| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115504 | A. BUILDING _____ B. WING _____ | 03/03/2016 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| NORTHEAST ATLANTA HEALTH AND REHABILITATION CENTER | 1500 S JOHNSON FERRY ROAD ATLANTA, GA 30319 |

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) |
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| F 0281<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Make sure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview it was determined that the facility failed to provide professional quality of care for one (1 ) resident (R1) of the seven (7) sampled who suffered a fractured femur by not reporting an x-rays report to the physician correctly for additional intervention.<br>This caused actual harm to R1 for nine (9) days at which time the resident was transferred to an acute care facility.<br>Findings include:<br>Review of the Medical Record for R1 revealed nurses notes dated February 3, 2016, indicating that Certified Nursing Assistant (CNA) AA was assisting R1 to transfer from the wheelchair to the toilet, when the R1 became weak and had to be lowered to the the floor. AA then notified the LPN, BB to help her with R1. BB found R1 on the floor. At that time they assisted R1 from the bathroom floor into the wheelchair. The Medical Doctor (MD) and Responsible Party (RP) were notified.<br>Further Medical record review revealed that R1 complained of right hip pain the next morning on 02/04/16, after receiving regularly scheduled pain medication of [MEDICATION NAME] - [MEDICATION NAME] 5/325 mg and an as needed dose of pain medication.<br>Further Medical Record Review revealed nurses note dated 02/04/16, resident complained of pain to the right hip due to fall from yesterday. Right hip noted to be swollen X-ray of the hip ordered.<br>A new order was received for an x-ray of the hip was ordered and was obtained on 02/04/16 and was subsequently reported from the nursing staff to the Medical doctor (MD) to be negative for any fractures.<br>However, review of the Mobilex Radiology report dated 02/08/16 revealed, stamped POSITIVE. Two x-ray reports noted on one page. On the upper page radiology report for knee 1-2 views (right) and on the lower half of the page radiology report results for Tibia/Fibula. The upper Knee report is noted to read:<br>Results: Fracture lucency of the distal tibial shaft. Soft tissue swelling. No gross malalignment. Conclusion: Acute distal femoral shaft, incompletely visualized with single view. Consider full exam when able.<br>The Radiology report on the lower half of the page is noted to be for the Tibia/Fibula and reads:<br>Tibia/Fibula (Right) Conclusion: No acute osseous abnormality. [MEDICAL CONDITION] changes.<br>Further Medical Record review revealed nurses note for R1 dated 02/15/16, for a urine analysis was ordered. Review of a Nurses noted on 02/16/16 at 11:51 a.m. revealed the resident appears confused, altered mental status, involuntary jerking, shaking and left facility via stretcher to local acute care hospital. MD and RP notified.<br>Interview on 03/01/16 at 1:00 p.m. with Licensed Practical Nurse (LPN) DD while reviewing the x-ray report of the knee dated 02/08/16, DD stated she does not know what fracture lucency means. DD stated that, incompletely visualized with a single view meant that additional x-rays should have been done, but were not done.<br>Interview on 03/01/16 at 1:13 p.m. with the Director of Nursing (DON). While reviewing the x-ray report for R1 ' s knee the DON stated she was not sure what fracture lucency meant but stated according to the conclusion on the radiology report of the knee that the x-ray was inconclusive and that R1 needed additional x-rays, that were not done. The DON stated her expectations of her staff are that when radiology reports are received that read: incompletely visualized consider a full exam, then she expected the nurses to call the physician and read the physician the entire report, not just a portion of the report, and ask the physician for an order for [REDACTED].