STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	**07/14/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	**5837 LYONS VIEW PIKE KNOXVILLE, TN 37919**

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 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on facility policy review, medical record review, facility investigation review, interview, and observation, the facility failed to immediately notify the resident's physician when there was a significant change in the resident's physical, mental and psychosocial status for 1 resident (#7) of 6 residents reviewed for accidents and incidents, of 8 sampled residents. The facility's failure to immediately inform the physician or Nurse Practitioner (NP) of a significant change in the resident's pain intensity and the resident's physical condition (swollen and bruised bilateral knees and resulting fractures) placed Resident #7 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The Immediate Jeopardy (IJ) was effective [DATE] and is ongoing. The findings include: Review of the facility's policy titled Change in a Resident's Condition or Status dated [DATE] revealed .1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician and the resident's representative when there has been .d. A significant change in the resident's physical/emotional/mental condition; that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications .2. A significant change of condition is a decline or improvement in the resident's status . Medical record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident was coded 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Further review revealed the resident required extensive assistance of 2 staff for bed mobility (how resident moves to and from lying position, turns side to side). Medical record review of the resident's Medication Administration Record (MAR) and nursing notes for (MONTH) (YEAR) revealed Resident #7 was to have a pain assessment every shift (7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM), and had an order for [REDACTED]. Further review of the MAR and nursing notes revealed the resident rated her pain as 0 daily and did not require any of the as needed [MEDICATION NAME] until [DATE], after she was diagnosed with [REDACTED]. Review of the facility's incident report dated [DATE] at 6:45 AM, revealed Resident #7 .was noted to slide off air mattress on to the floor during a bed change. Head to toe assessment performed, no injury noted .Sister .Dr (physician) .notified. Review of the facility's investigation revealed a written statement completed by Certified Nursing Assistant (CNA) #8 dated [DATE], which stated .I was in the middle of changing patient sheets, when patient rolled over. She slid out of the bed and landed on her knees and fell toward her left side and did not hit her head . Medical record review of Resident #7's MAR revealed on [DATE] the resident's pain was 6 out of 10 (with 10 being the most severe pain) on the 7:00 AM to 7:00 PM shift and was administered [MEDICATION NAME] 7.5 mg at 8:00 AM. Medical record review of a telephone order dated [DATE] at 10:45 AM, revealed .Bilateral hips & (and) L (left) shoulder x-ray .fall .VORB (verbal order read back) (name of the former Director of Nursing) . Continued review of the order revealed the order was a verbal order written by a Registered Nurse (RN) and received from the former Director of Nursing (DON). Further review revealed the order was signed by the Nurse Practitioner (NP) on [DATE]. Medical record review of nurse's notes dated [DATE] at 11:00 AM, revealed the resident complained of bilateral hip and left shoulder pain and x-rays were ordered. Medical record review of the radiology report dated [DATE] revealed no fracture or dislocation of the shoulder or hips was present. Medical record review of the nursing notes and the resident's MAR from [DATE] - [DATE] revealed the resident complained of pain daily that was rated between 5 and 7 on a scale of ,[DATE], with 10 being the worse pain and [MEDICATION NAME] 7.5 mg was given. Further review revealed no documentation the physician or NP was notified of the resident's increased pain or increased need for pain medication. Medical record review of nurse's notes dated [DATE] at 12:30 PM, revealed Resident #7's bilateral knees were swollen and bruised. Further review revealed .on Dr.'s (physician) Board for today (indicating the resident needed to be seen by the physician or the NP) . Medical record review of the resident's MAR and nursing notes for [DATE] and [DATE] revealed the resident continued to rate her pain at 6 out of 10, with [MEDICATION NAME] 7.5 mg administered for pain. Further review revealed no documentation the physician or NP was notified of the resident's increased pain, increased need for pain medication, or of the swollen and bruised knees. Medical record review of a physician's telephone order dated [DATE] at 1:30 PM, revealed a verbal order for x-ray of bilateral knees was written by an RN, verbally given by the NP. Medical record review of the radiology report dated [DATE] revealed .Impacted right knee fracture involving the distal femoral metaphysis .Impacted fracture (left) involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee) .Old internally fixated proximal tibial fracture . Continued review of the report revealed documentation the DON and a family member of the resident were notified of the results of the x-ray on [DATE] at 9:10 PM and 9:20 PM. Medical record review of a nursing note dated [DATE], with no time, revealed, Called results to (former DON) and sister .Re: (regarding) knee film . Further medical record review revealed no documentation the physician or NP were notified the resident had fractures in both legs. Medical record review of the resident's MAR and nursing