STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345293	A. BUILDING _____ B. WING _____	12/18/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff, resident, responsible party (RP), and physician interviews and record review, the facility failed to notify the physician of a fall sustained during transportation in the facility van on 11/23/15 which resulted in a [MEDICAL CONDITION] hip and multiple fractures of the right lower leg for 1 of 5 residents reviewed for supervision to prevent accidents (Resident #1). Immediate Jeopardy began on 11/23/15 when the facility did not notify Resident #1 ' s physician of a fall sustained on the transportation van resulting in multiple fractures. The facility was notified of the immediate jeopardy on 12/16/15 at 4:41 PM. Immediate jeopardy was removed on 12/18/15 at 11:45 AM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective. Findings included: Resident #1 ' s quarterly Minimum Data Set ((MDS) dated [DATE] indicated she was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Resident #1 was also coded as requiring total assistance with all transfers, non-ambulatory, and without pain during this MDS assessment. Resident #1 was further coded as not having received any scheduled or as needed pain medication. A review of the hospital records dated 11/27/15 indicated Resident was being transported in a van 5 days ago in her wheelchair when she slipped from the wheelchair onto her left hip with her right leg under her. She has been complaining of some pain in the area since that time. The pain was reported mostly to her left proximal femur and her right ankle which showed evidence of bruising and swelling. A splint was applied to her right lower extremity for immobilization and the orthopedic consult recommended no surgical intervention due to Resident #1 ' s bed bound status and severe MS with contractures. Pain management was recommended. Resident #1 was discharged back to the facility on [DATE] with pain medication orders In an interview on 12/8/15 at 12:00 PM, Resident #1 recalled falling from the wheelchair in the van on 11/23/15 while on a transport. Resident #1 stated she did not recall anyone coming to assess her legs after the fall on 11/23/15 and it was not until the Friday after Thanksgiving that she had a x-ray done and then was sent to the hospital on [DATE]. In a telephone interview on 12/8/15 at 2:30 PM, Transportation Aide (TA) #1 recalled taking Resident #1 to [MEDICAL CONDITION] center on 11/23/15. She recalled Resident #1 stated she was sliding from her wheelchair so she pulled over and with the assistance of the RP, they lifted Resident #1 and returned her to the wheelchair. She then proceeded to return to the facility. She stated she did not call the facility or call 911 for assistance because Resident #1 stated she was ok. Once she arrived back at the facility, she notified the Director of Nursing (DON) who told her to write a statement and inform Resident #1 ' s nurse. In an interview on 12/8/15 at 12:21 PM, the DON recalled TA #1 reporting to her that Resident #1 slipped in the van. The DON explained TA #1 stated Resident #1 ' s RP was present in the van and caught her and she was alright. The DON stated she was unsure if it was an actual fall at that time. She told the TA #1 to write a statement and inform Resident #1 ' s nurse to complete an incident report. The DON stated she did not go and assess Resident #1 for any injures or discuss the circumstances of the fall with her or the RP. She stated she did not recall instructing the nurse to notify the physician. In an interview on 12/8/15 at 4:35 PM, the RP recalled riding in the front passenger seat of the facility van to take Resident #1 to [MEDICAL CONDITION] center on 11/23/15. On their return to the facility, he recalled Resident #1 say I ' m fixing to slide out of my wheelchair. He explained Resident #1 had slid from her wheelchair and landed on the foot pedal of the wheelchair. He stated he was not aware that the staff never contacted the physician at any time until he insisted on something be done on 11/27/15 due to Resident #1 ' s reported pain. In an interview on 12/8/15 at 1:02 PM, Nurse #1 confirmed she was assigned Resident #1 on 11/23/15 when she returned from her appointment. She recalled TA #1 reporting to her Resident #1 fell in the van. Nurse #1 stated it was around shift change so she was busy. She recalled TA #1 told her Resident #1 slid from her wheelchair but she was fine. Nurse #1 stated she worked a double shift that day so after shift change she went and spoke to Resident #1 who was already back in the bed. Nurse #1 confirmed she did not notify the physician of the fall that occurred on 11/23/15. In an interview on 12/8/15 at 3:25 PM, Nurse #3 confirmed she worked second shift on 11/24/15 with Resident #1. Did Nurse #3 receive a report regarding the fall from the Nurse she relieved? No, but the fall happened the day before She stated Resident #1 did not report any pain to her and the assigned aide did not report any pain to her. She recalled also working second shift on 11/27/15 with Resident #1 and she contacted the physician about Resident #1 ' s leg pain and obtained orders for x-rays. Nurse #3 stated the x-rays returned positive for fractures to her left hip and right leg and she sent her to the hospital for an evaluation as ordered by the physician. In a telephone interview on 12/8/15 at 4:02 PM, the physician stated he was not notified of any incident involving a fall on the van with Resident #1 until 11/27/15 when the RP was at the facility stating Resident #1 was in severe pain and something had to be done. He stated he ordered x-rays and that was when he discovered the fractures. The physician stated his expectation was to be notified immediately when an incident like the one involving Resident #1 occurred and Resident #1 should have been assessed sooner in the hospital and her pain treated properly. A review of Resident #1 ' s nursing notes indicated a note dated 11/27/15 documenting the events that occurred on 11/23/15. This nursing note indicated the physician was made aware on 11/27/15 of Resident #1 ' s fall that occurred Monday 11/23/15 while she was on the facility transportation van. The physician ordered a series of x-rays. When the physician was notified of the x-ray results, orders were received to send Resident #1 to the hospital for an evaluation on 11/27/15 due multiple lower extremity fractures. The facility was notified of being placed into Immediate Jeopardy at approximately 4:45 PM, on December 16, 2015, related to an incident that took place on a facility van on November 23, 2015. Immediately a plan was put in place to complete a Credible Allegation. A. How the corrective action will be accomplished for those residents found to have been affected by deficient practice? Outcome? · On 11/27/15, the second shift 200 hall staff nurse notified resident number 1's physician regarding the incident that took place on 11/23/15. · On 11/27/15, the second shift 200 hall staff nurse assessed resident number 1 during medication administration and

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

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 disclosable 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 disclosable 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.

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F 0157 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) completed a head-to-toe skin assessment. The second shift 200 hall nurse notified the physician of her assessment which included bruising to the left foot and ankle. The second shift 200 hall staff nurse also notified the physician of resident number 1's complaints of pain to the left foot and ankle and the right hip. The physician gave an order for [REDACTED].>· On 11/27/15, X-rays were completed on resident number 1, of resident number 1 ' s left foot and ankle and right hip. The results of the x-ray were communicated to the physician, resident number 1, and resident number 1 ' s family member or RP by the second shift 200 hall staff nurse. · On 11/27/15, the physician gave an order to the second shift 200 hall staff nurse to send resident number 1 to the emergency room . Resident number 1 was discharged to the local hospital emergency room for further evaluation. · On 11/27/15, the second shift 200 hall staff nurse initiated an incident/accident report, as directed by the administrator, on behalf of the first shift 200 hall nurse who failed to initiate an incident/accident report on 11/23/15 for resident number 1. · On 12/17/15 the director of nursing received additional in-service training, from the administrator, regarding promptly notifying the resident ' s physician regarding an incident or accident. · On 12/17/15 the director of nursing administered additional in-service training, for the involved nurse from 11/23/15, regarding promptly notifying the resident ' s physician regarding an incident or accident. · How did the facility identify other residents having the potential to be affected by the same deficient practice? · On 12/9/15, the director of nursing initiated an in-service for all LPN's and RN's including all nurses working from 11/23/15 to 11/27/15 regarding the expectation that the nurse promptly notifies the physician post incident/accident. No LPN or RN will be allowed to complete a shift until they have completed and signed the in-service. This in-service will be incorporated into new employee orientation. · On 12/17/15, all incident/accident reports from 11/23/15 through 12/17/15 were reviewed by the director of nursing and the assistant director of nursing to ensure physician notification. · On 12/16/15, an in-service was initiated by the director of nursing for all certified nursing assistants, including all nursing assistants that worked from 11/23/15 through 11/27/15, stating it is the responsibility of the CNA to seek immediate guidance for residents presenting a change in condition or resident incident including but not limited to: calling code green (resident fall) if inside facility or on facility grounds, calling 911 if outside facility grounds, and calling the facility directly to obtain professional guidance by a licensed nurse and/or administration if outside of the facility grounds. This in-service will be incorporated into new employee orientation. B. Give specific dates of the corrective actions. · On 11/27/15 resident number 1's physician was notified of the incident. · On 11/27/15 resident number 1's physician was notified of the X-ray results. · On 11/27/15 resident number 1's physician directed that the resident be sent to the emergency room . · On 12/17 the director of nursing received additional training regarding incident and accident notification. · On 12/9/15 the director of nursing initiated an in-service for all LPN's and RN's, including all nurses working from 11/23/15 to 11/27/15, regarding the expectation that the physician is made aware of all incident and accidents. · On 12/17/15, all incident/accident reports from 11/23/15 through 12/17/15 were reviewed to ensure physician notification. The Credible Allegation (CA) was verified on 12/18/15 at 11:45 AM by observation of Resident #1 resting comfortably on 12/18/15 and no reports of pain. Resident #1 verified staff were assessing her pain frequently. The CA was verified on interview in-servicing of nurses regarding the notification of the physician incidents and accidents involving any resident.