<br>Interview on 03/02/16 at 9:00 a.m. with Physical Therapist EE revealed that the Rehabilitation Director had received, in report, during the morning meeting, on 02/10/16, that R1 had fallen on 02/03/16, but had not incurred any injuries and that she needed to be evaluated for physical therapy. EE stated R1 was referred to him/her on 02/10/16 for a physical therapy evaluation. EE stated he/she assessed R1 and completed a physical therapy evaluation on R1 on 02/10/16. EE stated that during the physical therapy evaluation he/she determined that R1 had range of motion impairment of the right knee. The right knee had ninety degree of knee flexion and you would expect to find one hundred and ten (110) to one hundred and twenty-five (125) degree of knee flexion. R1 was unable to stand and pain was nine out of ten 9/10. R1 was assessed to need diathermy (heat) treatment, biofreeze massage to the right knee, and strengthening exercises for the left leg. R1 was gotten out of bed, with a hoyer lift, and seen in the gym for physical therapy on 02/10/16, 02/11/16, and 02/15/16. EE stated that on 02/12/16 and 02/16/16 the resident remained in his/her bed and therapy was provided in the resident ' s room while the resident remained in the bed. EE stated that R1 had severe and excruciating pain every day, from the day of the initial evaluation on 02/10/16, until the resident was discharged from the facility to the hospital on [DATE].<br>EE stated he/she had access to the residents x-ray report but that he/she never reviewed the x-ray report dated 02/08/16, and that he/she never discussed R1 ' s pain with the resident ' s nurses or with the resident ' s physician. EE stated that if he/she had read R1 ' s x-ray report dated 02/08/16, then the resident would not have been picked up for physical therapy and that no physical therapy services would have been provided for R1. EE stated that he/she would have insisted that R1 needed to have additional x-rays and that no physical therapy services would have been provided until after the additional x-rays had been completed and it was determined that the resident was free of any injuries such as fractures.<br>Interview on 03/02/16 at 10:32 a.m. with Unit Manger revealed that the nurses working the medication carts are responsible for ordering, receiving and reporting the radiology reports. The Unit Manager stated the nurse told him/her that the x-ray report was called in to the physician and that he/she never read R1 ' s x-ray report of the right knee.<br>Interview on 03/03/16 at 11:34 a.m. with the Rehab Program Manager revealed that falls are reported in the morning meeting and that it was reported that the resident had a fall on 02/03/16, but that there were no injuries. The resident was evaluated for physical therapy and began physical therapy services on 02/10/16, after the resident had x-rays taken on 02/08/16. The Rehab Program Manager stated that she did not read the resident ' s x-ray report and that if he/she had read the resident ' s x-ray report then the resident would absolutely not have had therapy. The resident should have had additional x-rays, either in-house or the resident should have been sent out for additional x-rays. The Rehab Program Manager stated because we thought we were dealing with a negative x-ray we did not call the physician about the resident ' s continued excruciating pain.<br>Interview on 03/03/16 at 2:00 p.m. with J revealed that I don ' t know what happened on 02/03/16, whether R1 was lowered to the floor of if she fell ; however the surgeon told me that R1 ' s femur bone was shattered. J stated that the facility did not call him/her with the x-ray results for the x-rays obtained on 02/08/16.<br>Interview on 03/03/16 at 2:08 p.m. with MD revealed that he/she usually visits the resident every couple of weeks. MD stated that when the nurse called him on 02/08/16, regarding the x-ray report that was received on 02/08/16, that the nurse told him/her that there was no osseous abnormalities. MD stated that a few days after the nurse called him with the x-ray report |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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 0281<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>he came into the facility and that he read the x-ray report and signed off on the report. MD stated that when he read the report he did not realize that there were two x-ray reports on the one page and that he skimmed to the bottom of the page and only read the conclusion for the Tibia/Fibula and that he missed reading the conclusion for the knee. MD stated that he/she saw R1 on 02/12/16, but that he/she did not examine the resident ' s leg because he thought the x-rays taken of the resident ' s leg was negative (free from any fractures).<br>Interview on 03/03/16 at 4:26 p.m. with the Administrator when reviewing R1 ' s radiology report dated 02/08/16, that the Administrator stated he/she does not know what fracture lucency means but when the conclusion, on the x-ray report, of the knee reads: Conclusion: Acute distal femoral shaft, incompletely visualized with single view that meant that R1 needed additional x-rays. We should have had follow up x-rays done because that was what was being recommended, by the radiologist, in the radiology report. |