notes from [DATE] through [DATE] revealed the resident continued to have pain daily, rated at ,[DATE] on a ,[DATE] scale, and was given [MEDICATION NAME] 7.5 mg. Further review revealed no documentation the NP or physician was notified of the resident's increased pain, increased need for pain medication, bruising or swelling in the knees, or the x-ray results indicating the resident had bilateral fractures. Medical record review of the office visit History and Physical completed by the orthopedic physician dated [DATE] revealed Resident #7 was complaining of pain only in her knees and legs, but it was quite significant. Continued review revealed both knees were swollen and deformed with some flexion. Resident #7 had some mild ecchymosis (bruising) around the knees. The resident had bilateral distal femur fractures. The resident was admitted to the hospital due to the severity of the knee fractures. Medical record review of the hospital Death Summary completed by the orthopedic surgeon dated [DATE], revealed Resident #7 .sustained bilateral distal femur fractures. She was in extreme pain at the time of admission .the fractures were extremely

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0580 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) painful and they were repaired for palliative reasons .Palliative Care was consulted to discuss goals of care with the patient's family due to her severe debility and multiple comorbidities . The resident expired [DATE]. Telephone interview with the NP on [DATE] at 9:25 AM, revealed she remembered she gave the order for the x-ray on [DATE] because the resident was still having pain. Telephone interview with CNA #8 on [DATE] at 10:55 AM, revealed she was making her last round around 6:45 AM on [DATE], and went in to change the resident's bed sheet. CNA #8 stated when she turned Resident #7 over to change the sheet, the resident fell to the floor and landed on her knees. CNA #8 stated she screamed for help and the nurse came in to assess the resident and then the staff put the resident back to bed. CNA #8 stated the resident grabbed her knees after she fell . Interview with RN #2 on [DATE] at 11:30 AM, at a location outside the facility, revealed when she came in [DATE] for the 7:00 AM to 7:00 PM shift, she was informed Resident #7 rolled out of bed and had fallen to the floor. RN #2 stated she assessed the resident who complained of pain in the left shoulder and left hip. RN #2 stated the resident was in pain and would scream when moved or turned. Further interview with RN #2 revealed when she worked Sunday [DATE], the resident was still complaining of pain and she gave the resident pain medication to try to keep her comfortable. Continued interview with RN #2 revealed she was not working [DATE], [DATE], and [DATE]. RN #2 stated on [DATE] when she returned to work, the resident still had not been seen by the Nurse Practitioner or the physician, but stated the NP was at the nurses' station so she asked if she could get x-rays of the knees of Resident #7. Further interview with RN #2 confirmed the NP had not been made aware of the resident's complaints of knee pain until [DATE]. Telephone interview with RN #4 on [DATE] at 1:00 PM, revealed the resident was alert with confusion at times. RN #4 stated on [DATE] the resident was in so much pain the CNAs reported the resident would scream when she was turned. RN #4 stated she went in to talk with Resident #7 who stated her knees hurt her badly. RN #4 stated both knees were swollen and black and blue. RN #4 stated at this time there was a sign posted at the nurse's station to notify the supervisor before calling the physician or NP so she went to the Assistant Director of Nursing (ADON) and reported the resident was in severe pain. RN #4 stated the ADON said they had done x-rays and they were all negative. RN #4 then replied .no, we have not x-rayed the knees . The ADON replied it was too late to call the physician and just place it on the Dr.'s Board (used to list residents who need to be seen by the physician or NP on the next visit) for the resident to be seen the next day. RN #4 stated on [DATE] she saw the physician and the NP in the facility but they never came to the floor to see Resident #7 and when she reminded the ADON Resident #7 needed to be seen, the ADON replied to her the physician and NP were not seeing residents that day. RN #4 confirmed the resident was not seen by the physician or NP on [DATE] or [DATE] when she was on duty. Interview with CNA #4 on [DATE] at 10:50 AM, in the Resting Lounge, revealed after the fall the resident was in a lot of pain all the time. CNA #4 stated when she turned the resident, she would scream out in pain in her knees. The resident's knees were swollen and bruised. When asked if the complaint of pain was different after the fall the CNA replied .absolutely . CNA #4 stated the nurses told the CNAs they had been instructed to put the resident on the doctor's board and the resident could wait until the physician came. Interview with the DON (who was the ADON at the time of the incident) on [DATE] at 11:00 AM, in the Resting Lounge, revealed she could not remember the nurses saying anything to her about the resident having swollen or bruised knees, and if they had told her, she would have told them to call the physician or NP. During observation and interview with RN #4 on [DATE] at 12:10 PM, in the Resting Lounge, the nurse presented a piece of paper, which she stated she had taken down from the nurses' station, .Staff are never to call Dr. (Medical Doctor) or his NP until contact has been made with the on-call Nurse Mgr. (manager). If you have questions about this see (DON) or (ADON). The sign had the DON's name at the bottom. RN #4 also presented a copy of the physician board sheet which