated [DATE], revealed the resident had severe cognitive impairment with a BIMS score of 2, and he required extensive assistance of two staff for transfers and extensive assist with one staff for all other ADLs. The MDS further revealed the resident was not steady, only able to stabilize with staff assistance, and he used a walker/wheelchair for mobility. Review of Resident #1's care plan, revised 02/21/23, revealed he was at risk of falling related to weakness, poor safety awareness, history of many falls. The care plan reflected: Goal: will be free of falls. Intervention: ensure call light is in reach at all times, ensure assistive device is within reach at all times, educate on what to do if a fall occurs and safety reminders, keep water and needed items within reach, Therapy evaluations and treatment per physician orders. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/27/23 at 11:21 AM revealed Resident #1 was lying in bed, with a boot on the right foot. Resident #1 stated he encountered some type of fungus, and it had become an issue with ambulating. Resident #1 stated he did have a fall while trying to go to the restroom. The resident's call light was observed on the wall behind him, not within reach for use. Resident #1 stated his call light was usually not within reach, pretty much hanging on the wall. Resident #1 stated when he did attempt to use the call light for assistance staff usually did not respond in a timely manner at times more than an hour response time, which was why he attempted to go to the restroom on his own. Interview on 04/27/23 at 2:07 PM with CNA C revealed she had been working with Resident #1 for two days. This morning Resident #1 had a complete bed change and after that call light should have been put within reach. CNA C stated therapy may have come in after the bed change and relocated the call light and not put it back. CNA C stated it was the responsibility of the aides to ensure call lights were within reach. She stated every time she entered the room, she would try to check call light placement. CNA C stated it was very important that residents had access to the call light because it was their means of communication, and they could hurt themselves without it. Review of Resident #2's face sheet revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cystitis with hematuria (infection of your urinary bladder), history of falls, lack of coordination, paraplegia, foot drop, right foot; foot drop, left foot and muscle weakness (generalized). Review of Resident #2's MDS, dated [DATE], revealed the resident had severe cognitive impairment with a BIMS score of 5, she required extensive assistance of two staff for bed mobility and transfers, and extensive assist with one staff for all other ADLs except for eating and locomotion off the unit. Resident #2 was not steady, only able to stabilize with staff assistance, and she required a walker/wheelchair for mobility. Review of Resident #2's care plan, revised 04/27/21, revealed resident had alteration in musculoskeletal status related to spinal stenosis, left foot drop, right foot drop, muscle weakness, gout. The care plan reflected: Goal: will return to prior level of function. Intervention: Anticipate level of needs, be sure call light is within reach and respond promptly to all requests for assistance. Resident #2 is at risk for falls related to weakness, paraplegia. Goal: will be free of falls. Intervention: Be sure call light is within reach and encourage to use it to call for assistance as needed. Observation and interview on 04/27/23 at 11:42 AM revealed Resident #2 was sitting in wheelchair beside the bed with both feet propped on a pillow. Resident #2 asked the surveyor to close her window because she was getting cold. The surveyor asked Resident #2 to activate her call light. Resident #2's call light was located behind Resident #2 on the floor not within reach. According to Resident #2 most of the time the call light was within reach, however lately she had not had the call light within reach and would have to wait until staff came in to check on her. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 04/27/23 at 1:36 PM with CNA F revealed she was usually making frequent rounds on the hall. CNA F stated she completed training on call light placement about 2 months ago. CNA F stated it was the responsibility of the nursing staff to ensure residents have their call lights within reach at all times. CNA F stated Resident #2 will usually have her call light pinned on her or within reach, at times the call light will fall on the floor so during the rounds she will replace it near resident. Resident #2 was in therapy and perhaps therapy will forget to place the call light within reach when they leave the room. CNA F stated it is important for residents to have call light within reach to communicate their needs. Review of Resident #3's face sheet revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unsteadiness on feet, abnormalities of gait and mobility, difficulty walking, displaced fracture of fourth metatarsal bone, left foot, subsequent encounter for fracture with routine healing, age-related osteoporosis, muscle weakness, kidney disease stage 3. Review of Resident #3's MDS, dated [DATE], revealed a BIMS score of 13 indicating cognitive intact. Her Functional Status indicated she required limited assistance with one person assist with all ADLs except toileting was extensive assist with one person, supervision with locomotion off the unit and eating with one person assist. Resident# 3 is not steady, but able to stabilize without staff assistance. Review of Resident #3's care plan, revised 04/27/21, revealed resident is at risk for falls related to gait/balance problems, weakness. Goal: will be free of falls. Intervention: 04/23/23 Fall, family to provide proper fitting shoes, be sure the call light is within reach and encourage to use it to call for assistance as needed keep needed items close and within reach. Observation and interview on 04/27/23 at 11:50 AM revealed Resident #3 sitting on the right side of her bed. Resident #3's call light is on the left, opposite side of the bed on the floor. Resident #3 stated she did not have a fall, she slid down on the side of the bed. When Surveyor asked how she was able to alert staff, Resident #3 stated her call light is usually always on the floor and not within reach. Resident #3 stated if she needed assistance from staff, she would wait on staff to enter the room or ambulate in her wheelchair to find someone for assistance. During interview on 04/27/23 at 2:23 PM with CNA G revealed she was constantly walking the halls to ensure call lights were within reach. CNA G stated the facility seemed to be short staffed, and she had increased duties which may have created longer times to complete one round and return back around to the residents. CNA G stated it was the responsibility of all nursing staff to ensure call lights were within reach for the resident to use for alerting staff for help. CNA G stated when the call light is not within reach it creates opportunities for injuries. CNA G stated the facility has provided trainings on call light placement but could not recall the training done. During interview on 04/27/23 at 3:32 PM with RN H revealed Resident #3 recently had a fall. RN H stated Resident #3 had not been known to use the call light for assistance. RN H stated while rounds are to be completed at least every two hours, all staff are responsible for ensuring the call light is within reach for all residents. RN H stated not having the call light within reach puts residents at risk of attempting to go to the restroom alone, fall, or injury. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 04/27/23 at 5:07 PM with the DON revealed call lights should be within reach at all times, call lights should be answered as timely as possible. The DON stated it was her desire to have call lights answered within 5 minutes when not giving care to other residents on the halls. The DON stated all staff are responsible for ensuring call lights are within reach of each resident and all staff should answer the call lights if they see one lit on the hall. The DON stated there was no risk to the resident not having the call light within reach, but ideally, staff would want to have the call light within reach. Review of facility policy titled Call Light/Bell revised July 2015 reflected: .It is the policy of this facility to provide the resident a means of communication with nursing staff

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #4) of five residents reviewed for quality of care. The facility failed to retrieve results of an x-ray order of Resident #4's left hip in a timely manner, which resulted in delayed treatment of a dislocation for a period of approximately 28 hours. Resident #4 was found on the floor on 04/10/23 approximately 9:00 PM, STAT orders (referring to a diagnostic or therapeutic procedure that is to be performed immediately; prioritized in a lab, as the results have a potentially immediate impact on patient management) were submitted on 04/11/23 at approximately 4:56 AM, results retrieved on 04/12/23 at approximately 9:11 AM, by Physician I, and the resident was sent out to the hospital on 04/12/23 at approximately 11:21 AM. An Immediate Jeopardy was determined to have existed from 04/10/23 through 04/27/23. While the IJ was removed on 04/28/23, the facility remained out of compliance at a scope of actual harm that is not Immediate Jeopardy and a severity level of pattern, due to the facility's need to implement corrective systems. The facility implemented actions that corrected the Immediate Jeopardy prior to re-entering the facility on 05/11/23. The facility Administrator was provided the Immediate Jeopardy Template on 05/11/23 at 3:39 PM. This failure placed residents at risk of a delay in medical evaluation, treatment and decrease in quality of care. Findings included: Review of Resident #4's face sheet dated 04/27/23 revealed the resident was an [AGE] year-old-female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4's diagnosis included non-displaced intertrochanteric of fracture of left femur, unspecified fall, muscle weakness, difficulty in walking, abnormalities of gait and mobility, history of falling, lack of coordination, unsteadiness on feet. aphasia, major depressive disorder, vascular dementia with agitation. Review of Resident #4's quarterly MDS Assessment, dated 03/25/23, revealed Resident #4 was usually understood by others and was usually able to understand others; however, the resident's cognitive assessment/BIMS was not completed. Transferring between bed, chair, wheelchair, and standing position required extensive assistance with one person assist. Locomotion in the room required supervision with two person assist. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #4's care plan, undated, revealed Resident #4 had ADL self-care performance deficit related to weakness, dementia, and transient ischemic accident. Goal: will maintain current level of function in transfers, toilet use and personal hygiene, Intervention: Toilet use: requires x1 staff to assist, Transfer requires x1 staff assist with transferring. Resident #4 at risk for falls related to weakness. Goal: will not sustain serious injury. Intervention: 1/1/23 Fall; due to drop in blood pressure, 1/19/23 Fall; educated resident to call for assistance when picking up things off the floor, 02/12/23 Fall; offer bathroom assistance when making rounds, 04/10/23 Fall; fall mat to beside at all times, be sure the call light is within reach and encourage to use it to call for assistance as needed, keep needed items, water, etc. in reach. Resident #4 had an actual fall with minor injury. Goal: Sutures x4 to be removed 02/19/23 will resolve without complication. Intervention: offer bathroom assistance when making rounds, Bed in lowest position, provide activities that promote exercise and strength building where possible. Review of Resident #4's progress notes dated 04/10/23 at 10:11 PM, documented by LVN A reflected: resident was noted sitting on the floor at the end of bed facing the door next to wheelchair. The roommate says she was trying to get out of bed, and she slid out and sat on the floor. Head to toe assessment done. Alert with no signs or symptoms of acute distress, no injuries noted at this time, vitals checked, staff helped back in bed, denies pain at this time. Bed placed in low position, MD, DON, and family notified, will continue to monitor. Review of medication notes dated 04/11/23 at 4:55 AM documented by LVN A reflected: Acetaminophen Tablet 650 mg. Give 1 tablet by mouth every 6 hours as needed for general discomfort. Review of nurse's notes dated 04/11/23 at 4:56 AM documented by LVN A reflected: During routine rounds, this nurse noted Resident #4 holding left hip massaging it. Asked resident if she was in pain and resident nodded her head. Acetaminophen Tablet 650 MG Give 1 tablet by mouth was administered, MD notified, new order left hip x-ray to rule out fracture. X-ray order placed and waiting for the technician. Will continue to monitor. Review of medication notes dated 04/11/23 at 8:00 AM documented by the DON reflected: Acetaminophen Tablet 650 MG. Give 1 tablet by mouth every 6 hours as needed for general discomfort. Follow up: PRN administration was: Effective, Pain scale was: 2. Review of nurse's notes dated 04/11/23 at 9:55 PM documented by LVN A reflected: Follow up follow day 1 of 2, no delayed injury noted, able to move all extremities without difficult. Denies pain to left hip. Bed placed in low position. Will continue to monitor. Review of nurse's notes dated 04/12/23 at 11:21 AM documented by the ADON reflected: Resident complained of pain to right hip. Pain management administered with acetaminophen. X-rays ordered. Results showed fracture to right hip (error in the facility note). Resident sent to hospital via city ambulance by stretcher. Review of Resident #4's lab results dated 04/11/23 at 11:21 AM revealed interpretation: significant findings: left hip x-ray unilateral 2-3 views show a fracture of the left proximal femur at the intertrochanteric region. Impression: Acute fracture of the left proximal femur at the intertrochanteric region. Reviewed by doctor on 04/12/23 9:11 AM. There was a delay (approximately 28 hours) in getting medical treatment for Resident #4 due to the facility not being aware x-ray results (which showed hip fracture) had been received and not promptly notifying the physician of the results. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 04/27/23 at 11:48 AM with Resident #4 revealed communication was unclear. Resident #4 would nod head when asking her questions. Resident #4 stated she had some pain, she stated she fell , and she went to the hospital. Resident #4 was not able to say how the fall occurred. During an interview on 04/27/23 at 3:15 PM with CNA C revealed she was alerted to Resident #4's room by the roommate engaging the call light. CNA C stated she observed Resident #4 on the floor around 7:00 PM and called for the nurse to enter the room to assess. CNA C stated after the assessment Resident #4 was put in bed. CNA C stated she returned to check on Resident #4 and to complete incontinent care. CNA C stated Resident #4 was fighting with her and did not want me to change her. CNA C stated it was hard to tell if she was fighting or if she was displaying pain and alerted the nurse. CNA C stated Resident #4 usually did not talk too much but during her rounds the next day Resident #4 was crying. CNA C stated she informed the nurse Resident #4 was crying and appeared to be in pain, she stated the nurse then administered pain medication and ordered x-ray. CNA C stated Resident was not in the facility the following day when she arrived to work. During an interview on 04/27/23 at 3:48 PM with RN D revealed she was informed about Resident #4's fall. RN D stated she was not present when resident had fall or when the x-ray was completed. RN D stated it was protocol if a resident had a fall and complained of pain, nurses would contact the doctor, and the doctor would order an x-ray stat. RN D stated the x-ray techs would show up within the hour and would usually have the results returned the same day via fax. Upon the receipt of the result, nurses would send the results to the doctor, and wait on the doctor's new orders if any which could be pain management or send resident out to the hospital. If the doctor was busy the Nurse Practitioner would respond or would reach back out to the doctor if no response within 2-3 hours. It was the responsibility of all nurses to receive the x-ray results and alert the doctor of the results. RN D stated there was not one specific person who received the x-ray results; however, if you know your resident had an x-ray you should be looking for the results to come in so that you can alert the doctor. RN D stated not following up with x-ray results put the resident at risk of prolonged pain and not getting the services needed. On 04/27/23 at 4:10 PM an attempt to interview LVN A was unsuccessful. During an interview on 04/27/23 at 4:10 PM with the ADON revealed she was present on the day Resident #4 had a fall. ADON stated she and LVN A entered the room between 9:00 PM-9:30 PM after noting the call light was on and someone yelling. The ADON stated she found Resident #4 on the floor at the foot of the bed feet facing the door and head towards the wall. The ADON stated Resident #4's bed was observed to be at the lowest position. The ADON stated Resident #4 was assessed and back in the wheelchair. The ADON stated Resident #4 was crying and upset, you could tell she was in pain. According to the ADON, the next morning on 04/11/23 Resident #4 was hurting, in pain and grabbing her left side so she told the nurse to give pain medication and was told x-rays were already ordered. The ADON stated on 04/12/23 Resident #4 was showing signs of pain with crying and yelling. The ADON stated facility protocol would be to call out for mobile x-ray, when necessary, results were received pretty quick in the resident's chart and the nurse will contact the doctor immediately. The ADON stated she was not able to say who received Resident #4's x-ray results. The ADON stated any nurse on duty could review the x-ray results and contact the doctor. There was not one person responsible for following up with the doctor with the results. The ADON stated not getting the x-ray results in a timely manner could place residents at risk of getting proper medical care. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 04/27/23 at 4:48 PM an attempt to interview Physician I was unsuccessful. During an interview on 04/27/23 at 5:07 PM with the DON revealed she was notified by nursing staff on 04/10/23 at 8:00 PM that Resident #4 had a fall with no injuries. The DON stated LVN A stated during rounds he assessed Resident #4 and observed she was rubbing her hip, expressing that she was in pain. The DON stated LVN A contacted the doctor for an x-ray. The DON stated the x-ray was completed on 04/11/23 at 11:21 AM. The DON stated x-rays were returned the same day and were auto-posted into resident file. The DON stated there was no way to know when the results were uploaded to resident charts. The DON stated the charge nurse on duty for that resident would be the person to go into resident files to check for x-ray results, then contact the doctor. The DON stated in this case the doctor was the one that logged in, reviewed the results, and contacted us to send her out on 04/12/23. The DON stated Resident #4 was given Tylenol one time for pain and was sent to the hospital by stretcher. The DON stated without knowing what time the results came in it was hard to know the risk for Resident #4. During an interview on 04/28/23 at 12:26 PM with Physician I revealed he was reviewing all lab results and identified the results himself for Resident #4. Physician I stated he did not receive notification from the facility that the results were in. Physician I stated he notified the facility that Resident #4 needed to be sent out to the hospital right after revealing the results. Physician I stated he spoke to the DON to have the results sent directly to her so that she was aware when the results were in so she could notify the required authorities as soon as possible to prevent risk to the resident. During interview and record review it was revealed LVN A received a STAT order for an X-ray as of 04/11/23 at 4:56 AM. The x-ray was completed on 04/11/23 at 11:21 AM. Resident #4 was sent out to the hospital on 04/12/23 after the doctor reviewed the results on 04/12/23, he then notified the facility of the results. The ADON stated she did not follow up on the X-ray orders to see if they were received on 04/11/23 after the orders had been completed. ADON stated on 04/12/23 when she asked about orders for the X-ray on 04/12/23, she was notified the resident was being sent out to the hospital. Resident #4 had now been in pain during several shifts (10:00 PM-6:00 AM day 1 of 3, 6:00 AM-2:00 PM, 2:00 PM-10:00 PM, 10:00 PM-6:00 AM day 2 of 3, and 6:00 AM-until sent to the hospital day 3 of 3) according to both LVN A and ADON. Review of the EMAR revealed she was administered pain medication once on 04/11/23 at 4:55 AM throughout all shifts after the fall. Hospital records revealed Resident #4 admitting diagnosis was severe left hip pain, left hip fracture, leukocytosis, acute cystitis without hematuria, fall, dementia. An Immediate Jeopardy was determined to have existed from 04/10/23 through 04/27/23. The IJ was removed on 04/28/23 because the facility implemented actions that corrected the Immediate Jeopardy prior to re-entering the facility on 05/11/23. The facility Administrator was provided the Immediate Jeopardy Template on 05/11/23 at 3:39 PM. The facility submitted the following accepted Plan of Removal on 05/12/23: .Immediate Action: 1. ADON re-education was completed on 4/12/2023 was completed by DON. DON was educated by Clinical Resource .04/27/2023. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. The Medical Director was notified of IJ on 5/11/2023 at 3:51 PM and read at 3:59 PM . 3. Education was initiated with nurses by DON/ADON/Clinical Resource on 4/28/23 related to: a. Lab results reporting and checking lab and radiology PCC modules every 4 hours during per shift; b. Every shift to complete assessments on residents that have had a fall. Report any complaints of pain to MD immediately; c. Notification to MD of Abnormal Results; Notification to Responsible Party in the clinical record; d. Fall prevention; e. Stop and watch program; f. Abuse, neglect, misappropriation 4. Notified Medical Director of survey results on 4/28/23 and physician wrote a written statement of no harm or significant delay in care that we received on 5/1/23. (Relevance is that there is no harm or significant delay in care per the Medical Director). 5. Immediately notified Xray provider that all Abnormal and Critical Findings are required to be called to the DON if facility staff do not answer facility phone on 4/12/2023. 6. An Ad hoc QA meeting regarding items in IJ template was completed on 5/11/23 at 5:15pm. Attendees included the Administrator, DON, Medical Director and Clinical Resource. The plan of removal items and interventions were developed, reviewed, and agreed upon. Identification of Others Affected: Residents who have ordered diagnostic and radiology services have the potential to be affected. Systemic Change to Prevent Re-occurrence: 1. Education was initiated with nurses by DON/ADON/Clinical Resource on 4/28/23 related to: a. Lab results reporting and checking lab and radiology PCC modules every 4 hours during per shift; b. Every shift to complete assessments on residents that have had a fall. Report any complaints of pain to MD immediately; c. Notification to MD of Abnormal Results; Notification to Responsible Party with a progress note identifying results and notification made; d. Fall prevention; e. Stop and watch program; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	f. Abuse, neglect, misappropriation 2. Review of all radiology and diagnostic services to ensure completion and follow up with appropriate documentation, daily, in clinical morning meeting, effective 5/1/2023. 3. Immediately notified Xray provider that all Abnormal and Critical Findings are required to be called to the DON if facility staff do not answer facility phone on 4/12/2023. 4. An Ad hoc QA meeting regarding items in IJ template was completed on 5/11/23 at 5:15pm. Attendees included the Administrator, DON, Medical Director and Clinical Resource. The plan of removal items and interventions were developed, reviewed, and agreed upon. Monitoring: 1. Review of all radiology and diagnostic services to ensure completion and follow up with appropriate documentation, daily, in clinical morning meeting, effective 5/1/2023, by Clinical IDT, daily, for 4 weeks, and then routinely monitored through the change of condition process. 2. Weekly clinical meetings will include review of laboratory orders and results. Meeting attendees will include the clinical IDT and the Administrator. Meeting minutes will be reported to monthly QA by DON/ADON/designee. During an interview on 05/11/23 at 4:11 PM with the ADON revealed when she entered the facility on 04/11/23 she received updated information from LVN A and the 24-hour report for Resident #4. The ADON stated she was told an x-ray had been ordered and waiting on x-ray techs arrival. The ADON stated you get busy doing other things and then she realized the next day on 04/12/23, they were sending Resident #4 out to the hospital. The ADON stated since she worked the floor on 04/11/23, she should have followed up with looking for the results by looking in the chart or contacting the x-ray company for results then contacting the physician and the family about Resident #4's results. The ADON stated she completed training and in-services pertaining to labs and radiology services on 04/28/23 the day after the initial HHSC visit on 04/27/23. The ADON stated the facility had implemented daily clinical meetings to review order listing reports and orders from the previous day to be checked by the interdisciplinary team. The ADON stated the team would then reach out to the nurse who created the order or charge nurse on the floor that day to see if they had reviewed orders, reached out to the doctor, and documented in the chart. The ADON stated lab results with significant findings would be sent directly to the DON, the DON would contact the charge nurse and the physician with the findings. The ADON stated the nurses would communicate verbally and through the 24-hour report, whether residents had labs, doctor appointments, anything noted on the 24-hour report, that shift nurse was now responsible to ensure the task was completed, followed-up on and documented in the resident chart. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview on 05/11/23 at 6:11 PM with the DON revealed she received notification via text from LVN A on 04/10/23 the night of the fall after 9:00 PM. LVN A indicated Resident #4 had no apparent injury and no complaints of pain. The DON stated she returned to the facility on [DATE] about 5:45 AM and was verbally told by LVN A that Resident #4 started complaining of pain, and LVN A contacted the doctor and received an order for x-ray. The DON stated she would have expected x-ray to show up within 4-6 hours. The DON stated since LVN A's shift ended, the 24-hour report would alert the next shift nurse that Resident #4 was to complete x-ray. That shift nurse, which in this case was the ADON should have followed up to ensure the x-ray was completed and results given to the physician. The DON stated in-services were started on 04/28/23 with nurses to check lab results every 4 hours during 12-hour shift. The DON stated the facility had now implemented that after the morning stand-up meeting, the clinical team would review all orders from the previous day, check on the things that needed to be done, go over current orders, care plans, nurses' notes, documentation and calls to doctors and resident representatives. The DON stated she also contacted the imaging company to ensure they would send notification directly to her via text when there were significant findings with lab results. The DON stated the notifications came with a link so that she could access the results. The DON stated she would put in a progress note and notify the doctor, nurse, and resident representative. The DON stated for agency staff or as needed staff there would