| F 0309<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **Provide necessary care and services to maintain the highest well being of each resident**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Bases on record review and interview it was determined the facility failed to report one (1) radiology report of the knee and failed to obtain additional x-rays as recommended by the radiologist report for one (1) resident (R1) of the seven (7) sampled.<br>This failure caused actualharm to R1, for nine (9) days after a fall with fracture.<br>Findings include:<br>Record review of nurses notes dated February 3, 2016 for R1 revealed: Certified Nursing Assistant (CNA) AA was assisting R1 to transfer from the wheelchair to the toilet, in the bathroom, when R1 became weak and has lowered to the floor. CNA AA then notified the Licensed Practical Nurse (LPN) BB to help her with R1. BB found R1 on the floor. At that time they assisted R1 from the bathroom floor into wheel the wheelchair. The Medical Doctor (MD) and Responsible Party (RP) were notified.<br>Further record review revealed that R1 complained of right hip pain the next morning on 02/04/16, after receiving regularly scheduled pain medication of [MEDICATION NAME] - [MEDICATION NAME] 5/325 mg and an as needed dose of pain medication. A new<br>order was received for an x-ray of the hip was ordered and was obtained on 02/04/16 and was subsequently found to be negative for any fractures.<br>Further Medical Record Review revealed nurses note dated 02/04/16, resident complained of pain to the right hip due to fall from yesterday. Right hip noted to be swollen X-ray of the hip ordered.<br>R1 continued to complain of pain to the right leg until 02/08/16, when LPN, DD called the MD and received a new order for x-rays to be obtained of the right knee, right tibia, fibula and ankle.<br>The Radiology report was received from the radiologist on 02/08/16, and was called in to the MD on 02/08/16. Review of the nurses note dated 02/09/16, revealed that LPN CC, called the MD on 02/09/16 at 2:18 p.m. and reported that lab results stated no acute osseous abnormality, with [MEDICAL CONDITION] changes.<br>Review of the Mobilex Radiology report dated 02/08/16 revealed a stamped POSITIVE comment. On the upper page radiology report revealed right knee 1-2 views and on the lower half of the page radiology report results for Tibia/Fibula.<br>The upper Knee report is noted to read:<br>Results: Fracture lucency of the distal tibial shaft. Soft tissue swelling. No gross malalignment. Conclusion: Acute distal femoral shaft, incompletely visualized with single view. Consider full exam when able.<br>The Radiology report on the lower half of the page is noted to be for the Tibia/Fibula as follows:<br>Tibia/Fibula (Right) Conclusion: No acute osseous abnormality. [MEDICAL CONDITION] changes.<br>Continued Record Review revealed the R1 continued to receive regularly scheduled pain medication, [MEDICATION NAME] - [MEDICATION NAME] 5/325 mg twice daily for chronic pain, yet R1 continued to complain of pain and was administered [MEDICATION NAME] 325 mg two (2) tabs for pain on 02/04/16, 02/07/16, and 02/12/16, in an addition to the regularly scheduled pain medication.<br>Review of Nurses note dated 02/12/16 at 3:00 p.m. revealed: R1 was yelling in pain and first shift nurse had already treated for [REDACTED]. LPN BB tried therapeutic measures first, Ice pack on the localized area that was reported of pain as well as elevating the pillow.<br>Review of Nurses note dated 02/12/16 at 3:03 p.m. revealed R1 is complaining of pain in left lower extremity 650 mg of [MEDICATION NAME] was administered at 2:50 p.m. Resident advised that [MEDICATION NAME] isn ' t due until 8:00 p.m. resident requested to have [MEDICATION NAME] early, advised that wasn ' t possible.