revealed a notation dated [DATE] for Resident #7 XXX,[DATE] S/P (status [REDACTED]. Continued interview with RN #4 revealed the nurses were to call management before calling the physician. When asked when the sign was taken down from the nurses' station, the nurse replied when they found out they were being sued. Interview with the Regional Quality Specialist (RQS) on [DATE] at 3:20 PM, in the Resting Lounge, revealed, when asked what she would have expected the nursing staff to do when the resident continued to complain of pain, the Regional Quality Specialist replied .would have expected a call placed to the provider . Telephone interview with the resident's physician on [DATE] at 3:45 PM, revealed when asked what he would have expected the nursing staff to do for any change in resident status including increased pain, the physician stated he would expect to be called for any changes. The physician further confirmed he did not remember the facility calling him for any changes to Resident #7. Interview with CNA #17 on [DATE] at 4:00 PM, in the upper 400 hall shower room, revealed when she took care of Resident #7 she observed the knees swollen and the resident told the CNA she had fallen out of bed. CNA #17 reported to RN #4 the resident's pain on turning and was informed the RN had been instructed to put it on the doctor's board by the ADON. CNA #17 asked nursing again on [DATE] and was told the doctor had still not seen the resident. Interview with RN #2 on [DATE] at 5:45 PM, at the 400 hall nurses' station, revealed when she left on [DATE] the results of the x-rays of the bilateral knees for Resident #7 had not returned. She returned to work on [DATE], read the x-ray results, and was in contact with the DON per text messaging. Further interview confirmed she did not call the physician or NP with the results of the x-rays. Telephone interview with the Medical Director, who was the resident's attending physician, on [DATE] at 5:59 PM, revealed, when asked when he became aware of the bilateral fractures of Resident #7, he replied .this is the first I've heard right now . When asked if he would expect the physician to be notified, the Medical Director replied all fractures should be called to the physician or the person on call. Telephone interview with the NP on [DATE] at 6:20 PM, revealed she could not remember clearly if she was notified of the results of the bilateral knee x-rays and replied .I'm sorry I don't . The NP stated when she got home she would look at her notes and see if she had any notations of notification of the results. Telephone interview with the NP on [DATE] at 9:11 PM, revealed the NP had reviewed her notes for Resident #7 and found no notation of being notified of the results of the bilateral knee x-rays. Interview with the Administrator on [DATE] at 9:00 AM, in the Administrator's Office, revealed during review of nursing notes for [DATE] and [DATE], the Administrator confirmed she did not see documentation the physician or NP had been notified of the results of the bilateral knee x-rays. When asked when she became aware of the fall and fractures related to Resident #7, the Administrator replied when Adult Protective Services came in (MONTH) of (YEAR).
F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on review of facility policies, medical record review, review of the facility's investigation, interview, and observation, the facility failed to prevent neglect for 1 resident (#7) of 6 residents reviewed for neglect, of 8 residents reviewed. The facility's failure to prevent neglect resulted in a delay in receiving services and treatment after a fall with fractures, with Resident #7 experiencing intense pain, and placing Resident #7 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The facility was cited F600 at a scope and severity of J which constitutes Substandard Quality of Care (SQC). The Immediate Jeopardy (IJ) was effective [DATE] and is ongoing. The findings include: Review of the facility's policy titled Change in a Resident's Condition or Status dated [DATE] revealed .1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician and the resident's representative when there has been .d. A significant change in the resident's physical/emotional/mental condition; that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications . Review of the facility's policy titled Abuse Prevention/Reporting Policy and Procedure dated (YEAR) revealed .7. Neglect: the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Medical record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident was coded 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Further review revealed the resident required extensive assistance of 2 staff for bed mobility (how resident moves to and from lying position, turns side to side). Review of the facility's incident report dated [DATE] at 6:45 AM, revealed Resident #7 .was noted to slide off air mattress on to the floor during a bed change .no injury noted . Review of the facility's investigation revealed a written statement completed by Certified Nursing Assistant (CNA) #8 dated [DATE], which stated .I was in the middle of changing patient sheets, when patient rolled over. She slid out of the bed and landed on her knees and fell toward her left side . Medical record review of the Medication Administration Record [REDACTED]. Continued review revealed Resident #7 was prescribed [MEDICATION NAME]-APAP 7XXX,[DATE] milligrams (mg) every 4 hours as needed (PRN) for pain on [DATE]; [MEDICATION NAME] 50 mg every 12 hours for pain on [DATE]; and [MEDICATION NAME] 12 mcg (micrograms)/HR (per hour) patch every 72 hours for pain on [DATE] prior to the fall. Medical record review of the (MONTH) MAR indicated [REDACTED]. Medical record review of nurse's notes dated [DATE] at 11:00 AM, revealed the resident complained of bilateral hip and left shoulder pain and x-rays of the hips and shoulder were ordered. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of the radiology report for the bilateral hips and left shoulder x-rays dated [DATE] revealed no fracture or dislocation. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of nurse's notes dated [DATE] at 12:10 PM, revealed the resident still had complaints of pain related to the fall and pain medications were given as ordered. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of nurse's notes dated [DATE] at 12:30 PM revealed Resident #7's bilateral knees were swollen and bruised. Further review revealed .on Dr.'s (physician) board for today (indicating the resident was to be seen by the physician or Nurse Practitioner) . Further medical record review revealed no documentation the resident was seen by the physician or Nurse Practitioner (NP) on [DATE]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of nurse's notes dated [DATE] at 2:30 AM, revealed the resident woke up at night complaining of pain in the legs and knees and pain medication was given. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of a physician's telephone order dated [DATE] at 1:30 PM, revealed an order for [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of the radiology report dated [DATE] revealed .Impacted right knee fracture involving the distal femoral metaphysis .Impacted fracture (left) involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee) .Old internally fixated proximal tibial fracture . Medical record review of the radiology report and nursing notes dated [DATE] revealed the x-ray results was reported to the Director of Nursing (DON). Further review revealed no documentation the physician or NP were notified of the bilateral fractures. Further review revealed the nurse scheduled an appointment for Resident #7 to be seen by an orthopedic physician on [DATE]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of nurse's notes dated [DATE] revealed Resident #7's bilateral knees remained bruised. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review revealed the first documentation the resident was seen by a physician following the fall on [DATE] was on [DATE] when the resident was sent to the orthopedic physician's office. Medical record review of the History and Physical completed by the orthopedic physician dated [DATE] revealed Resident #7 was complaining of pain only in her knees and legs, but it was quite significant. Continued review revealed both knees were swollen and deformed with some flexion. Resident #7 had some mild ecchymosis (bruising) around the knees. Further review revealed Resident #7 had significant osteoporotic appearing bone with significant arthritis and previous tibial hardware in both legs. The resident had bilateral distal femur fractures. The resident was admitted to the hospital because of the severity of the knee fractures. Medical record review of the hospital Death Summary completed by the orthopedic surgeon dated [DATE] revealed Resident #7 .sustained bilateral distal femur fractures. She was in extreme pain at the time of admission .She was normally non ambulatory however the fractures were extremely painful and they were repaired for palliative reasons .Palliative Care was consulted to discuss goals of care with the patient's family due to her severe debility and multiple comorbidities . The resident expired [DATE]. Telephone interview with the NP on [DATE] at 9:25 AM, revealed she remembered Resident #7 had a fall. The NP stated she gave the order for x-ray of both knees on [DATE] because the resident was still hurting. Telephone interview with CNA #8 on [DATE] at 10:55 AM revealed she was making her last round around 6:45 AM on [DATE] and went into Resident #7's room to change the resident. CNA #8 stated when she turned Resident #7 over to change the sheet, the resident fell to the floor and landed on her knees. CNA #8 stated she screamed for help, the nurse came in to assess the resident, and they put the resident back to bed. CNA #8 stated the resident grabbed her knees after she fell . Interview with Registered Nurse (RN) #2 on [DATE] at 11:30 AM, at a location outside the facility, revealed when she came in to work on [DATE] for the 7:00 AM to 7:00 PM shift, she was told Resident #7 rolled out of bed and had fallen to the floor. RN #2 stated she assessed the resident who complained of pain in the left shoulder and left hip, so she texted the Director of Nursing (DON) at 9:30 AM, and was given verbal permission to get x-rays of the shoulder and bilateral hips. RN #2 stated the resident was in pain and would scream when moved or turned. Further interview with RN #2 revealed when she worked Sunday [DATE], the resident was still complaining of pain. RN #2 further stated she knew the resident was in pain. Continued interview with RN #2 revealed she did not work [DATE], [DATE], and [DATE]. On [DATE], when she returned to work, the resident still had not been seen by either the doctor or the Nurse Practitioner (NP), but the NP was at the nurses' station, so she asked if she could get x-rays of the knees for Resident #7. The nurse stated when she got the x-ray report on [DATE] she scheduled an appointment with an orthopedic surgeon for [DATE]. Further interview with RN #2 confirmed the NP had not been made aware of the resident's complaints of knee pain prior to [DATE]. Telephone interview with RN #4 on [DATE] at 1:00 PM, revealed the resident was alert with confusion at times. RN #4 stated Resident #7 was not a complainer and usually would not volunteer to tell you she was hurting. RN #4 stated on [DATE] the resident was in so much pain, the CNAs reported the resident would scream when she was turned. RN #4 stated she