F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff, resident, responsible party (RP), physician interviews and record review, the facility transportation aide (TA) #1 returned Resident #1 to her the wheelchair after sustaining a fall on 11/23/15 while on the facility transportation van and neglected to provide notification, assessment or guidance of emergency medical services or a licensed professional for 1 of 1 (Resident #1). The TA #1 transported Resident #1 back to her room and using the mechanical lift and lift sling with the assistance of Nursing Assistant (NA) #5, transferred Resident #1 back into her bed on 11/23/15 without seeking guidance or assessment by a nurse before moving Resident #1. The facility staff nelgected to perform a physical assessment and neglected to seek medical attention for 1 of 1 alert and oriented resident (Resident #1) who sustained a fall resulting in a [MEDICAL CONDITION] hip and fractures of the right tibia and fibula on 11/23/15. Immediate Jeopardy began on 11/23/15 when Resident #1 was not assessed and moved after a fall on the transportation van, not assessed and moved upon return to the facility after sustaining a fall on the transportation van on 11/23/15 and the facility staff failed to seek medical attention for Resident #1 who sustained a fall on the transportation van on 11/23/15 resulting in multiple fractures. The facility provided and implemented a credible allegation on 12/18/15 at 11:45 AM. The immediate jeopardy is lowered to scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure implementation of permanent change in the process of providing education and training regarding neglect and mistreatment of [REDACTED]. Findings included: Resident #1 ' s quarterly Minimum Data Set ((MDS) dated [DATE] indicated she was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. She was coded as requiring total assistance with all transfers and non-ambulatory. Resident #1 was coded as not having received any scheduled or as needed pain medication and was coded as reporting no pain on the MDS assessment. A review of Resident #1 ' s care plan dated as revised 10/21/15 included a pain risk care plan related to a patella fracture in [DATE] with intervention to include administrating pain medication as needed, reassessing the effectiveness of the pain medications and pain assessment for establish the effectiveness of the pain management system. A review of the October Medication Administration Record [REDACTED]. A review of the 24 hour Report form indicated Resident #1 received Tylenol on 11/23/15 at 10:30 PM and again on 11/24/15 at 5:00 AM. A review of the November MAR indicated [REDACTED]. In an interview on 12/8/15 at 12:00 PM, Resident #1 recalled falling from the wheelchair in the van on 11/23/15 while on a transport. An observation of Resident #1 revealed no evidence of surgical intervention to her left hip and an elastic wrap was observed around her right lower extremity. There was observed contractures to both lower extremities. Resident #1 stated she voiced pain after the fall and she was treated with Tylenol. She recalled it helped some but the pain became so bad the Tylenol didn ' t work to control her pain after a few days. Resident #1 stated she did not recall anyone coming to assess her legs after the fall on 11/23/15 and it was not until the Friday after Thanksgiving that she had a x-ray done and then was sent to the hospital on [DATE]. She stated the nurse had recently given her a pain pill that was stronger than Tylenol and it was helping control the pain. She stated she had to ask for the pain medication when she started to hurt. In a telephone interview on 12/8/15 at 2:30 PM, TA #1 recalled taking Resident #1 to [MEDICAL CONDITION] center on 11/23/15. She recalled Resident #1 stated she was sliding from her wheelchair so she pulled over and with the assistance of the RP, they lifted Resident #1 and returned her to the wheelchair. She then proceeded to return to the facility. She stated she did not call the facility or call 911 for assistance because Resident #1 stated she was ok. Once she arrived back at the facility, she notified the director of nursing (DON) who told her to write a statement and informed Resident #1 ' s nurse. In an interview on 12/8/15 at 12:21 PM. the director of nursing (DON) recalled transportation aide (TA) #1 reporting to her that Resident #1 slipped in the van. TA #1 stated Resident #1 ' s RP was present in the van and caught her and she was alright. The DON stated she was unsure if it was an actual fall at that time. She told the TA #1 to write a statement and inform Resident #1 ' s nurse to complete an incident report but the DON neglected to go and assess Resident #1 for any injures or discuss the circumstances of the fall with her or the RP. In an interview on 12/8/15 at 4:35 PM, the RP recalled riding in the front passenger seat to take Resident #1 to [MEDICAL

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) CONDITION] center on 11/23/15. On their return to the facility, he recalled Resident #1 say I ' m fixing to slide out of my wheelchair. Resident #1 had slid from her wheelchair and landed of the foot pedal of the wheelchair. The RP stated Resident #1 seemed scared and she did not complain of pain at that time. The RP recalled that once he and Resident #1 returned to her room, the staff was attempting to get her back into the bed using the mechanical lift and Resident #1 was complaining pain in her legs then. He stated he was not aware that the staff never contacted the physician at any time until he insisted on something be done on 11/27/15. He said he visited Resident #1 on 11/27/15 and when she raised her head to take a drink of water she screamed out in pain. He said he told him then something had better be done. In an interview on 12/8/15 at 1:02 PM, Nurse #1 confirmed she was assigned Resident #1 on 11/23/15 when she returned from her appointment. She recalled TA #1 reporting to her Resident #1 fell in the van. Nurse #1 stated it was around shift change so she was busy. She recalled TA #1 told her Resident #1 slid from her wheelchair but she was fine. Nurse #1 stated she worked a double shift that day so after shift change she went and spoke to Resident #1 who was already back in the bed. Nurse #1 stated she did not assess Resident #1 or attempt any range of motion because Resident #1 did not complain of any pain at that time and her RP was no longer present. Nurse #1 stated if Resident #1 had acted differently or acted like she was in pain, she would have gotten an x-ray that day. In an interview on 12/8/15 at 3:28 PM, NA # 5 confirmed she worked second shift on 11/23/15 with Resident #1 and assisted TA #1 in putting her back into the back after she returned from her appointment the day she fell . NA #5 stated Resident #1 complained of pain in both legs. She recalled reporting the pain to the nurse because she had never complained of pain in her legs before. NA #5 stated Resident #1 refused her activities of daily living (ADL) care until around 10:00 PM. NA #5 stated Resident #1 was almost crying because she was in so much pain and the nurse gave her two Tylenol. NA #5 elaborated to say she had facial grimacing commonly associated with pain and was moaning when lying still in bed. In an interview on 12/8/15 at 2:10 PM, Nurse #2 confirmed she worked with Resident #1 on 11/24/15 first shift. She recalled Resident #1 complaining of pain all over but nothing directly related to her legs. Nurse #2 stated she thought the pain was related to the [MEDICAL CONDITION] and [MEDICAL CONDITION] she started the day before. She stated she was not aware that Resident #1 had a fall in the van. In an interview on 12/9/15 at 12:10 PM, NA #8 confirmed she worked first shift on 11/24/15 and 11/26/15 with Resident #1. She stated Resident #1 complained of pain on one of those days and said she was sore from the fall. NA #8 stated she did not report the voiced soreness to the nurse because she said the nurse already knew. NA #8 stated Resident #1 allowed her to complete her ADLs and she did not notice her legs looking any differently. NA #8 stated she observed no bruising or swelling to either leg. In an interview on 12/8/15 at 3:15 PM, NA #3 confirmed she worked second shift on 11/24/15 with Resident #1. NA #3 stated Resident #1 complained of pain in both legs due a fall on the van. NA #3 stated she reported it to the nurse but she was unsure of she medicated Resident #1. NA #3 stated Resident #1 refused incontinence care later in the her shift and she had never refused incontinence care before. In an interview on 12/8/15 at 3:25 PM, Nurse #3 confirmed she worked second shift on 11/24/15 with Resident #1. She stated Resident #1 did not report any pain to her and the assigned aide did not report any pain to her. She recalled also working second shift on 11/27/15 with Resident #1 and she contacted the physician about Resident #1 ' s leg pain and obtained orders for x-rays. She recalled Resident #1 ' s right foot appeared swollen but stated she did not assess her legs on 11/24/15 since she did not report any pain to her. Nurse #3 stated the x-rays returned positive for fractures to her left hip and right leg and she sent her to the hospital for an evaluation as ordered by the physician. In an interview on 12/8/15 at 3:10 PM, NA #1 confirmed she worked first shift on 11/25/15 with Resident #1. NA #1 stated Resident #1 complained of both legs hurting and could not turn over for incontinence care due to the pain. NA #1 stated she reported the complaints of leg pain to the nurse. She stated she was not aware of Resident #1 was ever medicated but she continued to complain of pain the entire shift. In a telephone interview on 12/9/15 at 11:25 AM, Nurse #5 confirmed she worked first shift on 11/25/15 and 11/26/15 with Resident #1. She stated Resident #1 never complained of pain and never asked for anything for pain. She stated she did not do a physical assessment of Resident #1 because she was not aware of the fall and she did not complain of leg pain. In an interview on 12/8/15 at 3:17 PM, NA #4 confirmed she worked second shift on 11/25/15 with Resident #1. NA #4 recalled Resident #1 complaining of pain in her legs when she and NA #3 were assisting Resident #1 back into the bed using the mechanical lift after she returned from [MEDICAL CONDITION] center. NA #4 stated Resident #1 was complaining of leg pain but she thought the pain was due to her contractures and not related the fall on Monday. NA #4 recalled telling the nurse about Resident #1 ' s pain. In an interview on 12/8/15 at 6:02 PM, Nurse #4 confirmed she worked second shift on 11/25/15. She stated Resident #1 did not complain of any pain and nobody reported any problems to her. Nurse #4 stated she was not aware Resident #1 had a fall on the van until 11/27/15. She stated the only thing Resident #1 ever complained about was an occasional headache. In an interview on 12/8/15 at 3:12 PM, NA #2 confirmed she worked second shift on 11/26/15 with Resident #1. NA #2 stated Resident #1 did complain of pain during her shift but she did not recall if the pain was in her legs. NA #2 stated that when she provided incontinence care on Resident #1 she groaned some and not was not normal for her. NA #2 stated Resident #1 very seldom complained of pain except for a headache on occasion. In an interview on 12/9/15 at 10:18 AM, NA #6 confirmed she worked third shift with Resident #1 on 11/23/15, 11/24/15, 11/25/15 and 11/26/15. She recalled Resident #1 telling her that she was sore from slipping out of the wheelchair and NA #5 reported it to the nurse who worked nights but NA #6 was unsure which night it was that Resident #1 complained. NA #5 stated Resident #1 allowed her to perform ADLs and never directly complained of leg pain. In a telephone interview on 12/9/15 at 11:40 AM, Nurse #6 confirmed she worked night shift 11/23/15, 11/24/15, 11/25/15 and 11/26/15 with Resident #1. Nurse #6 stated she was not aware of a fall on the van but the aide told her that Resident #1 was sore on 11/23/15 but she thought it was due to the [MEDICAL CONDITION]. Nurse #6 stated she failed to assess Resident #1 because she did not complain of pain specifically to her legs. Nurse #6 stated she became aware of the fall on 11/24/15 but again she did not assess Resident #1 because she did not complain of pain to her. In another telephone interview on 12/9/15 at 3:22 PM, NA #7 confirmed she also worked first shift on 11/27/15 with Resident #1. She stated Resident #1 complained of pain all over on Friday and would not let her do any ADLs. She would not let her turn her and she even asked the nurse to help her because Resident #1 was hurting so bad. NA #7 stated before the fall on 11/23/15, Resident #1 could turn onto her left side without any complaints of pain. She stated Resident #1 ' s pain was different but she wasn ' t crying. She did not want anyone to touch her. And that was unusual. In an interview on 12/10/15 at 9:00 AM, the medical records director recalled the RP approaching her Friday 11/27/15 late in the afternoon stated he needed to talk to someone about getting help for Resident #1 ' s pain from the fall on the van. She stated she was not aware of a fall but she reported what the RP told her to talk to the administrator. She told the RP to report the pain to Resident #1 ' s nurse and he stated the nurse was aware of her pain and had not done anything. In a telephone interview on 12/8/15 at 4:02 PM, the physician stated he was not notified of any incident involving a fall on the van with Resident #1 until 11/27/15 when the RP was at the facility stating Resident #1 was in severe pain and something had to be done. He stated he ordered x-rays and that was when he discovered the fractures. The physician stated his expectation was to be notified immediately when an incident like the one involving Resident #1 occurred and Resident #1 should have assessed sooner in the hospital and her pain treated properly. A review of Resident #1 ' s nursing notes indicated a note dated 11/27/15 documenting the events that occurred on 11/23/15. This nursing note indicated the physician was made aware on 11/27/15 of Resident #1 ' s fall that occurred Monday 11/23/15 while she was on the facility transportation van. The physician ordered a series of x-rays. When the physician was notified of the x-ray results, orders were received to send Resident #1 to the hospital for an evaluation on 11/27/15 due multiple lower extremity fractures. A review of the hospital records dated 11/27/15 indicated Resident was being transported in a van 5 days ago in her wheelchair when she slipped from the wheelchair onto her left hip when her right leg under her. She has been complaining of some pain in the area since that time. The pain was reported mostly to her left proximal femur and her right ankle which showed evidence of bruising and swelling. A splint was applied to her right lower extremity for immobilization and the orthopedic consult recommended no surgical intervention due to Resident #1 ' s bed bound status and severe MS with contractures. Pain management was recommended. Resident #1 was discharged back to the facility on [DATE] with orders for [MEDICATION NAME]-[MEDICATION NAME] 5 milligrams (mg)-325 mg (narcotic [MEDICATION NAME]) one tablet every 4hours for a