<br>Further Medical Record review revealed nurses note dated 02/12/16 at 5:02 p.m. MD notified about R1 localized pain in the right knee. A new order received from the MD for a one time dose of [MEDICATION NAME] 5-325 mg to be administered, in addition to her regularly scheduled dose of pain medication.<br>There was no further nursing notes for R1 until 02/15/16, when an order for [REDACTED].<br>Nurses note dated 02/16/16 at 11:51 a.m. revealed R1 left facility via stretcher to local acute care hospital. MD and RP notified.<br>Interview on 03/01/16 at 1:00 p.m. with LPN DD while reviewing the x-ray report of the knee dated 02/08/16, DD stated she does not know what fracture lucency means. DD stated that, incompletely visualized with a single view meant that additional x-rays should have been done, but were not done.<br>Interview on 03/01/16 at 1:13 p.m. with the Director of Nursing (DON) revealed, while reviewing the x-ray report of the knee, the DON stated she was not sure what fracture lucency meant but stated according to the conclusion on the radiology report for knee that the x-ray was inconclusive and that R1 needed additional x-rays, that were not done.<br>The DON stated her expectations of her staff are that when radiology reports are received that read: incompletely visualized consider a full exam, then she expected the nurses to call the physician and read the physician the entire report, not just a portion of the report, and ask the physician for an order for [REDACTED].<br>The DON stated she had not in-serviced the staff regarding the correct reading and reporting of x-ray reports but instructed the East Wing Unit Manager to in-service (educate) the staff regarding correctly reading and reporting x-rays to the physicians.<br>At that time, the DON called the Unit Manager and asked the Unit Manger if he/she had in-serviced (educated) the staff regarding correctly reading and reporting radiology reports?<br>The Unit Manger stated he had talked with the staff but did not have any sign-in sheets showing that he had in-serviced the staff. The Unit Manger went on to say he spoke with the staff but he/she thought that he/she needed to speak with the staff again about this topic.<br>On 03/02/16, after stating on 03/01/16 that he/she had not in-serviced (educated) the staff regarding correctly reading and reporting radiology reports, the DON presented the surveyor with a copy of in-services dated 02/10/16 with a typed list of topics which included Lab Processes, and stated that she had in-serviced the staff on correctly reading and reporting radiology reports.<br>Interview on 03/02/16 at 9:00 a.m. with Physical Therapist EE revealed that the Rehabilitation Director had received, in report, during the morning meeting, on 02/10/16, that R1 had fallen on 02/03/16, but had not incurred any injuries and that she needed to be evaluated for physical therapy. EE stated R1 was referred to him/her on 02/10/16 for a physical therapy evaluation. EE stated he/she assessed R1 and completed a physical therapy evaluation on R1 on 02/10/16. EE stated that during the physical therapy evaluation he/she determined that R1 had range of motion impairment of the right knee. The right knee had ninety degree of knee flexion and you would expect to find one hundred and ten (110) to one hundred and twenty-five (125) degree of knee flexion. R1 was unable to stand and pain was nine out of ten 9/10. R1 was assessed to need diathermy (heat) treatment, biofreeze massage to the right knee, and strengthening exercises for the left leg. R1 was gotten out of bed, with a hoyer lift, and seen in the gym for physical therapy on 02/10/16, 02/11/16, and 02/15/16. EE stated that on 02/12/16 and 02/16/16 the resident remained in his/her bed and therapy was provided in the resident ' s room while the resident remained in the bed. EE stated that R1 had severe and excruciating pain every day, from the day of the initial evaluation on 02/10/16, until the resident was discharged from the facility to the hospital on [DATE]. EE stated he/she had access to the residents x-ray report but that he/she never reviewed the x-ray report dated 02/08/16, and that he/she never discussed R1 ' s pain with the resident ' s nurses or with the resident ' s physician. EE stated that if he/she had read R1 ' s x-ray report dated 02/08/16, then the resident would not have been picked up for physical therapy |