then went in to talk with Resident #7, who stated her knees hurt badly. RN #4 stated both knees were swollen and black and blue. RN #4 stated on [DATE] there was a sign posted at the nurses' station to go to the supervisor before calling the physician, so she went to the Assistant Director of Nursing (ADON). The RN told the ADON the resident was in severe pain and the ADON asked .from what . RN #4 replied, .probably from the fall she had . According to RN #4, the ADON stated they had performed x-rays and they were all negative. RN #4 informed the ADON, .no, we have not x-rayed the knees . The ADON replied it was too late to call the physician and to place the resident on the Dr.'s Board (place to notify the physician or NP residents who need to be seen on next visit) for the resident to be seen the next day. RN #4 stated on [DATE], she saw the physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) and the NP in the facility, but they never came to the floor to see Resident #7. RN #4 revealed when she spoke to the ADON on [DATE], she reminded her Resident #7 needed to be seen. The ADON replied the physician and NP were not seeing residents that day. RN #4 stated she did not work on [DATE], [DATE], and [DATE]. RN #4 confirmed the resident was not seen by the physician or NP on [DATE] or [DATE] when she was on duty and she had reported to the ADON the resident needed to be seen. RN #4 further confirmed Resident #7 was never a good eater, but was not eating as much since the accident, and the resident was in pain. RN #4 further confirmed she administered the resident pain medication as much as possible to keep her comfortable. Interview with the Restorative Aide on [DATE] at 9:50 AM, in the Resting Lounge, revealed she had worked with Resident #7 multiple times doing Range of Motion (ROM). The Restorative Aide stated after the fall on [DATE], the resident didn't want her to do ROM on her legs at all. The Restorative Aide stated the resident told her she had a fall and was in .so much pain . The Restorative Aide further stated the resident was also moaning, and her complaint of pain was different from her normal baseline and .enough to get my attention . Interview with CNA #4 on [DATE] at 10:50 AM, in the Resting Lounge, revealed Resident #7 was never really one to complain of pain but would close her eyes and crunch up her face when in pain. CNA #4 stated before the fall when she would turn the resident, she would complain of pain and may complain more on rainy or cold days. After the fall, the resident was in a lot of pain all the time. CNA #4 stated when she turned the resident, she would scream out in pain and complained her knees were hurting. The CNA stated the resident's knees were swollen and bruised. CNA #4 stated she was working [DATE], and it was either [DATE] or [DATE], when she first noticed the bruising and swelling of both knees of Resident #7 and notified the nurse. When asked if the resident's complaints of pain were different after the fall, the CNA replied .absolutely . CNA #4 stated the resident was screaming with intense pain, especially on turning. CNA #4 stated the nurses told the CNAs nursing had been instructed to put it on the doctor's board and the resident's condition could wait until the physician came. CNA #4 stated she felt the nurses on the floor and the CNAs did everything they could do, but she .laid there several days in pain . Telephone interview with the former DON (who was DON at the time of the incident) on [DATE] at 10:15 AM, revealed he did not remember anything about the incident. The DON confirmed several days after the fall, when he was told the resident was complaining of knee pain and the nurses had seen bruising, he told the nurse to obtain x-rays of the knees and an orthopedic appointment. During observation and interview with RN #4 on [DATE] at 12:10 PM, in the Resting Lounge, the nurse presented a piece of paper, which she stated she had taken down from the nurses' station, .Staff are never to call Dr. (Medical Director) or his NP until contact has been made with the on-call Nurse Mgr. (manager). If you have questions about this see (DON) or (ADON). The sign had the DON's name typed at the bottom. RN #4 also presented a copy of the physician board sheet which revealed a notation dated [DATE] for Resident #7 XXX,[DATE] S/P (status [REDACTED]. Continued interview with RN #4 revealed the nurses were to call management before calling the physician. When asked when the sign was taken down from the nurses' station, the nurse replied when they found out they were being sued. RN #4 confirmed she saw a big change in Resident #7after the fall where she didn't eat as well and she didn't want to be changed by the CNAs. Interview with the Regional Quality Specialist on [DATE] at 3:20 PM, in the Resting Lounge, revealed, when asked what she would have expected the nursing staff to do when the resident continued to complain of pain, and especially knee pain, the Regional Quality Specialist replied .would have expected a call placed to provider . Telephone interview with the attending physician (medical doctor) on [DATE] at 3:45 PM revealed, when asked what he would have expected the nursing staff to do for any change in resident status including increased pain or swelling and bruising of both knees, the physician stated he would have expected to be called regarding these changes. The physician further confirmed he did not remember the facility calling him for any changes to Resident #7. Interview with CNA #17 on [DATE] at 4:00 PM, in the upper 400 hall shower room, revealed when she took care of Resident #7, she observed the knees swollen and the resident stated she had fallen out of bed. The CNA informed RN #4 the resident's knees were swollen and painful on turning. The CNA stated RN #4 said