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) pain score of 4-6. A review of the electronic medical record indicated no pain assessment completed in 2015 until 12/4/15 upon return from the hospital after the fall in the van that resulted in a left [MEDICAL CONDITION] and a right tibia and fibula fracture. The administrator was notified of the immediate jeopardy at F224 on 12/16/15 at 4:41 PM Immediately a plan was put in place to complete a Credible Allegation. A. How the corrective action will be accomplished for those residents found to have been affected by deficient practice? Outcome? · On 11/23/15, resident number 1 ' s family member/responsible party was aware of the incident as he was present on the van when the incident occurred. · On 11/23/15, the transportation aide reported the incident to the director of nursing and the second shift 200 hall nurse upon entering the facility. · On 11/23/15, the director of nursing asked resident number 1 if the resident was okay and if she had any pain. Resident number 1 stated she did not have any pain. · On 11/23/15, according to the second shift 200 hall nurses statement, although there is no documentation, she assessed resident number 1 during medication administration. According to the second shift 200 hall nurse ' s statement, she assessed resident number 1 ' s level of discomfort and pain. The second shift 200 hall nurse stated she determined that resident number 1 was at her baseline. The second shift 200 hall nurse stated she pulled back the covers and assessed the lower extremities for redness, pain, swelling, and bruising. There was no bruising, swelling, redness, or pain. The second shift 200 hall nurse reported she did not assess range of motion due to the resident number 1 ' s discomfort related to [MEDICAL CONDITION] and lower extremity contractures. According to the nurses ' written statement. The resident had no complaint of pain and exhibited normal behavior and activity. · On 11/27/15, the second shift 200 hall nurse assessed resident number 1 during medication administration and completed a head-to-toe skin assessment. On 11/27/15, the second shift 200 hall nurse made the initial notification of the incident to the physician. · On 11/27/15, X-rays were completed by MMDS x-ray provider, in the facility, of the resident ' s left ankle and foot and right hip. On 11/27/15, the results of the x-ray were communicated to the physician, the resident, and resident number 1 ' s family member/responsible party. Resident number 1 was discharged to the local hospital for further evaluation per physician order. · On 11/27/15, the second shift 200 hall nurse initiated an incident/accident report for the 11/23/15 incident/accident. · On 12/3/15, resident number 1 was returned to facility. While at the hospital resident number 1 received no surgical intervention. · On 12/8/15, the MDS nurse reviewed and updated resident number 1 ' s care plan and care guide to reflect fracture related pain. On 12/8/15, the MDS nurse also performed an updated pain assessment. · On 12/9/15, the director of nursing initiated an in-service for all LPN ' s and RN ' s, including all LPN ' s and RN ' s that worked from 11/23/15 to 11/27/15. The in-service covered assessing the resident post incident/accident. Assessment will include pain, swelling, redness, or other changes in condition. The in-service also covered the requirement to document the assessment in the electronic medical record. No nursing staff will be allowed to complete a work shift until this in-service is completed. This in-service will be incorporated into new employee orientation. · On 12/9/15, the director of nursing initiated an in-service for LPN ' s, RN ' s and Medication Aides, including all LPN ' s, RN ' s, and Medication Aides that worked from 11/23/15 to 11/27/15, reinforcing communication during shift reports of incident/accidents, pain, changes in condition, or potential problems. No nursing staff will be allowed to complete a work shift until this in-service is completed. This in-service will be incorporated into new employee orientation. · On 12/9/15, the director of nursing initiated an in-service for all LPN ' s, RN ' s, and Medication Aides, including all LPN ' s, RN ' s, and medication aides that worked from 11/23/15 to 11/27/15, stating that during shift report it is imperative nurses communicate any incident/accident, pain, changes in condition, or potential problems to ensure thorough and appropriate follow up care is provided. It is also a strong recommendation to note any of the above on your 24 hour nurse report. Make sure any of the above is also noted in the electronic medical record. This in-service will be incorporated into new employee orientation. · On 12/2/15 the director of nursing was in-serviced by the administrator that all incidents must be entered into the electronic medical record. · On 12/17/15 the director of nursing was in-serviced by the administrator that the resident ' s physician must be promptly made aware of all incidents and accidents. · On 12/16/15, the director of nursing initiated an in-service on abuse and neglect for 100% of staff including all staff that worked from 11/23/15 to 11/27/15. No nursing staff will be allowed to complete a work shift until this in-service is completed. This in-service will be incorporated into new employee orientation. · On 12/17/15 the director of nursing was in-serviced by the administrator that the resident ' s physician must be promptly made aware of all incidents and accidents. · On 12/17/15, the administrator in-serviced the director of nursing regarding abuse and neglect. B. How did the facility identify other residents having the potential to be affected by the same deficient practice? · On 11/27/15, the administrator conducted interviews with alert and oriented residents that had received van transport regarding seat belt use during transport and overall wellbeing and safety with no negative findings. Residents that were interviewed were transported between the dates of 11/23/15 to 11/27/15. · On 11/27/15, the assistant director of nursing/staff initiated an in-service for all licensed nurses. The in-service covered the requirement for licensed nurses, to include all of the nurses that worked from 11/23/15 through 11/27/15, to initiate an incident accident report in a timely manner in the electronic medical record when a resident is involved in an incident/accident. On 12/9/15, 100% of licensed nurses have completed the in-service. This in-service will be incorporated into new employee orientation. · On 12/8/15 the hall nurses started assessing pain levels on residents every shift and documenting it on the Medication Administration Record, [REDACTED] · On 12/16/15, an in-service was initiated by the director of nursing for all certified nursing assistants, including all nursing assistants that worked from 11/23/15 through 11/27/15, stating it is the responsibility of the CNA to seek immediate guidance for residents presenting a change in condition or resident incident including but not limited to: calling code green (resident fall) if inside facility or on facility grounds, calling 911 if outside facility grounds, and calling the facility directly to obtain professional guidance by a licensed nurse and/or administration if outside of the facility grounds. Any certified nursing assistant will not be able complete their shift without completing the in-service. This in-service will be incorporated into new employee orientation. · On 12/16/15, the director of nursing initiated an in-service on abuse and neglect for 100% of staff including all staff that worked from 11/23/15 to 11/27/15. No nursing staff will be allowed to complete a work shift until this in-service is completed. This in-service will be incorporated into new employee orientation. · On 12/17/15 the director of nursing was in-serviced by the administrator that the resident ' s physician must be promptly made aware of all incidents and accidents. · On 12/17/15, the administrator in-serviced the director of nursing regarding abuse and neglect. C. Give specific dates of the corrective actions. · On 11/23/15, resident number 1 ' s family member/responsible party was aware. · On 11/23/15, resident number 1 was assessed for pain, bruising, swelling, and redness by the second shift 200 hall nurse. · On 11/27/15, resident number 1 was assessed from head to toe by the second shift 200 hall nurse. · On 11/27/15, resident number 1's physician was notified of the incident. · On 11/27/15, resident number 1's physician was notified of the X-ray results. · On 11/27/15, resident number 1's physician directed that the resident be sent to the emergency room . · On 11/27/15, the incident accident report for resident number was initiated for the incident/accident that took place on 11/23/15. · On 11/27/15, the assistant director of nursing initiated an in-service. · On 12/4/15, therapy evaluation was completed on resident number 1, after resident number 1 returned from the hospital on

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) [DATE]. · On 12/8/15, resident number 1 ' s care guide and care plan was updated regarding pain. A new pain assessment was completed. · On 12/8/15 the DON directed each nurse to ask each resident on their assignment about pain/discomfort. · On 12/9/15, the director of nursing initiated an in-service on communication during shift report for all LPN ' s, RN ' s, and medication aides. · On 12/9/15, the director of nursing initiated an in-service on performing physical assessment post incident or accident for LPN ' s and RN ' s. · On 12/16/15, the director of nursing initiated an in-service for all CNA ' s on calling code green (resident fall) or calling 911in the event of an accident or incident. To seek guidance from a licensed professional. Any certified nursing assistant will not be able complete their shift without completing the in-service. This in-service will be incorporated into new employee orientation. · On 12/9/15 the director of nursing initiated an in-service for all LPN's and RN's regarding the expectation that the physician is made aware of all incident and accidents. · On 12/16/15, the director of nursing initiated an in-service for all CNA ' s on calling code green (resident fall) or calling 911in the event of an accident or incident. To seek guidance from a licensed professional. · On 12/17/15 the director of nursing was in-serviced by the administrator that the resident ' s physician must be promptly made aware of all incidents and accidents. · On 12/17/15, the administrator in-serviced the director of nursing regarding abuse. The Credible Allegation (CA) was verified on 12/18/15 at 11:45 AM by observation of Resident #1 resting comfortably on 12/18/15 and no reports of pain. Resident #1 verified staff were assessing her pain frequently. The CA was verified by staff interviews for in-servicing of nurses, aides, the DON on abuse and neglect
F 0281 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to administer a nutritional supplement as ordered by the physician for 1 of 2 residents reviewed for diet orders (Resident #2). Findings included: Review of the clinical record of Resident #2 indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Continued review of the resident ' s clinical record revealed a physician's order [REDACTED]. The order was transcribed on 7/27/15 onto the resident ' s July 2015 Medication Administration Record (MAR). The nutritional supplement was administered as ordered from 7/27/15 through 7/31/15. The supplement order was not transcribed onto the August, September, October, November or December 2015 MARs. Further medical record review revealed no physician's order [REDACTED]. On 12/10/15 at 12:17 p.m., Nurse #7 was interviewed and reported she checked the August 2015 MAR for accuracy by comparing it to the July 2015 MAR. She stated she must not have seen the entry for the nutritional supplement on the July 2015 MAR and therefore it was not carried forth onto the August 2015 MAR or any of the following months ' MARs. A review of a nurse progress note dated 12/9/15 at 1:48 p.m. revealed the Director of Nursing (DON) had contacted physician #2 on 12/9/15 and had received a telephone order to continue the nutritional supplement. On 12/9/15 at 2:20 p.m., in an interview with physician #2, the physician stated it was his expectation that nursing staff followed his orders as prescribed. The physician stated he had reordered the nutritional supplement at this time. On 12/10/15 at 12:17 p.m., in an interview with the DON, the DON stated the expectation of the nursing staff was they immediately implemented any new order.