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| F 0309<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>and that no physical therapy services would have been provided for R1. EE stated that he/she would have insisted that R1 needed to have additional x-rays and that no physical therapy services would have been provided until after the additional x-rays had been completed and it was determined that the resident was free of any injuries such as fractures.<br>Interview on 03/02/16 at 10:32 a.m. with Unit Manger revealed that the nurses working the medication carts are responsible for ordering, receiving and reporting the radiology reports. As the Unit Manager, he/she is responsible for making sure that if an order for [REDACTED].-ray report of the right knee.<br>Interview on 03/02/16 at 11:00 a.m. with Certified Nursing Assistant CNA, FF that he/she was the CNA for R1 on a regular basis and that after the resident had the fall on 02/03/16 that R1 was complaining of pain in the leg a lot and that he/she had reported that pain to the resident ' s nurse. FF did not remember who he/she had reported R1 ' s pain to.<br>Interview on 03/02/16 at 2:02 p.m. with the RN Staff Development Manager revealed that he/she is responsible for keeping up with all in-services that are given in the facility and that he/she keeps a copy of all of the in-services that had been given in a binder. The RN Staff Development Manager stated that if there had been any in-services regarding correctly reading and reporting radiology reports since the resident fell on [DATE] he/she was not aware of it.<br>Interview on 03/02/16 at 2:31 p.m. with CNA, GG revealed that after the resident fell that she would complain and say her/his hip hurt and I knew that wasn ' t usual for R1 and I knew that something was wrong. I told the nurse on duty that the resident was hurting and that he/she didn ' t want to get out of bed. GG said, I don ' t know which nurse I told but I told one of the nurses.<br>Interview on 03/03/16 at 11:02 a.m. with LPN, HH revealed that prior to the resident falling on 02/03/16, resident was able to stand, pivot, turn and sit him/herself on the toilet with one person standby assistance, but after the fall, now we have to use a hoyer lift to get the resident out of bed.<br>Interview on 03/03/16 at 11:34 a.m. with the Rehab Program Manager revealed that falls are reported in the morning meeting and that it was reported that the resident had a fall on 02/03/16, but that there were no injuries. The resident was evaluated for physical therapy and began physical therapy services on 02/10/16, after the resident had x-rays taken on 02/08/16. The Rehab Program Manager stated that she did not read the resident ' s x-ray report and that if he/she had read the resident ' s x-ray report then the resident would absolutely not have had therapy. The resident should have had additional x-rays, either in-house or the resident should have been sent out for additional x-rays. The Rehab Program Manager stated because we thought we were dealing with a negative x-ray we did not call the physician about the resident ' s continued excruciating pain.<br>Interview on 03/03/16 at 2:00 p.m. with J revealed that I don ' t know what happened on 02/03/16, whether R1 was lowered to the floor of if she fell ; however the surgeon told me that R1 ' s femur bone was shattered. J stated that the facility did not call him/her with the x-ray results for the x-rays obtained on 02/08/16. However, J stated a friend was visiting R1 on 02/12/16, and called me and told me that R1 was in a lot of pain so I called the facility and spoke with the nurse BB. BB told me that R1 had an x-ray done but that the x-ray didn ' t show any broken bones so he/she didn ' t know why R1 was complaining of pain.<br>Interview on 03/03/16 at 2:08 p.m. with MD revealed that he/she usually visits the resident every couple of weeks. MD stated that when the nurse called him on 02/08/16, regarding the x-ray report that was received on 02/08/16, that the nurse told him/her that there was no osseous abnormalities. MD stated that a few days after the nurse called him with the x-ray report he came into the facility and that he read the x-ray report and signed off on the report. MD stated that when he read the report he did not realize that there were two x-ray reports on the one page and that he skimmed to the bottom of the page and only read the conclusion for the Tibia/Fibula and that he missed reading the conclusion for the knee. MD stated that he/she saw R1 on 02/12/16, but that he/she did not examine the resident ' s leg because he thought the x-rays taken of the resident ' s leg was negative (free from any fractures).