she had been told to put it on the doctor's board. CNA #17 confirmed both knees were swollen and the resident complained of a lot of pain on [DATE]. The CNA stated she asked nursing again on [DATE] about the resident being seen by the physician and was told the doctor had still not seen the resident. Interview with CNA #18 on [DATE] at 4:15 PM, in the upper 400 hall shower room, revealed Resident #7's legs and knees were swollen and she .screamed . when turned and would say .Oh Please, Please, Please . during ADL (activities of daily living) care. The CNA further stated she asked staff everyday if anything had been done for the resident, such as an x-ray, and was told no. Interview with RN #2 on [DATE] at 5:45 PM, at the 400 hall nurses' station, revealed when she left work on [DATE] the results of the x-rays of the bilateral knees for Resident #7 had not returned. RN #2 stated when she came in on [DATE], she read the x-ray results and was in contact with the DON per text messaging. RN #2 stated she received a text from the DON, ortho (orthopedic physician) appointment ? When the RN was asked who gave the order for Resident #7 to go to the orthopedic physician's office, the nurse replied the DON. The RN stated she then started calling around to orthopedics and many did not want to see the resident due to the resident's previous surgery and hardware in her leg. The RN stated she talked to the resident, who could not remember the name of the orthopedic she had previously seen. RN #2 stated she kept calling and finally got in touch with the orthopedic who had done the previous surgery and made an appointment for Monday,[DATE]. When RN #2 was asked if she had given the resident or the Power of Attorney (POA) the option of going to the hospital or waiting to go to the orthopedic surgeon, the RN replied she did not but didn't know if anyone else had. When RN #2 was asked how Resident #7 was from [DATE] until the doctor appointment on [DATE], the RN replied the same. RN #2 stated they kept the resident comfortable with the [MEDICATION NAME], and [MEDICATION NAME] the resident had been prescribed prior to the accident on [DATE]. Telephone interview with the Medical Director, who was the resident's attending physician, on [DATE] at 5:59 PM, revealed, when asked did he know about the bilateral fractures of Resident #7, he replied .this is the first I've heard right now . When asked if he would have expected to be notified, the physician replied all fractures should be called to the physician or the person on call. When asked what would be his plan of care, the physician replied he would ask the resident and/or family if they wanted to go to the hospital, go to the physician, or did they need to be seen now. Telephone interview with the NP on [DATE] at 9:11 PM, revealed the NP had reviewed her notes for Resident #7 and found no notation of being notified of the results of the bilateral knee x-rays. Interview with the Administrator on [DATE] at 9:00 AM, in the Administrator's Office, revealed during review of nursing notes for [DATE] and [DATE], the Administrator did not see the physician or NP had been notified of the results of the bilateral knee x-rays. When asked when she became aware of the fall and fractures related to Resident #7, the Administrator replied when Adult Protective Services came in (MONTH) of (YEAR). Continued interview with the Administrator confirmed when asked if the documentation showed the physician or the NP had been made aware of the results of the bilateral knee x-rays the Administrator shook her head back and forth and stated .no .
F 0656 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review, facility investigation review, and interview, the facility failed to implement a comprehensive care plan for 1 resident (#7) of 6 residents reviewed for accidents and incidents, of 8 sampled residents. The facility's failure to implement the care plan interventions resulted in impacted fractures of both lower extremities and placed Resident #7 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The Immediate Jeopardy (IJ) was effective 11/11/17 and is ongoing. The findings include: Medical record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident scored 15 (cognitively

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) intact) on the Brief Interview for Mental Status (BIMS). Further review revealed the resident required extensive assistance of 2 staff for bed mobility (how resident moves to and from lying position, turns side to side). Medical record review of Resident #7's care plan, reviewed and updated 9/1/17, revealed for the problem of self-care deficit related to bedbound status, the resident's approach included .Bed mobility extensive assist of two . Medical record review of the Interdisciplinary Care Plan (used by the Certified Nurse Assistants (CNAs)), not dated, revealed Resident #7 was a two person assist for bed mobility. Review of the facility's incident report dated 11/11/17 at 6:45 AM revealed Resident #7 .was noted to slide off air mattress on to the floor during a bed change. Resident did not strike her head. Head to toe assessment performed, no injury noted .Two CNAs will be needed to turn resident on air mattress to prevent further falls . Review of the resident's care plan and assessment revealed the resident required a two person assist for bed mobility prior to the accident on 11/11/17. Review of the facility's investigation revealed a written statement completed by CNA #8 dated 11/11/17, which stated .I was in the middle of changing patient sheets, when patient rolled over. She slid out of the bed and landed on her knees and fell toward her left side and did not hit her head . Medical record review of nursing notes dated 11/11/17 revealed the resident complained of pain in the