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff, resident, responsible party (RP), interviews and record review, the facility failed to follow the care plan and remove the lift sling from the wheelchair for 1 of 1 alert and oriented resident (Resident #1) resulting in a fall on the transportation van resulting in a [MEDICAL CONDITION] hip and multiple fractures of the right lower leg. Immediate Jeopardy began on 11/23/15 when the facility failed to follow established care plan interventions resulting in a fall while on the facility transportation van with resulting multiple fractures and was removed at 11:45 AM on 12/18/15 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the implementation of their corrective action in the process of following care plan interventions. Findings included: Resident #1 ' s quarterly Minimum Data Set ((MDS) dated [DATE] indicated she was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. She was coded as cognitively intact and exhibited no behavioral problems and coded as requiring total assistance with all transfers, and non-ambulatory. A review of Resident #1 ' s care plan revised on 10/21/15 included a fall risk care plan with an intervention to remove the lift sling after placing Resident #1 in her wheelchair with the initiation date for this intervention as 10/8/15. In an interview on 12/8/15 at 12:00 PM, Resident #1 recalled falling from the wheelchair in the van on 11/23/15 while on a transport. Resident #1 stated the aide who got her up for the appointment did not remove the lift sling from her wheelchair once she was placed in the wheelchair. An observation of Resident #1 revealed an elastic wrap around her right lower extremity A review of the incident report dated 11/27/15 revealed the following: According to transportation aide (TA) #1 on 11/23/15, Resident #1 had an appointment at [MEDICAL CONDITION] center with her Responsible Party (RP) present at the time. Upon leaving her appointment, Resident #1 was placed in the transport van and secured. While riding back to facility, Resident #1 stated I ' m sliding out of my chair. Before TA # 1 could stop the van, Resident #1 slid out of her chair onto the pedals of her wheelchair. TA #1 pulled over and with the assistance of Resident #1 ' s RP, they were able to get Resident #1 back into her wheelchair. TA #1 stated she asked Resident #1 if she was ok, the resident stated yes . TA #1 proceeded to drive back to the facility where she reported the incident to Resident #1 ' s assigned nurse and the Director of Nursing (DON). She stated the DON asked her to write a statement which she did and gave it to the DON. A review of Resident #1 ' s nursing notes indicated a note dated 11/27/15 documenting the events that occurred on 11/23/15. This nursing note indicated the physician was made aware on 11/27/15 of Resident #1 ' s fall that occurred Monday 11/23/15 while she was on the facility transportation van. The physician ordered a series of x-rays. When the physician was notified of the x-ray results, orders were received to send Resident #1 to the hospital for an evaluation on 11/27/15 due multiple lower extremity fractures. In a telephone interview on 12/9/15 at 11:10 AM, NA #7 confirmed she worked first shift on 11/23/15 with Resident #1 and got her up out of bed and placed her in her wheelchair the morning of 11/23/15. She stated she was unable to recall if she removed the lift sling out from under Resident #1 after she got her up to the wheelchair to go out to her appointment. She recalled the RP assisted her with getting Resident #1 up out of the bed that day. NA #7 stated she was aware that the lift sling was not to be left under Resident #1 because she had trouble sitting up in the wheelchair due to her leg contractures and she had fallen in the past. In a telephone interview on 12/8/15 at 2:30 PM, TA #1 recalled taking Resident #1 to [MEDICAL CONDITION] center on 11/23/15. On the way back to the facility she heard Resident #1 saying she was sliding, TA #1 stated she pulled over and with the assistance of the RP, they lifted Resident #1 off the wheelchair foot pedals using the lift sling and returned her to the wheelchair. She then proceeded to return to the facility. She stated she did not call the facility or call 911 for assistance because Resident #1 stated she was ok. Once she arrived back at the facility, she notified the DON who told her to write a statement and inform Resident #1 ' s nurse of the incident. TA #1 stated Resident #1 was already up in her wheelchair when she went to get her to put her on the van. She did not notice the lift sling was still under Resident #1

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 5) until she used it to pull her back up into the wheelchair when she slid onto the foot pedals. In an interview on 12/8/15 at 4:35 PM, the RP recalled riding in the transportation van in the front passenger seat to take Resident #1 to [MEDICAL CONDITION] center on 11/23/15. The RP recalled hearing Resident #1 say I ' m fixing to slide out of my wheelchair. He stated TA #1 pulled over and he got behind Resident #1 while TA #1 remained in the front of the van. He stated the lift sling was under Resident #1 and he thought it was not to be under her because it caused her to slide from her wheelchair in the recent past. The RP stated he and TA #1 used the lift sling straps to lift Resident #1 off the wheelchair foot pedals and move her back into the wheelchair. He stated TA #1 told him she would complete a report about what happened. The RP recalled that once he and Resident #1 returned to her room, the staff was attempting to get her back into the bed using the mechanical lift and Resident #1 was complaining of pain in her legs then. In an interview on 12/8/15 at 12:21 PM. the DON recalled TA #1 reported to her that Resident #1 slipped in the van. TA #1 stated Resident #1 ' s RP was present in the van and caught her and she was alright. The DON stated she was unsure if it was an actual fall at that time. She told TA #1 to write a statement and inform Resident #1 ' s nurse to complete an incident report but the DON did not discuss the circumstances of the fall with TA #1 or the RP. In an interview on 12/8/15 at 2:20 PM, the Administrator stated he did not become aware of the incident until 11/27/15 when he immediately stopped all transports. He stated he started an investigation when he became aware and so far, he felt TA #1 did not have the shoulder belt in use. The administrator stated he was not aware that the lift sling was not removed from the wheelchair after the resident was placed in the wheelchair. The Administrator was not aware that Resident #1 ' s care plan included an interventions to remove the lift sling after placing the resident in a wheelchair. In an interview on 12/8/15 at 3:28 PM, Nursing Assistant (NA) # 5 confirmed she worked second shift on 11/23/15 with Resident #1. NA #5 stated she put Resident #1 in the bed after she returned from the appointment the day she fell . She stated the lift sling was under Resident #1 when she returned and she was not supposed to have it under her when she was up in her wheelchair because she has been known to slide out of her wheelchair off the sling In an interview on 12/9/15 at 8:45 AM, TA #2 stated she was trained by the Quality Assurance (QA) nurse and the previous transporter. TA #2 stated she served as the backup transporter for over one year. TA #2 confirmed that the lift sling was to be removed from underneath Resident #1 whenever she was up in her wheelchair. TA #2 stated Resident #1 had trouble sitting up in her wheelchair due to contractures in both legs and the lift sling was slippery and had resulted in her falling in the past. In an interview on 12/9/15 at 10:40 AM, the MDS nurse stated she completed the quarterly MDS on Resident #1 and updated her care plan on 10/21/15. She explained the QA nurse added the intervention to remove the lift sling from underneath Resident #1 since it was determined to be the cause of a fall dated 10/8/15. She stated whenever the care plan was updated with a new intervention, it should be added to the resident care guide located in Resident #1 ' s closet. A review at this time of Resident #1 ' s care guide dated as printed 12/8/15 did not include the intervention to remove the lift sling from underneath Resident #1. The MDS nurse stated it should have been added and it was an oversight. In an interview on 12/9/15 at 10:45 AM, the QA nurse confirmed he added the care plan intervention to remove the lift sling from under Resident #1 after she fell from her wheelchair on 10/8/15. The QA nurse stated he neglected to add it to Resident #1 ' s care guide at the time of the fall. The Administrator was notified on 12/8/15 at 6:18 PM of the immediate jeopardy related to Resident #1 ' s fall during van transport from an appointment to the facility on [DATE]. The Administrator provided the following credible allegation of compliance on 12/9/15 at 5:00 PM: Immediately a plan was put in place to complete a Credible Allegation. A. How the corrective action will be accomplished for those residents found to have been affected by deficient practice? Outcome? · On 12/8/15, the MDS nurse reviewed and updated the resident ' s care plan and care guide, in response to the incident report, to reflect fracture related pain. · On 12/9/15, the MDS nurse updated resident 1 ' s care plan/care guide to include resident 1 will not be transported with lift pad under her in the facility van. · On 12/9/15, the director of nursing initiated an in-service for all nursing staff, RN ' s, LPN ' s, CNA ' s, medication aides, restorative aides, and transportation aides, including staff involved with care from 11/23/15 through 11/27/15. The following was covered; All nursing staff must follow the resident care guide, posted in the resident ' s closet. Please especially pay attention to the handling and movement directions on the care guide. For example, the care guide may instruct you to remove the resident ' s lift pad after transferring the resident from the bed to the chair as well as it may include the removal of the lift pad when being transferred in the company van. If you have any comments or questions please see the director of nursing. All nursing staff, RN ' s, LPN ' s, CNA ' s, medication aides, restorative aides, and transportation aides will complete this in-service prior to completing their shift. This in-service will be incorporated into new employee orientation. · On 12/17/15, the administrator in-serviced the MDS coordinator, director of nursing, and assistant director of nursing to review incident accident interventions and ensure interventions are appropriately reflected on the resident care plan including the resident care guide. B. How did the facility identify other residents having the potential to be affected by the same deficient practice? · On 12/9/15, the MDS coordinator reviewed all residents using sling lift pads for safety while in wheelchair. The MDS coordinator assessed the residents that utilize the sling lift and updated the residents ' care plans and care guides to reflect if the sling lift pad needs to be removed for safe transport in the facility van. · On 12/9/15, an in-service was initiated by the director of nursing, for 100% of nursing staff, including the nurses that worked from 11/23/15 through 11/27/15, relating to following the care guide for lift pad removal for when the resident is in the wheelchair or when the resident is being transported in the facility van. In-services for department heads was initiated on 12/17/15. Nursing staff and department heads will be required to complete this in-service prior to completing their shift. This in-service will be incorporated into new employee orientation. C. Give specific dates of the corrective actions. · On 12/9/15, resident number 1 ' s care guide/care plan updated. · On 12/9/15, the director of nursing initiated an in-service for nursing staff on following the care guide and care plan. · On 12/9/15, the MDS coordinator reviewed all residents using sling lift pads. · On 12/9/15, the director of nursing initiated an in-service for all nursing staff regarding following the care guide for if the lift pad should be removed. · On 12/17/15, the administrator in-service the MDS coordinator, DON, and ADON to review incidents and accidents for appropriate interventions. The Credible Allegation (CA) was verified 12/18/15 at 11:45 AM by observations and interviews of other alert and oriented Residents care planned to have the lift sling removed from underneath them while up in their wheelchairs. Resident #1 was not observed up out of her bed in her wheelchair but she verified she was not to have the lift sling under her when she was up sitting in her wheelchair. The MDS nurse verified she updated all the care plans and care guide for residents identified a fall risk to remove the lift sling from the wheelchair when in use. The CA was also verified for in-servicing of nurses and nursing assistants staff through interviews to remove the lift sling from resident identified a fall risk and to review the resident care guide prior to rendering care.