<br>Interview on 03/03/16 at 3:06 p.m. with CNA, AA revealed that he/she has been a CNA for six months and that he/she was the CNA that assisted R1 to the bathroom on the night of 02/03/16. AA stated that when he/she had previously taken R1 to the bathroom that R1 would push to the rail and stand and bear his/her own weight but AA stated that on 02/03/16, R1 stated she couldn ' t hang on anymore and that AA tried, but could not reach R1 ' s wheelchair, so she lowered R1 to the floor. AA stated R1 complained of pain after he/she was lowered to the floor. AA stated he/she went to get the nurse and they assisted R1 back into his/her wheelchair. AA stated he/she had been R1 ' s CNA one other time, since the fall, and that was the day R1 was sent out to the hospital. AA stated that the day R1 was sent out of the facility, to the hospital, that R1 kept saying that he/she was in pain and saying that his/her knee was hurting. AA stated since R1 has gotten back to the facility from being admitted to the hospital that he/she cries a lot and R1 states he/she doesn ' t know what ' s going on and that asks, what ' s wrong with me?<br>Interview on 03/03/16 at 4:26 p.m. with the Administrator when reviewing R1 ' s radiology report dated 02/08/16, that the Administrator stated he/she does not know what fracture lucency means but when the conclusion, on the x-ray report, of the knee reads: Conclusion: Acute distal femoral shaft, incompletely visualized with single view that meant that R1 needed additional x-rays. We should have had follow up x-rays done because that was what was being recommended, by the radiologist, in the radiology report.<br>Interview on 03/03/16 at 5:02 p.m. with LPN, BB revealed that BB was working the night of 02/03/16, when the CNA AA came and got BB and said that he/she had lowered R1 to the floor. BB stated that when he/she entered R1 ' s bathroom R1 was in a sitting position on the floor with both legs in a straight position. BB stated they lifted the resident up into the wheelchair and R1 said his/her leg was hurting. BB said that R1 said, I fell , but that CNA, AA redirected R1 and said no, you didn ' t fall I helped you and I lowered you to the floor. BB said that R1 kept saying, I fell , I fell but that R1 was redirected and told no, you didn ' t fall that AA lowered you to the floor. BB stated that another CAN, came into the room, and that the resident told that CNA that she fell but AA again told R1 that no, you didn ' t fall I helped you and I lowered you to the floor. BB stated that she did not know who the other CNA was. BB stated that after the resident fell on [DATE], that he/she worked with R1 again on 02/12/16. BB stated that when he/she came onto shift that afternoon that he/she could hear R1 yelling, in pain, all the way to the nurses station. BB stated that the nurse, on the first shift, stated he/she had already given R1 pain medication and that BB and the first shift nurse went in and told R1 that he/she had already been given pain medication and that R1 could not get any more pain medication. BB stated he/she had to go in to the residents room and tell the resident four more times that he/she had already had her pain medicine and could not have any more pain medicine at that time. BB stated she put ice on R1 ' s knee and elevated the pillow under R1 ' s right leg but that the visitor, that was visiting R1, removed the ice pack. BB stated after she had told R1 that R1 could not have any more pain medication that R1 called her son and told her son that she was in pain. BB stated then R1 ' s son called BB and asked what was going on? BB stated that he/she had received in report, from the first shift nurse, that R1 ' s x-ray had come back with no fractures and that BB did not know why the resident was complaining of pain. BB told R1 ' s son that BB would call the physician. BB stated that he/she called the physician and got an order for [REDACTED]. BB said, the last time I worked with R1 I knew something wasn ' t right.<br>Cross refer 281 |