hips and left shoulder and x-rays of the bilateral hips and left shoulder were ordered. Medical record review of the radiology report dated 11/11/17 revealed .Minimal to moderate [MEDICAL CONDITION] changes to the right hip .Moderate to severe [MEDICAL CONDITION] changes of the left hip . No fracture, dislocation, [MEDICAL CONDITION] changes or destructive [MEDICAL CONDITION] of the left shoulder were present. Medical record review of the resident's care plan revealed on 11/13/17 .noodles to bed . had been added as an intervention for at risk for falls due to decrease in mobility. Medical record review of a physician's telephone order dated 11/16/17 at 1:30 PM revealed an order for [REDACTED]. Medical record review of the radiology report dated 11/16/17 revealed .Impacted right knee fracture involving the distal femoral metaphysis .Impacted fracture (left) involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee) .Old internally fixated proximal tibial fracture . Interview with the Administrator on 7/10/18 at 9:00 AM, in the Conference Room, revealed Resident #7 did have a fall in (MONTH) of (YEAR) when a CNA turned the resident in the bed and the resident fell to the floor. Continued interview with the Administrator revealed the resident should have been turned by 2 staff members. When asked if the resident was care planned for 2 staff members the Administrator stated yes. Telephone interview with CNA #8 on 7/10/18 at 10:55 AM revealed she was making her last round around 6:45 AM on 11/11/17 when she went into Resident #7's room. The CNA stated when she went to change the resident she noticed something on her sheet, so she decided she would change the sheet. CNA #8 stated the resident had always grabbed the hand rail to hold when she turned but for some reason she did not get a grip on the hand rail. The CNA stated when she turned Resident #7 over to change the sheet, the resident fell to the floor and landed on her knees. CNA #8 stated she screamed for help and the nurse came in to assess the resident and then they put the resident back to bed. CNA #8 stated the resident grabbed her knees after she fell . When CNA #8 was asked had she been turning Resident #7 by herself, the CNA responded she had always turned the resident by herself. When CNA #8 was asked how did she know if a resident was a 1 person or a 2 person assist for bed mobility or transfer, the CNA stated .by word of mouth .asked other CNAs . Interview with Registered Nurse (RN) #3 on 7/10/18 at 12:05 PM, in the Conference Room, revealed each nurses' station had a CNA binder book which had the Interdisciplinary Care Plans for the CNAs to follow and included assistance needed for Activities of Daily Living (ADL). Interviews with 16 CNAs on 7/10/18 and 7/11/18 revealed all but 2 (CNA #8 and #11) knew about the CNA binders at each nurses' station. Interview with CNA #11 on 7/10/18 at 5:18 PM, at the 300 Hall nurses' station, revealed when asked about the CNA binder, he replied .never used it . Telephone interview with the former Director of Nursing (DON) on 7/11/18 at 10:15 AM, revealed when he was asked if he was aware Resident #7 was care planned for a 2 person assist during bed mobility, he replied no, she was a 2 person assist only for transfer from bed to chair. The DON stated he did remember implementing a practice change to deflate the air mattress before doing care and turning. Interview with the Regional Quality Specialist on 7/11/18 at 3:20 PM, in the Resting Lounge, revealed when the Regional Quality Specialist was asked what she would have expected when a CNA stated she was not aware of the CNA Care Guides, which documented assistance needed for ADLs, the Regional Quality Specialist replied .would have expected all CNAs would have been in-serviced on the Care Guides . Refer to F-689
F 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based review of facility's policies, review of Rules and Regulations of Registered Nurses, review of Tennessee Code Annotated, medical record review, facility investigation review, interview, and observation, the facility failed to assure the services provided met professional standards of quality and acceptable standards of clinical practice for 1 resident (#7), of 8 residents reviewed. The facility's failure to ensure care was provided within professional scope of practice resulted in Resident #7 sustaining bilateral fractures, nursing staff ordering interventions without consulting with physician services, and placed Resident #7 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, impairment or death to a resident). The Immediate Jeopardy (IJ) was effective 11/11/17 and is ongoing. The findings include: Review of the facility's policy titled Change in a Resident's Condition or Status dated 12/28/16 revealed .1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician .when there has been .d. A significant change in the resident's physical/emotional/mental condition; that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications .2. A significant change of condition is a decline or improvement in the resident's status . Review of the Tennessee Rules and Regulations of Registered Nurses Chapter 1000-01 revised June, (YEAR) revealed .3 .(a) Responsibility .Registered nurses are liable if they perform delegated functions they are not prepared to handle by education and experience and for which supervision is not provided. In any patient care situation, the registered nurse should perform only those acts for which each has been prepared and has demonstrated ability to perform, bearing in mind the individual's personal responsibility under the law . Review of the Tennessee Code Annotated 63-7-103 Practice of professional nursing and professional nursing defined revealed .(F) .