be a binder with in-services and test to complete to ensure all nursing staff were aware to check for laboratory, radiology, diagnostic result every 4 hours, and to call doctor and resident representatives with results, and to document in the resident chart. During interview on 05/11/23 at 6:46 PM with LVN A revealed the aide alerted him that Resident #4 had fallen on 04/10/23 between 8:00 PM-9:00 PM. LVN A stated when he entered the room Resident #4 was sitting down next to the bed legs straight out, the call light had been initiated by the roommate. LVN A stated the roommate stated Resident #4 was trying to get up off the bed and slid down to the floor. LVN A stated after his assessment her vitals were normal, no findings with range of motion and no indication of pain, Resident #4 was assisted to her bed. LVN A stated during his rounds at 12:00 AM Resident #4 was sleeping, during his rounds at 4:00 AM, Resident #4 was rubbing her left hip continuously. LVN A stated he asked her if she was in pain and the way she replied confirmed she was in pain. LVN A stated he provided her with pain medication which she has an order for use as needed. LVN A stated he contacted the physician and received order for X-ray, contacted the family and notified the DON. LVN A stated when the next shift nurse came, rounds were completed together, completed the 24-hour report so that she could follow up with X-ray. LVN A stated the next day when he entered the facility he completed rounds, Resident #4 was sleep, not showing signs of pain. LVN A stated he thought the results were received and the physician was notified. LVN A stated he did not think to look or ask about the x-ray results, LVN A stated he should have followed up on the results himself. LVN A stated he completed several in-service training about 2 weeks ago covering labs and x-ray results, checking for results every 4 hours during shift and if the results were critical to contact the physician and resident representative immediately, and document. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview on 05/12/23 at 1:47 PM with Physician I revealed the reason he sent Resident #4 out to the hospital was due to her results of acute fracture of her left hip. Physician I stated Resident #4 did not have an emergency; however, it was urgent, and they needed to act with urgency. Physician I stated he was not sure when the results were sent or received and speaking with the x-ray company, they did not think the hip fracture was considered critical. Physician I stated communication was completed with them to have the understanding to contact the facility through phone call and fax with critical findings. It was discussed with the x-ray company that a hip fracture was a critical result and should have been called to the facility and not just faxed. Physician I stated some things were critical and needed action right away and this was one. Physiciani I stated even if the results came in the same day and she was sent to the hospital that night, the surgery would not have happened until 2-3 days later, and they were still in that window. During interview on 05/12/23 at 3:19 PM with a representative from the x-ray company revealed she had been communicating with the facility a number of ways to alert the facility when results came in. The x-ray company representative stated the results were automatically sent to the same number and emailed whether the findings were significant or not. The x-ray company representative stated after Resident #4's fall more functionality was provided to the alerts and as of 04/17/23 the facility would now be automatically emailed the findings and if there were significant results then the DON would also get a text notifying the DON of the critical result. The x-ray company representative confirmed monitoring and there had not been any further concerns. Review of in-services and interviews on 05/12/23 with nurses, ADON, DON, Clinical Resources revealed the facility implemented in-services on 04/28/23 on the following topics: 1. Notification to MD of abnormal results. Notification to responsible party (RP), progress notes, stating results and notification. 2. Reporting Lab results, check Lab & Radiology Q4 hours during a 12 hour shift. 3. Stop & Watch training with the Nurses, MAs, and CNAs. 4. Response on Resident call lights. Call light in reach of resident. 5. Fall Prevention Review of facility's Nursing Clinical policy and procedure, revised May 2007, reflected the following: Policy- It is the policy of this facility that the resident's attending physician will be notified of the results of diagnostic tests. Procedures: 1. Results of laboratory, radiological, and diagnostic tests shall be reported in writing to the resident's attending physician or to the facility. 2. Should the test results be provided to the facility, the attending physician shall be notified of the results. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. The Director of Nursing Services, or Charge Nurse receiving the test results, shall be responsible for notifying the physician of such test results .

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview and record review, the facility failed to 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 for one (Resident #4) of five residents reviewed for radiology services. The facility failed to retrieve results of an x-ray order of Resident #4's left hip in a timely manner, which resulted in delayed treatment of a dislocation for a period of approximately 28 hours. Resident #4 was found on the floor on 04/10/23 approximately 9:00 PM, STAT orders (referring to a diagnostic or therapeutic procedure that is to be performed immediately; prioritized in a lab, as the results have a potentially immediate impact on patient management) were submitted on 04/11/23 at approximately 4:56 AM, results retrieved on 04/12/23 at approximately 9:11 AM, by Physician I, and the resident was sent out to the hospital on 04/12/23 at approximately 11:21 AM. An Immediate Jeopardy was determined to have existed from 04/10/23 through 04/27/23. While the IJ was removed on 04/28/23, the facility remained out of compliance at a scope of potential of actual harm that is not Immediate Jeopardy and a severity level of pattern, due to the facility's need to implement corrective systems. The facility implemented actions that corrected the Immediate Jeopardy prior to re-entering the facility on 05/11/23. The facility Administrator was provided the Immediate Jeopardy Template on 05/11/23 at 3:39 PM. This failure placed residents at risk of a delay in medical evaluation, treatment and decrease in quality of care. Findings included: Review of Resident #4's face sheet dated 04/27/23 revealed the resident was an [AGE] year-old-female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4's diagnosis included non-displaced intertrochanteric of fracture of left femur, unspecified fall, muscle weakness, difficulty in walking, abnormalities of gait and mobility, history of falling, lack of coordination, unsteadiness on feet. aphasia, major depressive disorder, vascular dementia with agitation. Review of Resident #4's quarterly MDS Assessment, dated 03/25/23, revealed Resident #4 was usually understood by others and was usually able to understand others; however, the resident's cognitive assessment/BIMS was not completed. Transferring between bed, chair, wheelchair, and standing position required extensive assistance with one person assist. Locomotion in the room required supervision with two person assist. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #4's care plan, undated, revealed Resident #4 had ADL self-care performance deficit related to weakness, dementia, and transient ischemic accident. Goal: will maintain current level of function in transfers, toilet use and personal hygiene, Intervention: Toilet use: requires x1 staff to assist, Transfer requires x1 staff assist with transferring. Resident #4 at risk for falls related to weakness. Goal: will not sustain serious injury. Intervention: 1/1/23 Fall; due to drop in blood pressure, 1/19/23 Fall; educated resident to call for assistance when picking up things off the floor, 02/12/23 Fall; offer bathroom assistance when making rounds, 04/10/23 Fall; fall mat to beside at all times, be sure the call light is within reach and encourage to use it to call for assistance as needed, keep needed items, water, etc. in reach. Resident #4 had an actual fall with minor injury. Goal: Sutures x4 to be removed 02/19/23 will resolve without complication. Intervention: offer bathroom assistance when making rounds, Bed in lowest position, provide activities that promote exercise and strength building where possible. Review of Resident #4's progress notes dated 04/10/23 at 10:11 PM, documented by LVN A reflected: resident was noted sitting on the floor at the end of bed facing the door next to wheelchair. The roommate says she was trying to get out of bed, and she slid out and sat on the floor. Head to toe assessment done. Alert with no signs or symptoms of acute distress, no injuries noted at this time, vitals checked, staff helped back in bed, denies pain at this time. Bed placed in low position, MD, DON, and family notified, will continue to monitor. Review of medication notes dated 04/11/23 at 4:55 AM documented by LVN A reflected: Acetaminophen Tablet 650 mg. Give 1 tablet by mouth every 6 hours as needed for general discomfort. Review of nurse's notes dated 04/11/23 at 4:56 AM documented by LVN A reflected: During routine rounds, this nurse noted Resident #4 holding left hip massaging it. Asked resident if she was in pain and resident nodded her head. Acetaminophen Tablet 650 MG Give 1 tablet by mouth was administered, MD notified, new order left hip x-ray to rule out fracture. X-ray order placed and waiting for the technician. Will continue to monitor. Review of medication notes dated 04/11/23 at 8:00 AM documented by the DON reflected: Acetaminophen Tablet 650 MG. Give 1 tablet by mouth every 6 hours as needed for general discomfort. Follow up: PRN administration was: Effective, Pain scale was: 2. Review of nurse's notes dated 04/11/23 at 9:55 PM documented by LVN A reflected: Follow up follow day 1 of 2, no delayed injury noted, able to move all extremities without difficult. Denies pain to left hip. Bed placed in low position. Will continue to monitor. Review of nurse's notes dated 04/12/23 at 11:21 AM documented by the ADON reflected: Resident complained of pain to right hip. Pain management administered with acetaminophen. X-rays ordered. Results showed fracture to right hip (error in the facility note). Resident sent to hospital via city ambulance by stretcher. Review of Resident #4's lab results dated 04/11/23 at 11:21 AM revealed interpretation: significant findings: left hip x-ray unilateral 2-3 views show a fracture of the left proximal femur at the intertrochanteric region. Impression: Acute fracture of the left proximal femur at the intertrochanteric region. Reviewed by doctor on 04/12/23 9:11 AM. There was a delay (approximately 28 hours) in getting medical treatment for Resident #4 due to the facility not being aware x-ray results (which showed hip fracture) had been received and not promptly notifying the physician of the results. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 04/27/23 at 11:48 AM with Resident #4 revealed communication was unclear. Resident #4 would nod head when asking her questions. Resident #4 stated she had some pain, she stated she fell , and she went to the hospital. Resident #4 was not able to say how the fall occurred. During an interview on 04/27/23 at 3:15 PM with CNA C revealed she was alerted to Resident #4's room by the roommate engaging the call light. CNA C stated she observed Resident #4 on the floor around 7:00 PM and called for the nurse to enter the room to assess. CNA C stated after the assessment Resident #4 was put in bed. CNA C stated she returned to check on Resident #4 and to complete incontinent care. CNA C stated Resident #4 was fighting with her and did not want me to change her. CNA C stated it was hard to tell if she was fighting or if she was displaying pain and alerted the nurse. CNA C stated Resident #4 usually did not talk too much but during her rounds the next day Resident #4 was crying. CNA C stated she informed the nurse Resident #4 was crying and appeared to be in pain, she stated the nurse then administered pain medication and ordered x-ray. CNA C stated Resident was not in the facility the following day when she arrived to work. During an interview on 04/27/23 at 3:48 PM with RN D revealed she was informed about Resident #4's fall. RN D stated she was not present when resident had fall or when the x-ray was completed. RN D stated it was protocol if a resident had a fall and complained of pain, nurses would contact the doctor, and the doctor would order an x-ray stat. RN D stated the x-ray techs would show up within the hour and would usually have the results returned the same day via fax. Upon the receipt of the result, nurses would send the results to the doctor, and wait on the doctor's new orders if any which could be pain management or send resident out to the hospital. If the doctor was busy the Nurse Practitioner would respond or would reach back out to the doctor if no response within 2-3 hours. It was the responsibility of all nurses to receive the x-ray results and alert the doctor of the results. RN D stated there was not one specific person who received the x-ray results; however, if you know your resident had an x-ray you should be looking for the results to come in so that you can alert the doctor. RN D stated not following up with x-ray results put the resident at risk of prolonged pain and not getting the services needed. On 04/27/23 at 4:10 PM an attempt to interview LVN A was unsuccessful. During an interview on 04/27/23 at 4:10 PM with the ADON revealed she was present on the day Resident #4 had a fall. ADON stated she and LVN A entered the room between 9:00 PM-9:30 PM after noting the call light was on and someone yelling. The ADON stated she found Resident #4 on the floor at the foot of the bed feet facing the door and head towards the wall. The ADON stated Resident #4's bed was observed to be at the lowest position. The ADON stated Resident #4 was assessed and back in the wheelchair. The ADON stated Resident #4 was crying and upset, you could tell she was in pain. According to the ADON, the next morning on 04/11/23 Resident #4 was hurting, in pain and grabbing her left side so she told the nurse to give pain medication and was told x-rays were already ordered. The ADON stated on 04/12/23 Resident #4 was showing signs of pain with crying and yelling. The ADON stated facility protocol would be to call out for mobile x-ray, when necessary, results were received pretty quick in the resident's chart and the nurse will contact the doctor immediately. The ADON stated she was not able to say who received Resident #4's x-ray results. The ADON stated any nurse on duty could review the x-ray results and contact the doctor. There was not one person responsible for following up with the doctor with the results. The ADON stated not getting the x-ray results in a timely manner could place residents at risk of getting proper medical care. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 04/27/23 at 4:48 PM an attempt to interview Physician I was unsuccessful. During an interview on 04/27/23 at 5:07 PM with the DON revealed she was notified by nursing staff on 04/10/23 at 8:00 PM that Resident #4 had a fall with no injuries. The DON stated LVN A stated during rounds he assessed Resident #4 and observed she was rubbing her hip, expressing that she was in pain. The DON stated LVN A contacted the doctor for an x-ray. The DON stated the x-ray was completed on 04/11/23 at 11:21 AM. The DON stated x-rays were returned the same day and were auto-posted into resident file. The DON stated there was no way to know when the results were uploaded to resident charts. The DON stated the charge nurse on duty for that resident would be the person to go into resident files to check for x-ray results, then contact the doctor. The DON stated in this case the doctor was the one that logged in, reviewed the results, and contacted us to send her out on 04/12/23. The DON stated Resident #4 was given Tylenol one time for pain and was sent to the hospital by stretcher. The DON stated without knowing what time the results came in it was hard to know the risk for Resident #4. During an interview on 04/28/23 at 12:26 PM with Physician I revealed he was reviewing all lab results and identified the results himself for Resident #4. Physician I stated he did not receive notification from the facility that the results were in. Physician I stated he notified the facility that Resident #4 needed to be sent out to the hospital right after revealing the results. Physician I stated he spoke to the DON to have the results sent directly to her so that she was aware when the results were in so she could notify the required authorities as soon as possible to prevent risk to the resident. During interview and record review it was revealed LVN A received a STAT order for an X-ray as of 04/11/23 at 4:56 AM. The X-ray was completed on 04/11/23 at 11:21 AM. Resident #4 was sent out to the hospital on 04/12/23 after the doctor reviewed the results on 04/12/23, he then notified the facility of the results. The ADON stated she did not follow up on the X-ray orders to see if they were received on 04/11/23 after the orders had been completed. ADON stated on 04/12/23 when she asked about orders for the X-ray on 04/12/23, she was notified the resident was being sent out to the hospital. Resident #4 had now been in pain during several shifts (10:00 PM-6:00 AM day 1 of 3, 6:00 AM-2:00 PM, 2:00 PM-10:00 PM, 10:00 PM-6:00 AM day 2 of 3, and 6:00 AM-until sent to the hospital day 3 of 3) according to both LVN A and ADON. Review of the EMAR revealed she was administered pain medication once on 04/11/23 at 4:55 AM throughout all shifts after the fall. Hospital records revealed Resident #4 admitting diagnosis was severe left hip pain, left hip fracture, leukocytosis, acute cystitis without hematuria, fall, dementia. An Immediate Jeopardy was determined to have existed from 04/10/23 through 04/27/23. The IJ was removed on 04/28/23 because the facility implemented actions that corrected the Immediate Jeopardy prior to re-entering the facility on 05/11/23. The facility Administrator was provided the Immediate Jeopardy Template on 05/11/23 at 3:39 PM. The facility submitted the following accepted Plan of Removal on 05/12/23: .Immediate Action: 1. ADON re-education was completed on 4/12/2023 was completed by DON. DON was educated by Clinical Resource .04/27/2023. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	f. Abuse, neglect, misappropriation 2. Review of all radiology and diagnostic services to ensure completion and follow up with appropriate documentation, daily, in clinical morning meeting, effective 5/1/2023. 3. Immediately notified Xray provider that all Abnormal and Critical Findings are required to be called to the DON if facility staff do not answer facility phone on 4/12/2023. 4. An Ad hoc QA meeting regarding items in IJ template was completed on 5/11/23 at 5:15pm. Attendees included the Administrator, DON, Medical Director and Clinical Resource. The plan of removal items and interventions were developed, reviewed, and agreed upon. Monitoring: 1. Review of all radiology and diagnostic services to ensure completion and follow up with appropriate documentation, daily, in clinical morning meeting, effective 5/1/2023, by Clinical IDT, daily, for 4 weeks, and then routinely monitored through the change of condition process. 2. Weekly clinical meetings will include review of laboratory orders and results. Meeting attendees will include the clinical IDT and the Administrator. Meeting minutes will be reported to monthly QA by DON/ADON/designee. During an interview on 05/11/23 at 4:11 PM with the ADON revealed when she entered the facility on 04/11/23 she received updated information from LVN A and the 24-hour report for Resident #4. The ADON stated she was told an x-ray had been ordered and waiting on x-ray techs arrival. The ADON stated you get busy doing other things and then she realized the next day on 04/12/23, they were sending Resident #4 out to the hospital. The ADON stated since she worked the floor on 04/11/23, she should have followed up with looking for the results by looking in the chart or contacting the x-ray company for results then contacting the physician and the family about Resident #4's results. The ADON stated she completed training and in-services pertaining to labs and radiology services on 04/28/23 the day after the initial HHSC visit on 04/27/23. The ADON stated the facility had implemented daily clinical meetings to review order listing reports and orders from the previous day to be checked by the interdisciplinary team. The ADON stated the team would then reach out to the nurse who created the order or charge nurse on the floor that day to see if they had reviewed orders, reached out to the doctor, and documented in the chart. The ADON stated lab results with significant findings would be sent directly to the DON, the DON would contact the charge nurse and the physician with the findings. The ADON stated the nurses would communicate verbally and through the 24-hour report, whether residents had labs, doctor appointments, anything noted on the 24-hour report, that shift nurse was now responsible to ensure the task was completed, followed-up on and documented in the resident chart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676029	A. Building B. Wing	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark Rehabilitation and Living	900 Westpark Way Euless, TX 76040