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff, resident, responsible party (RP), physician interviews and record review, the facility transportation aide (TA) #1 returned Resident #1 to her the wheelchair after sustaining a fall on 11/23/15 while on the facility transportation van without notification, assessment or guidance of emergency medical services or a licensed professional for 1 of 1 (Resident #1). The TA #1 transported Resident #1 back to her room and using the mechanical lift and lift sling with the assistance of Nursing Assistant (NA) #5, transferred Resident #1 back into her bed on 11/23/15 without seeking guidance or assessment by a nurse before moving Resident #1. The facility staff failed to perform a physical assessment and seek medical attention for 1 of 1 alert and oriented resident

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) (Resident #1) who sustained a fall resulting in a [MEDICAL CONDITION] hip and fractures of the right tibia and fibula on 11/23/15. Immediate Jeopardy began on 11/23/15 when Resident #1 was not assessed and moved after a fall on the transportation van, not assessed and moved upon return to the facility after sustaining a fall on the transportation van on 11/23/15 and the facility staff failed to seek medical attention for Resident #1 who sustained a fall on the transportation van on 11/23/15 resulting in multiple fractures. The facility provided and implemented a credible allegation on 12/18/15 at 11:45 AM. The immediate jeopardy is lowered to scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure implementation of permanent change in the process of assessment and treatment of [REDACTED]. Findings included: Resident #1 ' s quarterly Minimum Data Set ((MDS) dated [DATE] indicated she was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. She was coded as requiring total assistance with all transfers and non-ambulatory. Resident #1 was coded as not having received any scheduled or as needed pain medication and was coded as reporting no pain on the MDS assessment. A review of Resident #1 ' s care plan dated as revised 10/21/15 included a pain risk care plan related to a patella fracture in [DATE] with intervention to include administrating pain medication as needed, reassessing the effectiveness of the pain medications and pain assessment for establish the effectiveness of the pain management system. A review of the October Medication Administration Record [REDACTED]. A review of the 24 hour Report form indicated Resident #1 received Tylenol on 11/23/15 at 10:30 PM and again on 11/24/15 at 5:00 AM. A review of the November MAR indicated [REDACTED]. In an interview on 12/8/15 at 12:00 PM, Resident #1 recalled falling from the wheelchair in the van on 11/23/15 while on a transport. An observation of Resident #1 revealed no evidence of surgical intervention to her left hip and an elastic wrap was observed around her right lower extremity. There was observed contractures to both lower extremities. Resident #1 stated she voiced pain after the fall and she was treated with Tylenol. She recalled it helped some but the pain became so bad the Tylenol didn ' t work to control her pain after a few days. Resident #1 stated she did not recall anyone coming to assess her legs after the fall on 11/23/15 and it was not until the Friday after Thanksgiving that she had a x-ray done and then was sent to the hospital on [DATE]. She stated the nurse had recently given her a pain pill that was stronger than Tylenol and it was helping control the pain. She stated she had to ask for the pain medication when she started to hurt. In a telephone interview on 12/8/15 at 2:30 PM, TA #1 recalled taking Resident #1 to [MEDICAL CONDITION] center on 11/23/15. She recalled Resident #1 stated she was sliding from her wheelchair so she pulled over and with the assistance of the RP, they lifted Resident #1 and returned her to the wheelchair. She then proceeded to return to the facility. She stated she did not call the facility or call 911 for assistance because Resident #1 stated she was ok. Once she arrived back at the facility, she notified the director of nursing (DON) who told her to write a statement and informed Resident #1 ' s nurse. In an interview on 12/8/15 at 12:21 PM. the DON recalled transportation aide (TA) #1 reporting to her that Resident #1 slipped in the van. TA #1 stated Resident #1 ' s RP was present in the van and caught her and she was alright. The DON stated she was unsure if it was an actual fall at that time. She told the TA #1 to write a statement and inform Resident #1 ' s nurse to complete an incident report but the DON did not go and assess Resident #1 for any injures or discuss the circumstances of the fall with her or the RP. In an interview on 12/8/15 at 4:35 PM, the RP recalled riding in the front passenger seat to take Resident #1 to [MEDICAL CONDITION] center on 11/23/15. On their return to the facility, he recalled Resident #1 say I ' m fixing to slide out of my wheelchair. Resident #1 had slid from her wheelchair and landed of the foot pedal of the wheelchair. The RP stated Resident #1 seemed scared and she did not complain of pain at that time. The RP recalled that once he and Resident #1 returned to her room, the staff was attempting to get her back into the bed using the mechanical lift and Resident #1 was complaining pain in her legs then. He stated he was not aware that the staff never contacted the physician at any time until he insisted on something be done on 11/27/15. He said he visited Resident #1 on 11/27/15 and when she raised her head to take a drink of water she screamed out in pain. He said he told him then something had better be done. In an interview on 12/8/15 at 1:02 PM, Nurse #1 confirmed she was assigned Resident #1 on 11/23/15 when she returned from her appointment. She recalled TA #1 reporting to her Resident #1 fell in the van. Nurse #1 stated it was around shift change so she was busy. She recalled TA #1 told her Resident #1 slid from her wheelchair but she was fine. Nurse #1 stated she worked a double shift that day so after shift change she went and spoke to Resident #1 who was already back in the bed. Nurse #1 stated she did not assess Resident #1 or attempt any range of motion because Resident #1 did not complain of any pain at that time and her RP was no longer present. Nurse #1 stated if Resident #1 had acted differently or acted like she was in pain, she would have gotten an x-ray that day. In an interview on 12/8/15 at 3:28 PM, NA # 5 confirmed she worked second shift on 11/23/15 with Resident #1 and assisted TA #1 in putting her back into the back after she returned from her appointment the day she fell . NA #5 stated Resident #1 complained of pain in both legs. She recalled reporting the pain to the nurse because she had never complained of pain in her legs before. NA #5 stated Resident #1 refused her activities of daily living (ADL) care until around 10:00 PM. NA #5 stated Resident #1 was almost crying because she was in so much pain and the nurse gave her two Tylenol. NA #5 elaborated to say she had facial grimacing commonly associated with pain and was moaning when lying still in bed. In an interview on 12/8/15 at 2:10 PM, Nurse #2 confirmed she worked with Resident #1 on 11/24/15 first shift. She recalled Resident #1 complaining of pain all over but nothing directly related to her legs. Nurse #2 stated she thought the pain was related to the [MEDICAL CONDITION] and [MEDICAL CONDITION] she started the day before. She stated she was not aware that Resident #1 had a fall in the van. In an interview on 12/9/15 at 12:10 PM, NA #8 confirmed she worked first shift on 11/24/15 and 11/26/15 with Resident #1. She stated Resident #1 complained of pain on one of those days and said she was sore from the fall. NA #8 stated she did not report the voiced soreness to the nurse because she said the nurse already knew. NA #8 stated Resident #1 allowed her to complete her ADLs and she did not notice her legs looking any differently. NA #8 stated she observed no bruising or swelling to either leg. In an interview on 12/8/15 at 3:15 PM, NA #3 confirmed she worked second shift on 11/24/15 with Resident #1. NA #3 stated Resident #1 complained of pain in both legs due a fall on the van. NA #3 stated she reported it to the nurse but she was unsure of she medicated Resident #1. NA #3 stated Resident #1 refused incontinence care later in the her shift and she had never refused incontinence care before. In an interview on 12/8/15 at 3:25 PM, Nurse #3 confirmed she worked second shift on 11/24/15 with Resident #1. She stated Resident #1 did not report any pain to her and the assigned aide did not report any pain to her. She recalled also working second shift on 11/27/15 with Resident #1 and she contacted the physician about Resident #1 ' s leg pain and obtained orders for x-rays. She recalled Resident #1 ' s right foot appeared swollen but stated she did not assess her legs on 11/24/15 since she did not report any pain to her. Nurse #3 stated the x-rays returned positive for fractures to her left hip and right leg and she sent her to the hospital for an evaluation as ordered by the physician. In an interview on 12/8/15 at 3:10 PM, NA #1 confirmed she worked first shift on 11/25/15 with Resident #1. NA #1 stated Resident #1 complained of both legs hurting and could not turn over for incontinence care due to the pain. NA #1 stated she reported the complaints of leg pain to the nurse. She stated she was not aware of Resident #1 was ever medicated but she continued to complain of pain the entire shift. In a telephone interview on 12/9/15 at 11:25 AM, Nurse #5 confirmed she worked first shift on 11/25/15 and 11/26/15 with Resident #1. She stated Resident #1 never complained of pain and never asked for anything for pain. She stated she did not do a physical assessment of Resident #1 because she was not aware of the fall and she did not complain of leg pain. In an interview on 12/8/15 at 3:17 PM, NA #4 confirmed she worked second shift on 11/25/15 with Resident #1. NA #4 recalled Resident #1 complaining of pain in her legs when she and NA #3 were assisting Resident #1 back into the bed using the mechanical lift after she returned from [MEDICAL CONDITION] center. NA #4 stated Resident #1 was complaining of leg pain but she thought the pain was due to her contractures and not related the fall on Monday. NA #4 recalled telling the nurse about Resident #1 ' s pain. In an interview on 12/8/15 at 6:02 PM, Nurse #4 confirmed she worked second shift on 11/25/15. She stated Resident #1 did not complain of any pain and nobody reported any problems to her. Nurse #4 stated she was not aware Resident #1 had a fall on the van until 11/27/15. She stated the only thing Resident #1 ever complained about was an occasional headache.

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	345293	A. BUILDING _____ B. WING _____	12/18/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) In an interview on 12/8/15 at 3:12 PM, NA #2 confirmed she worked second shift on 11/26/15 with Resident #1. NA #2 stated Resident #1 did complain of pain during her shift but she did not recall if the pain was in her legs. NA #2 stated that when she provided incontinence care on Resident #1 she groaned some and not was not normal for her. NA #2 stated Resident #1 very seldom complained of pain except for a headache on occasion. In an interview on 12/9/15 at 10:18 AM, NA #6 confirmed she worked third shift with Resident #1 on 11/23/15, 11/24/15, 11/25/15 and 11/26/15. She recalled Resident #1 telling her that she was sore from slipping out of the wheelchair and NA #5 reported it to the nurse who worked nights but NA #6 was unsure which night it was that Resident #1 complained. NA #5 stated Resident #1 allowed her to perform ADLs and never directly complained of leg pain. In a telephone interview on 12/9/15 at 11:40 AM, Nurse #6 confirmed she worked night shift 11/23/15, 11/24/15, 11/25/15 and 11/26/15 with Resident #1. Nurse #6 stated she was not aware of a fall on the van but the aide told her that Resident #1 was sore on 11/23/15 but she thought it was due to the [MEDICAL CONDITION]. Nurse #6 stated she did not assess Resident #1 because she did not complain of pain specifically to her legs. Nurse #6 stated she became aware of the fall on 11/24/15 but again she did not assess Resident #1 because she did not complain of pain to her. In another telephone interview on 12/9/15 at 3:22 PM, NA #7 confirmed she also worked first shift on 11/27/15 with Resident #1. She stated Resident #1 complained of pain all over on Friday and would not let her do any ADLs. She would not let her turn her and she even asked the nurse to help her because Resident #1 was hurting so bad. NA #7 stated before the fall on 11/23/15, Resident #1 could turn onto her left side without any complaints of pain. She stated Resident #1 ' s pain was different but she wasn ' t crying. She did not want anyone to touch her. And that was unusual. In an interview on 12/10/15 at 9:00 AM, the medical records director recalled the RP approaching her Friday 11/27/15 late in the afternoon stated he needed to talk to someone about getting help for Resident #1 ' s pain from the fall on the van. She stated she was not aware of a fall but she reported what the RP told her to the administrator. She told the RP to report the pain to Resident #1 ' s nurse and he stated the nurse was aware of her pain and had not done anything. In a telephone interview on 12/8/15 at 4:02 PM, the physician stated he was not notified of any incident involving a fall on the van with Resident #1 until 11/27/15 when the RP was at the facility stating Resident #1 was in severe pain and something had to be done. He stated he ordered x-rays and that was when he discovered the fractures. The physician stated his expectation was to be notified immediately when an incident like the one involving Resident #1 occurred and Resident #1 should have assessed sooner in the hospital and her pain treated properly. A review of Resident #1 ' s nursing notes indicated a note dated 11/27/15 documenting the events that occurred on 11/23/15. This nursing note indicated the physician was made aware on 11/27/15 of Resident #1 ' s fall that occurred Monday 11/23/15 while she was on the facility transportation van. The physician ordered a series of x-rays. When the physician was notified of the x-ray results, orders were received to send Resident #1 to the hospital for an evaluation on 11/27/15 due multiple lower extremity fractures. A review of the hospital records dated 11/27/15 indicated Resident was being transported in a van 5 days ago in her wheelchair when she slipped from the wheelchair onto her left hip when her right leg under her. She has been complaining of some pain in the area since that time. The pain was reported mostly to her left proximal femur and her right ankle which showed evidence of bruising and swelling. A splint was applied to her right lower extremity for immobilization and the orthopedic consult recommended no surgical intervention due to Resident #1 ' s bed bound status and severe MS with contractures. Pain management was recommended. Resident #1 was discharged back to the facility on [DATE] with orders for [MEDICATION NAME]-[MEDICATION NAME] 5 milligrams (mg)-325 mg (narcotic [MEDICATION NAME]) one tablet every 4 hours for a pain score of 4-6. A review of the electronic medical record indicated no pain assessment completed in 2015 until 12/4/15 upon return from the hospital after the fall in the van that resulted in a left [MEDICAL CONDITION] and a right tibia and fibula fracture. Richmond Pines was placed into Immediate Jeopardy at 6:18 PM, on December 8, 2015, related to an incident that took place on a facility van on November 23, 2015. Immediately a plan was put in place to complete a Credible Allegation. A. How the corrective action will be accomplished for those residents found to have been affected by deficient practice? Outcome? · On 11/23/15, resident number 1 ' s family member/responsible party was aware of the incident as he was present on the van when the incident occurred. · On 11/23/15, the transportation aide reported the incident to the director of nursing and the second shift 200 hall nurse upon entering the facility. · On 11/23/15, the director of nursing asked resident number 1 if the resident was okay and if she had any pain. Resident number 1 stated she did not have any pain. · On 11/23/15, according to the second shift 200 hall nurses statement, although there is no documentation, she assessed resident number 1 during medication administration. According to the second shift 200 hall nurse ' s statement, she assessed resident number 1 ' s level of discomfort and pain. The second shift 200 hall nurse stated she determined that resident number 1 was at her baseline. The second shift 200 hall nurse stated she pulled back the covers and assessed the lower extremities for redness, pain, swelling, and bruising. There was no bruising, swelling, redness, or pain. The second shift 200 hall nurse reported she did not assess range of motion due to the resident number 1 ' s discomfort related to [MEDICAL CONDITION] and lower extremity contractures. According to the nurses ' written statement. The resident had no complaint of pain and exhibited normal behavior and activity. · On 11/27/15, the second shift 200 hall nurse assessed resident number 1 during medication administration and completed a head-to-toe skin assessment. On 11/27/15, the second shift 200 hall nurse made the initial notification of the incident to the physician. · On 11/27/15, X-rays were completed by MMDS x-ray provider, in the facility, of the resident ' s left ankle and foot and right hip. On 11/27/15, the results of the x-ray were communicated to the physician, the resident, and resident number 1 ' s family member/responsible party. Resident number 1 was discharged to the local hospital for further evaluation per physician order. · On 11/27/15, the second shift 200 hall nurse initiated an incident/accident report for the 11/23/15 incident/accident. · On 12/3/15, resident number 1 was returned to facility. While at the hospital resident number 1 received no surgical intervention. · On 12/8/15, the MDS nurse reviewed and updated resident number 1 ' s care plan and care guide to reflect fracture related pain. On 12/8/15, the MDS nurse also performed an updated pain assessment. · On 12/9/15, the director of nursing initiated an in-service for all LPN ' s and RN ' s, including all LPN ' s and RN ' s that worked from 11/23/15 to 11/27/15. The in-service covered assessing the resident post incident/accident. Assessment will include pain, swelling, redness, or other changes in condition. The in-service also covered the requirement to document the assessment in the electronic medical record. No nursing staff will be allowed to complete a work shift until this in-service is completed. This in-service will be incorporated into new employee orientation. · On 12/9/15, the director of nursing initiated an in-service for LPN ' s, RN ' s and Medication Aides, including all LPN ' s, RN ' s, and Medication Aides that worked from 11/23/15 to 11/27/15, reinforcing communication during shift reports of incident/accidents, pain, changes in condition, or potential problems. No nursing staff will be allowed to complete a work shift until this in-service is completed. This in-service will be incorporated into new employee orientation. · On 12/9/15, the director of nursing initiated an in-service for all LPN ' s, RN ' s, and Medication Aides, including all LPN ' s, RN ' s, and medication aides that worked from 11/23/15 to 11/27/15, stating that during shift report it is imperative nurses communicate any incident/accident, pain, changes in condition, or potential problems to ensure thorough and appropriate follow up care is provided. It is also a strong recommendation to note any of the above on your 24 hour nurse report. Make sure any of the above is also noted in the electronic medical record. This in-service will be incorporated into new employee orientation. · On 12/2/15 the director of nursing was in-serviced by the administrator that all incidents must be entered into the electronic medical record. · On 12/17/15 the director of nursing was in-serviced by the administrator that the resident ' s physician must be promptly made aware of all incidents and accidents. B. How did the facility identify other residents having the potential to be affected by the same deficient practice?

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) · On 11/27/15, the administrator conducted interviews with alert and oriented residents that had received van transport regarding seat belt use during transport and overall wellbeing and safety with no negative findings. Residents that were interviewed were transported between the dates of 11/23/15 to 11/27/15. · On 11/27/15, the assistant director of nursing/staff initiated an in-service for all licensed nurses. The in-service covered the requirement for licensed nurses, to include all of the nurses that worked from 11/23/15 through 11/27/15, to initiate an incident accident report in a timely manner in the electronic medical record when a resident is involved in an incident/accident. On 12/9/15, 100% of licensed nurses have completed the in-service. This in-service will be incorporated into new employee orientation. · On 12/8/15 the hall nurses started assessing pain levels on residents every shift and documenting it on the Medication Administration Record, [REDACTED] · On 12/16/15, an in-service was initiated by the director of nursing for all certified nursing assistants, including all nursing assistants that worked from 11/23/15 through 11/27/15, stating it is the responsibility of the CNA to seek immediate guidance for residents presenting a change in condition or resident incident including but not limited to: calling code green (resident fall) if inside facility or on facility grounds, calling 911 if outside facility grounds, and calling the facility directly to obtain professional guidance by a licensed nurse and/or administration if outside of the facility grounds. Any certified nursing assistant will not be able complete their shift without completing the in-service. This in-service will be incorporated into new employee orientation. C. Give specific dates of the corrective actions. · On 11/23/15, resident number 1 ' s family member/responsible party was aware. · On 11/23/15, resident number 1 was assessed for pain, bruising, swelling, and redness by the second shift 200 hall nurse. · On 11/27/15, resident number 1 was assessed from head to toe by the second shift 200 hall nurse. · On 11/27/15, resident number 1's physician was notified of the incident. · On 11/27/15, resident number 1's physician was notified of the X-ray results. · On 11/27/15, resident number 1's physician directed that the resident be sent to the emergency room . · On 11/27/15, the incident accident report for resident number was initiated for the incident/accident that took place on 11/23/15. · On 11/27/15, the assistant director of nursing initiated an in-service. · On 12/4/15, therapy evaluation was completed on resident number 1, after resident number 1 returned from the hospital on [DATE]. · On 12/8/15, resident number 1 ' s care guide and care plan was updated regarding pain. A new pain assessment was completed. · On 12/8/15 the DON directed each nurse to ask each resident on their assignment about pain/discomfort. · On 12/9/15, the director of nursing initiated an in-service on communication during shift report for all LPN ' s, RN ' s, and medication aides. · On 12/9/15, the director of nursing initiated an in-service on performing physical assessment post incident or accident for LPN ' s and RN ' s. · On 12/16/15, the director of nursing initiated an in-service for all CNA ' s on calling code green (resident fall) or calling 911in the event of an accident or incident. To seek guidance from a licensed professional. Any certified nursing assistant will not be able complete their shift without completing the in-service. This in-service will be incorporated into new employee orientation. · On 12/9/15 the director of nursing initiated an in-service for all LPN's and RN's regarding the expectation that the physician is made aware of all incident and accidents. The Credible Allegation (CA) was verified on 12/18/15 at 11:45 AM by observation of Resident #1 resting comfortably on 12/18/15 and no reports of pain. Resident #1 verified staff were assessing her pain frequently. The CA was verified for in-servicing of staff regarding the assessment of pain every shift, assessment for a resident after a reported fall and reporting any voiced pain to the physician.