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview on 05/11/23 at 6:11 PM with the DON revealed she received notification via text from LVN A on 04/10/23 the night of the fall after 9:00 PM. LVN A indicated Resident #4 had no apparent injury and no complaints of pain. The DON stated she returned to the facility on [DATE] about 5:45 AM and was verbally told by LVN A that Resident #4 started complaining of pain, and LVN A contacted the doctor and received an order for x-ray. The DON stated she would have expected x-ray to show up within 4-6 hours. The DON stated since LVN A's shift ended, the 24-hour report would alert the next shift nurse that Resident #4 was to complete x-ray. That shift nurse, which in this case was the ADON should have followed up to ensure the x-ray was completed and results given to the physician. The DON stated in-services were started on 04/28/23 with nurses to check lab results every 4 hours during 12-hour shift. The DON stated the facility had now implemented that after the morning stand-up meeting, the clinical team would review all orders from the previous day, check on the things that needed to be done, go over current orders, care plans, nurses' notes, documentation and calls to doctors and resident representatives. The DON stated she also contacted the imaging company to ensure they would send notification directly to her via text when there were significant findings with lab results. The DON stated the notifications came with a link so that she could access the results. The DON stated she would put in a progress note and notify the doctor, nurse, and resident representative. The DON stated for agency staff or as needed staff there would be a binder with in-services and test to complete to ensure all nursing staff were aware to check for laboratory, radiology, diagnostic result every 4 hours, and to call doctor and resident representatives with results, and to document in the resident chart. During interview on 05/11/23 at 6:46 PM with LVN A revealed the aide alerted him that Resident #4 had fallen on 04/10/23 between 8:00 PM-9:00 PM. LVN A stated when he entered the room Resident #4 was sitting down next to the bed legs straight out, the call light had been initiated by the roommate. LVN A stated the roommate stated Resident #4 was trying to get up off the bed and slid down to the floor. LVN A stated after his assessment her vitals were normal, no findings with range of motion and no indication of pain, Resident #4 was assisted to her bed. LVN A stated during his rounds at 12:00 AM Resident #4 was sleeping, during his rounds at 4:00 AM, Resident #4 was rubbing her left hip continuously. LVN A stated he asked her if she was in pain and the way she replied confirmed she was in pain. LVN A stated he provided her with pain medication which she has an order for use as needed. LVN A stated he contacted the physician and received order for X-ray, contacted the family and notified the DON. LVN A stated when the next shift nurse came, rounds were completed together, completed the 24-hour report so that she could follow up with X-ray. LVN A stated the next day when he entered the facility he completed rounds, Resident #4 was sleep, not showing signs of pain. LVN A stated he thought the results were received and the physician was notified. LVN A stated he did not think to look or ask about the x-ray results, LVN A stated he should have followed up on the results himself. LVN A stated he completed several in-service training about 2 weeks ago covering labs and x-ray results, checking for results every 4 hours during shift and if the results were critical to contact the physician and resident representative immediately, and document. (continued on next page)

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	676029	A. Building B. Wing	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview on 05/12/23 at 1:47 PM with Physician I revealed the reason he sent Resident #4 out to the hospital was due to her results of acute fracture of her left hip. Physician I stated Resident #4 did not have an emergency; however, it was urgent, and they needed to act with urgency. Physician I stated he was not sure when the results were sent or received and speaking with the x-ray company, they did not think the hip fracture was considered critical. Physician I stated communication was completed with them to have the understanding to contact the facility through phone call and fax with critical findings. It was discussed with the x-ray company that a hip fracture was a critical result and should have been called to the facility and not just faxed. Physician I stated some things were critical and needed action right away and this was one. Physician I stated even if the results came in the same day and she was sent to the hospital that night, the surgery would not have happened until 2-3 days later, and they were still in that window. During interview on 05/12/23 at 3:19 PM with a representative from the x-ray company revealed she had been communicating with the facility a number of ways to alert the facility when results came in. The x-ray company representative stated the results were automatically sent to the same number and emailed whether the findings were significant or not. The x-ray company representative stated after Resident #4's fall more functionality was provided to the alerts and as of 04/17/23 the facility would now be automatically emailed the findings and if there were significant results then the DON would also get a text notifying the DON of the critical result. The x-ray company representative confirmed monitoring and there had not been any further concerns. Review of in-services and interviews on 05/12/23 with nurses, ADON, DON, Clinical Resources revealed the facility implemented in-services on 04/28/23 on the following topics: 1. Notification to MD of abnormal results. Notification to responsible party (RP), progress notes, stating results and notification. 2. Reporting Lab results, check Lab & Radiology Q4 hours during a 12 hour shift. 3. Stop & Watch training with the Nurses, MAs, and CNAs. 4. Response on Resident call lights. Call light in reach of resident. 5. Fall Prevention Review of facility's Nursing Clinical policy and procedure, revised May 2007, reflected the following: Policy- It is the policy of this facility that the resident's attending physician will be notified of the results of diagnostic tests. Procedures: 1. Results of laboratory, radiological, and diagnostic tests shall be reported in writing to the resident's attending physician or to the facility. 2. Should the test results be provided to the facility, the attending physician shall be notified of the results. (continued on next page)

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