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff, resident, responsible party (RP), physician interviews and record review, the facility failed to follow manufacturer instructions for the facility van securement system by not securing the over the retractable shoulder belt and remove the lift sling from the wheelchair for 1 of 1 alert and oriented resident (Resident #1) resulting in a fall on the transportation van, a fracture of the left hip and fractures of the right tibia and fibula. Immediate Jeopardy began on 11/23/15 at the time of the fall when Resident #1 was not properly secured in the facility ' s transportation van. The facility provided a Creditable Allegation on 12/10/15 at 12:45 PM. The immediate jeopardy is lowered to scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure implementation of permanent change in the process of ensuring the safety of residents while on transports. Findings included: A review of the manufacturer instructions regarding the use of the retractable shoulder belt for facility ' s transport van (name of company and identifier of product series) read in part, Bring the triangular fitting of the shoulder belt over the shoulder across the chest of the occupant and connect it to the pin of the lap belt latch plate. Pull on the shoulder belt to ensure that it is properly attached. The retractor will automatically adjust the tension. The document included the following caution: Always ensure that the shoulder belt is properly extended over the shoulder and across the chest area of the occupant when connecting it to the lap belt. In an observation on 12/8/15 at 12:05 PM of the internal safety mechanisms inside the facility ' s transport van, it was noted to be equipped with a 4 point tie down mechanism, lap belt and a retractable shoulder strap. Resident #1 ' s quarterly Minimum Data Set ((MDS) dated [DATE] indicated she was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. She required total assistance with all transfers and non-ambulatory according to the assessment. A review of Resident #1 ' s care plan revised on 10/21/15 included a fall risk care plan with intervention to remove the lift sling after the Resident #1 was placed in her wheelchair with the initiation date for this intervention as 10/8/15. In an interview on 12/8/15 at 12:00 PM, Resident #1 recalled falling from her wheelchair in the facility van on 11/23/15 while on a transport. She recalled that the transportation aide (TA) #1 did not secure the van ' s shoulder belt to her prior to transporting her in the van and she slid out of the wheelchair falling onto the leg rest of the wheelchair. Resident #1 stated the aide who got her up for the appointment did not remove the lift sling from her wheelchair once she was placed in the wheelchair. Resident #1 stated she rode in the van with TA #1 in the recent past and she never recalled TA #1 securing the van ' s shoulder belt to her. She stated she was uncomfortable with riding on the van since the incident but rode with TA #1 again on 11/24/15 and 11/25/15 to go to her chemotherapy and radiation treatments. An observation of Resident #1 revealed an elastic wrap around her right lower extremity. Resident #1 stated she voiced pain after the fall and she was treated with Tylenol. She recalled it helped some but the pain became so bad the Tylenol didn ' t work to control her pain after a few days. Resident #1 stated she did not recall anyone coming to assess her legs after the fall on 11/23/15 and it was not until the Friday after Thanksgiving that she had an x-ray done and then was sent to the hospital on [DATE]. In a telephone interview on 12/9/15 at 11:10 AM, Nursing Assistant (NA) #7 confirmed she worked first shift on 11/23/15 with Resident #1. She stated she was unable to recall if she removed the lift sling out from under Resident #1 after she got her up to the wheelchair to go out to her appointment. She recalled the RP assisted her with getting Resident #1 out of the bed that day. NA #7 stated she was aware that the lift sling was not to be left under Resident #1 because she had trouble sitting up in the wheelchair due to her leg contractures and she had fallen in the past. A review of the incident report dated 11/27/15 read as follows: According to TA #1 on 11/23/15, Resident #1 had an appointment at the cancer center with her RP present at the time. Upon leaving her appointment, Resident #1 was placed in the transport van and secured. When asked was she ok, Resident #1 stated yes . While driving back to facility, Resident #1

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) stated I ' m sliding out of my chair. Before TA # 1 could stop, Resident #1 slid out of her chair onto the pedals of her wheelchair. TA #1 pulled over and with the assistance of Resident #1 ' s RP, they were able to get Resident #1 back into her wheelchair. TA #1 stated she asked Resident #1 if she was ok, she stated yes . TA #1 proceeded to drive back to the facility where she reported the incident to Resident #1 ' s assigned nurse and the director of nursing (DON). In a telephone interview on 12/8/15 at 2:30 PM, TA #1 recalled transporting Resident #1 to the cancer center in the facility ' s van on 11/23/15. She stated the resident ' s RP rode in the van ' s front passenger seat while Resident #1 rode in the back of the van in her wheelchair. TA #1 recalled using the motorized ramp to raise Resident #1 in her wheelchair up to be rolled into the back of the van where TA #1 strapped the wheelchair into place using the 4 point tie downs. She then recalled securing the lap belt around Resident #1 ' s waist allowing for 2 finger widths of space for comfort. She stated she then proceeded to drive back to the facility. On questioning, TA #1 stated she did not secure Resident #1 with the van ' s shoulder belt prior to transporting Resident #1 back to the facility and she normally never used the shoulder strap during resident transports. TA #1 stated she had been doing resident transports since July 2015 and the previous quality assurance (QA) nurse trained her on transporting residents. She did not recall being trained to use the van ' s shoulder strap during transports. TA #1 recalled when transporting Resident #1 in the facility van on 11/23/15 she was merging onto highway 74 when she heard Resident #1 state she was sliding. TA #1 stated she pulled over and with the assistance of the RP, they lifted Resident #1 off the wheelchair foot pedals using the lift sling straps and returned her to the wheelchair. She then proceeded to transport the resident back to the facility. She stated she did not call the facility or call 911 for assistance because Resident #1 stated she was ok. Once she arrived back at the facility, she notified the DON who told her to write a statement and informed Resident #1 ' s nurse. TA #1 confirmed she transported Resident #1 again to the cancer center on 11/24/15 and 11/25/15, but she was off Thanksgiving and the following day. She stated she received a call on 11/27/15 from the administrator and she met him at the facility on 11/28/15 to go over all of her transports for October 2015 and November 2015. On 11/30/15 she stated the administrator called her again and told her to come to the facility. She was asked to reenact how she put Resident #1 into the van. It was at this time, the administrator told her he would be in touch with her after he concluded his investigation. TA #1 stated she went to the facility to get her paycheck on 12/3/15 and waited to see the administrator who was busy at that time. She left and called back to the facility and spoke with the DON who informed her she was suspended. In an interview on 12/8/15 at 4:35 PM, the RP recalled riding in the facility ' s transportation van in the front passenger seat to take Resident #1 to the cancer center on 11/23/15. He stated TA #1 loaded Resident #1 into the van. The RP stated TA #1 secured the resident ' s wheelchair to the van and the lap belt to the resident. The RP stated TA #1 did not secure the van ' s shoulder belt nor had he ever seen observed her use it on Resident #1 in the past. The RP recalled during the transport TA #1 was waiting to turn onto highway 74. She approached the turn yielding to oncoming traffic and at the first chance, she accelerated to turn and merge onto the highway. He stated he felt TA #1 may have slowed to 45 miles per hour. He recalled commenting to TA #1 that she almost threw him from his seat when he heard Resident #1 say I ' m fixing to slide out of my wheelchair. He stated TA #1 pulled over and he got behind Resident #1 while the TA #1 remained in the front of the van. He stated the lift sling was under Resident #1 and he thought it was not to be under her because it caused her to slide from her wheelchair in the recent past. The RP stated they used the lift sling straps to lift Resident #1 off the wheelchair foot pedals and move her back into the wheelchair. He recalled Resident #1 seemed scared but she did not complain of pain at that time. He stated TA #1 tightened the lap belt back on Resident #1 because he stated it was too loose. TA #1 did not apply the shoulder strap to Resident #1 but he sat in the back with Resident #1 and held onto her to ease her anxiety. The RP stated TA #1 never offered to call 911 or call the facility put rather proceeded to drive back to the facility. He stated she told him she would complete a report about what happened. The RP recalled that once he and Resident #1 returned to her room, the staff was attempting to get her back into the bed using the mechanical lift and Resident #1 was complaining pain in her legs then. He stated he was not aware that the staff ever contacted the physician at any time until he insisted on something be done on 11/27/15. The RP stated that on 11/24/15 he again observed Resident #1 being transported by TA #1 in the facility van without the resident being secured by the van ' s shoulder strap during the transport. The RP stated he was not able to go with her on 11/25/15 but she did go in the van and TA #1 transported her again according to Resident #1. He said he visited Resident #1 on 11/27/15 and when she raised her head to take a drink of water she screamed out in pain. The RP stated he informed staff at this time something had to be done. In an interview on 12/8/15 at 12:21 PM, the DON recalled TA #1 reported to her that Resident #1 slipped in the van on 11/23/15. TA #1 stated Resident #1 ' s RP was present in the van and caught her and she was alright. The DON stated she was unsure if it was an actual fall at that time. She told TA #1 to write a statement and inform Resident #1 ' s nurse to complete an incident report but the DON did not go and assess Resident #1 for any injures or discuss the circumstances of the fall with her or the RP. In an interview on 12/8/15 at 1:02 PM, Nurse #1 confirmed she was assigned Resident #1 on 11/23/15 when she returned from her appointment. She recalled TA #1 reporting to her Resident #1 fell in the van. Nurse #1 stated it was around shift change so she was busy. She recalled TA #1 told her Resident #1 slid from her wheelchair but she was fine. Nurse #1 stated she worked a double shift that day so after shift change she went and spoke to Resident #1 who was already back in the bed. Nurse #1 stated she did not assess Resident #1 or attempt any range of motion because Resident #1 did not complain of any pain at that time and her RP was no longer present. Nurse #1 stated she did not ask Resident #1 what happened in the van at the time of the fall and she did not complete an incident report because the fall did not happened at the facility. Nurse #1 stated she did not document the fall in the medical record nor did she recall passing the incident along to the next shift during shift report. Nurse #1 stated if Resident #1 had acted differently or acted like she was in pain, she would have gotten an x-ray that day. In an another interview on 12/8/15 at 3:00 PM, the DON stated she asked TA #1 if she had Resident #1 secured properly in the van and she verbalized she did. The DON confirmed she asked TA #1 to write a statement but the DON stated she forgot to tell the administrator. The DON stated if Resident #1 had been injured, she would have informed the administrator. The DON confirmed she did not perform a physical assessment on Resident #1 but rather instructed Nurse #1 to complete it. She stated she did not follow up with Resident #1 at any point after 11/23/15. The DON stated she was off on 11/27/15 when she got a call from the administrator asking about the incident. The DON stated the administrator stated the RP was at the facility upset insisting Resident #1 be evaluated due her continued complaints of pain. In an interview on 12/8/15 at 3:28 PM, NA # 5 confirmed she worked second shift on 11/23/15 with Resident #1. NA #5 stated she put Resident #1 in the bed after she returned from the appointment the day she fell . She stated the lift sling was under Resident #1 in the wheel chair when she returned and she was not supposed to have it under her when she was up in her wheelchair because she had been known to slide out of her wheelchair off the sling. In an interview on 12/8/15 at 3:17 PM, NA #4 confirmed she worked second shift on 11/25/15 with Resident #1. NA #4 recalled she and NA #3 assisted Resident #1 back into the bed using the mechanical lift after she returned from the cancer center. NA #4 confirmed the lift sling was under Resident #1 in the wheel chair on her return from the cancer center on 11/25/15. In an interview on 12/8/15 at 2:20 PM, the administrator stated he did not become aware of Resident #1 falling in the facility ' s transport van until 11/27/15 and he immediately stopped all transports. He confirmed TA #1 continued to transport Resident #1 and other residents on 11/24/15 and 11/25/15. He stated he started an investigation when he became aware and so far, he felt TA #1 did not have the shoulder belt in use when Resident #1 fell . He recalled speaking to TA #1 and suspended her effective 11/30/15 pending the outcome of his investigation. He stated there was no transports on 11/26/15 or 11/27/15 due to the Thanksgiving holiday. The administrator verified he or the previous QA nurse were the staff who trained TA #1 and TA #2. In an interview on 12/8/15 at 1:43 PM, the maintenance director stated he was not aware of the fall Resident #1 experienced in the facility transport van on 11/23/15, but on 11/30/15, the administrator asked him to inspect the lap straps, shoulder straps and tie downs on the van. He stated he was not responsible for training the transportation aides on proper use of the equipment. But rather the administrator was responsible for the training. He stated he was responsible for a monthly safety inspection of the van. A review of the monthly check off van inspection form included the condition of the seat belt and the consistent use of the seat belt by the staff and residents. He stated he had checked those off on the monthly inspections provided but he was unsure who verified the staff use using the straps properly. He provided evidence of a monthly inspections for 9/29/15, 11/3/15 and 12/8/15. He stated he did not complete a monthly inspection in October 2015. He stated he did not perform any observations of the TA ' s securing the residents in the van.

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	345293	A. BUILDING _____ B. WING _____	12/18/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) In an interview on 12/9/15 at 8:45 AM, TA #2 stated she was trained by the Quality Assurance (QA) nurse and the previous transporter on how to transport residents in the facility ' s transport van. TA #2 stated she served as the backup transporter for over one year. She stated she was checked off for safety before she was allowed to transport residents. She stated she always used the lap belt and the shoulder belt to secure the resident in the wheelchair during transport. TA #2 stated the administrator recently retrained her and stressed to her that the shoulder strap was the most important strap. TA #2 stated she had not had any issues with falls during her transports but if she did, she would call 911 and not move the resident. TA #2 confirmed that the lift sling was to be removed from underneath Resident #1 whenever she was up in her wheelchair. TA #2 stated Resident #1 had trouble sitting up in her wheelchair due to her bilateral leg contractures and the lift sling was slippery and had resulted in her falling in the past. TA #2 also stated she always had a co-worker present during all resident transports for safety. She stated she had never been told she had to transport alone but rather administration knew she always had another staff member with her on her transports. In an interview on 12/9/15 at 10:45 AM, the QA nurse confirmed he added the care plan intervention to remove the lift sling from under Resident #1 when she fell from her wheelchair on 10/8/15. The QA nurse also confirmed he did the training on mechanical lift operation, securing the wheelchair with tie downs, how to apply safety belts to include the lap and shoulder belts and driving of the transportation van for TA #1 and TA #2 with the assistance of the administrator. He was able to provide training evidence for TA #2 dated 11/12/14 and provided a typed statement that he trained TA #1 on 7/13/15 through 7/15/15 on transporting residents in the facility van. He stated he trained TA #1 to use the shoulder strap during every resident transport for safety. A review of Resident #1 ' s nursing notes indicated a note dated 11/27/15 documenting the events that occurred on 11/23/15. This nursing note indicated the physician was made aware on 11/27/15 of Resident #1 ' s fall that occurred Monday 11/23/15 while she was on the facility transportation van. The physician ordered a series of x-rays. When the physician was notified of the x-ray results, orders were received to send Resident #1 to the hospital for an evaluation on 11/27/15 due an acute impacted left hip fracture of the left femoral neck and posttraumatic deformities of the distal tibia and fibula of the right ankle. In a telephone interview on 12/8/15 at 4:02 PM, the physician stated he was not notified of any incident involving a fall on the van with Resident #1 until 11/27/15 when the RP was at the facility very upset stating Resident #1 was in severe pain and something had to be done. He stated he ordered x-rays and that was when he discovered the fractures. The physician stated his expectation was to be notified immediately when an incident like the one involving Resident #1 occurred so proper assessment and treatment would not be delayed and his expectation would be that anytime a resident was placed in the transportation van, the resident would be properly secured for safety. A review of the hospital records dated 11/27/15 indicated Resident was being transported in a van 5 days ago in her wheelchair when she slipped from the wheelchair onto her left hip when her right leg under her. She has been complaining of some pain in the area since that time. The pain was reported mostly to her left proximal femur and her right ankle which showed evidence of bruising and swelling. A splint was applied to her right lower extremity for immobilization and the orthopedic consult recommended no surgical intervention due to Resident #1 ' s bed bound status and severe MS with contractures. Pain management was recommended and she was diagnosed with [REDACTED]. Richmond Pines was placed into Immediate Jeopardy at 6:18 PM, on December 8, 2015, related to an incident that took place on a facility van on November 23, 2015. Immediately a plan was put in place to complete a Credible Allegation. A. How the corrective action will be accomplished for those residents found to have been affected by deficient practice? Outcome? · On 11/27/15, the administrator stopped all facility transports with facility van. · On 11/30/15, the maintenance director completed an inspection of the van tie downs, tracks, and seatbelts and all were found to be in proper working order. · On 12/1/15, the administrator educated the director of nursing, the assistant director of nursing and the scheduler on how to properly secure a resident in the facility van with the appropriate tie down straps, waist belt, and shoulder harness per the manufacturer recommendations/instructions. The director of nursing, the assistant director of nursing, and the scheduler all provided correct return demonstrations per the manufacturer recommendations/instructions. · On 12/1/15, the administrator personally conducted training and successful return demonstration with the scheduler, assistant director of nursing, and the director of nursing. The administrator used, as a reference document, the QRT Max Work book for trainees. (The manufacturer ' s recommendation/instruction regarding the application of the wheelchair restraint system.) The administrator included in the training and return demonstration, wheelchair positioning, appropriate placement of wheelchair tie downs, appropriate positioning and fastening of lap and shoulder belts. · On 12/1/15, transportation resumed with the facility van after training and return demonstration. · On 12/9/15, the MDS nurse updated the resident ' s care plan to include resident will not be transported with lift pad under her. · On 12/9/15, an in-service was initiated for 100% of LPN ' s, RN ' s, and CNA ' s relating to following the care guide for lift pad removal for when the resident is in the wheelchair or when the resident is being transported in the facility van. No RN ' s, LPN ' s, and CNA ' s will be allowed to complete a work shift until this in-service is completed. This in-service will be incorporated into new employee orientation. · On 12/9/15, the director of nursing initiated an in-service for all nursing staff, RN ' s, LPN ' s, CNA ' s, medication aides, restorative aides, and transportation aides, including staff involved with care from 11/23/15 through 11/27/15. The following was covered; All nursing staff must follow the resident care guide, posted in the resident ' s closet. Please especially pay attention to the handling and movement directions on the care guide. For example, the care guide may instruct you to remove the resident ' s lift pad after transferring the resident from the bed to the chair as well as it may include the removal of the lift pad when being transferred in the company van. If you have any comments or questions please see the director of nursing. All nursing staff, RN ' s, LPN ' s, CNA ' s, medication aides, restorative aides, and transportation aides will complete this in-service prior to completing their shift. This in-service will be incorporated into new employee orientation. · On 12/9/15, resident number 1 ' s care plan was updated to include resident number 1 will not be transported in the facility van with a lift pad under her. · On 12/9/15 scheduler/backup van driver, assistant director of nursing, and the director of nursing successfully completed a Transportation Skill Checklist and return demonstration prior to initiation of transports by company van. This was verified by the administrator. Included but not limited to appropriate placement of the tie down straps and application of the van seat belts. · Effective 12/9/15, the scheduler, assistant director of nursing, and the director of nursing completed the Resident Transport Checklist tool ensuring each step of properly securing a resident has been completed appropriately during the securing process each transport. B. How did the facility identify other residents having the potential to be affected by the same deficient practice? · On 11/27/15, the administrator stopped all facility transports with facility van. · On 12/1/15, the administrator educated the director of nursing, the assistant director of nursing and the scheduler on how to properly secure a resident in the facility van with the appropriate tie down straps, waist belt, and shoulder harness per the manufacturer recommendations. The director of nursing, the assistant director of nursing, and the scheduler all provided correct return demonstrations. · On 12/1/15, the administrator personally conducted training and successful return demonstration with the scheduler, assistant director of nursing, and the director of nursing. The administrator used, as a reference document, the QRT Max Work book for trainees. The administrator included in the training and return demonstration, wheelchair positioning, appropriate placement of wheelchair tie downs, appropriate positioning and fastening of lap and shoulder belts. · Transporting with facility van resumed on 12/1/15. · On 11/27/15, the administrator conducted interviews with alert and oriented residents that had received van transport regarding seat belt use during transport and overall wellbeing and safety with no negative findings. Residents that were interviewed were transported between the dates of 11/23/15 to 11/27/15. · On 11/27/15, the administrator interviewed resident number 1 involved in the incident regarding seat belt use during

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) transport. The resident was unable to recall if the seatbelt was properly in place. · On 11/28/15, the administrator obtained the transportation driver ' s statement relating to her recall of the van incident. The transportation driver was drug tested and remains suspended. · On 11/30/15, the maintenance director completed an inspection of the van tie downs, tracks, and seatbelts and all were found to be in proper working order. · On 12/9/15, the MDS coordinator reviewed all residents using sling lift pads for safety while in wheelchair. The MDS coordinator assessed the residents that utilize the sling lift and updated the residents ' care plans and care guides to reflect if the sling lift pad needs to be removed for safe transport in the facility van. Determination for having the lift pad removed will be based upon resident preference, resident upper body, strength, coordination, and balance (ability to sit up straight independently). · On 12/9/15, the director of nursing initiated an in-service for all nursing staff, RN ' s, LPN ' s, CNA ' s, medication aides, restorative aides, and transportation aides, including staff involved with care from 11/23/15 through 11/27/15. The following was covered; All nursing staff must follow the resident care guide, posted in the resident ' s closet. Please especially pay attention to the handling and movement directions on the care guide. For example, the care guide may instruct you to remove the resident ' s lift pad after transferring the resident from the bed to the chair as well as it may include the removal of the lift pad when being transferred in the company van. If you have any comments or questions please see the director of nursing. All nursing staff, RN ' s, LPN ' s, CNA ' s, medication aides, restorative aides, and transportation aides will complete this in-service prior to completing their shift. This in-service will be incorporated into new employee orientation. · On 12/9/15 scheduler/backup van driver, assistant director of nursing, and the director of nursing successfully completed a Transportation Skill Checklist and return demonstration prior to initiation of transports by company van. This was verified by the administrator. · Effective 12/9/15, the scheduler, assistant director of nursing, and the director of nursing completed the Resident Transport Checklist tool ensuring each step of properly securing a resident has been completed appropriately during the securing process each transport. C. Give specific dates of the corrective actions. · On 11/27/15, the administrator stopped all facility transports with facility van. · On 11/30/15, the maintenance director inspected the facility van wheelchair tie down equipment. · On 12/1/15, administrator educated the director of nursing, the assistant director of nursing, and the scheduler regarding wheelchair tie downs. · On 12/1/15, transportation resumed with the facility van after training and return demonstration. · On 12/9/15, the MDS nurse updated the care plans regarding the placement of the lift pad. · On 12/9/15, an in-service was conducted by the DON regarding care guides. · On 12/9/15, the scheduler, the assistant director of nursing, and the director of nursing completed a transportation skills checklist and the resident transportation checklist tool. The Credible Allegation (CA) was verified 12/10/15 at 12:45 PM by observation of TA #2 proper usage of shoulder belt, lap belt and the 4 point tie down system while securing a resident in the van for transport. The administrator verified no resident has been transported in the van since 11/27/15 and TA #1 was suspended 11/30/15. The CA was further verified by observation of residents and interviews of staff regarding the removal of the lift pads from underneath identified residents while up in their wheelchairs. The CA was verified for in-servicing of staff regarding the reporting of incidents to the physician, documenting incidents and assessments of residents after a reported incidents.