(b) Notwithstanding subsection (a), the practice of professional nursing does not include acts of medical [DIAGNOSES REDACTED]. Medical record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident was coded 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Review of the facility's investigation revealed a written statement completed by Certified Nursing Assistant (CNA) #8 dated 11/11/17, which stated .I was in the middle of changing patient sheets, when patient rolled over. She slid out of the bed and landed on her knees and fell toward her left side and did not hit her head . Medical record review of nurse's notes dated 11/11/17 at 11:00 AM, revealed the resident complained of bilateral hip and left shoulder pain and x-rays had been ordered. Medical record review of a telephone order dated 11/11/17, at 10:45 AM, revealed .Bilateral hips & (and) L (left) shoulder x-ray .fall .VORB (verbal order read back) (name of the former Director of Nursing) Continued review of the order revealed the order was a verbal order written by a Registered Nurse (RN) and given by the former Director of Nursing (DON). Medical record review of the radiology report for the hips and left shoulder dated 11/11/17 revealed no fracture or dislocation of left shoulder or hips was present. Medical record review of nurse's notes dated 11/14/17 at 12:30 PM, revealed the resident's bilateral knees were swollen and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) bruised. Further review revealed .on Dr.'s (physician) Board (meaning the resident was on the list to be seen by the physician) for today . Medical record review of a physician's telephone order dated 11/16/17 at 1:30 PM, revealed a verbal order for x-ray of bilateral knees given by the Nurse Practitioner (NP). Medical record review of the radiology report dated 11/16/17 revealed .Impacted right knee fracture involving the distal femoral metaphysis .Impacted fracture (left) involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee) .Old internally fixated proximal tibial fracture . Medical record review of a nursing progress note dated 11/16/17 revealed the DON was notified of the results of the x-ray on 11/16/17 at 9:10 PM. Continued review of the nursing progress note and the radiology report revealed no documentation the physician or NP had been notified. Medical record review of a nurse's note dated 11/17/17 revealed .spoke to resident's sister .to notify her of resident's orthopedic appt (appointment) . Medical record review revealed there was no documentation of an order for [REDACTED].>Telephone interview with the Nurse Practitioner (NP) on 7/10/18 at 9:25 AM, confirmed she gave the order for the x-ray of the knees on 11/16/17 because the resident was still in pain. Interview with RN #2 on 7/10/18 at 11:30 AM, at a location outside the facility, revealed when she came to work on 11/11/17 for the 7:00 AM to 7:00 PM shift, she was told Resident #7 rolled out of bed and had fallen to the floor. RN #2 stated she assessed the resident who complained of pain in the left shoulder and left hip, so she texted the DON at 9:30 AM and was given verbal permission by the DON to order x-rays of the shoulder and bilateral hips. Continued interview with RN #2 revealed when she returned to work on 11/16/17 the resident still had not been seen by the Nurse Practitioner (NP) or the physician, but the NP was at the nurses' station, so she asked if she could get x-rays of the knees of Resident #7. Telephone interview with RN #4 on 7/10/18 at 1:00 PM, revealed on 11/13/17 and 11/14/17 there was a sign posted at the nurses' station to notify the supervisor before calling the physician or NP, so she reported to the Assistant Director of Nursing (ADON) Resident #7 was having knee pain and x-rays of the knees had not been done. The ADON instructed RN #4 to place the resident on the Dr.'s Board. RN #4 confirmed Resident #7 was not seen by the physician or the NP on 11/13/17 or 11/14/17. Telephone interview with the former DON (who was DON at time of the incident) on 7/11/18 at 10:15 AM, revealed he didn't remember anything about the incident. The DON confirmed several days after the fall, when he was made aware the resident was having a lot of pain and swelling and bruising of both knees, he instructed the nurses to get x-rays and an orthopedic appointment. Observation and interview with RN #4 on 7/11/18 at 12:10 PM, in the Resting Lounge, revealed she presented a sign she stated she took down from the nurses station which read .Staff are never to call Dr. (Medical Director) or his NP until contact has been made with the on-call Nurse Mgr. (manager). If you have questions about this see (DON) or (ADON). The DON's name was typed on the bottom. Continued interview with RN #4 revealed the nurses were to call management first. Interview with the Regional Quality Specialist on 7/11/18 at 3:20 PM, in the Resting Lounge, revealed she was in the building at least monthly 2-3 days at a time. When asked if she had ever seen the sign regarding not to call the physician or NP, the Regional Quality Specialist stated she had not seen it and the DON (who was ADON at time of incident) had told her there was no sign. When asked what she would have expected the nursing staff to do when the resident continued to complain of pain, and especially knee pain, the Regional Quality Specialist replied .would have expected a call placed to the provider . Interview with RN #2 on 7/13/18 at 5:45 PM, at the 400 hall nurses' station, revealed when she left work on 11/16/17, the results of the x-rays of the bilateral knees for Resident #7 had not returned. RN #2 stated when she returned to work on 11/17/18 she read the x-ray results and was in contact with the DON per text messaging. RN #2 stated she received a text from the DON regarding .ortho (orthopedic physician) appointment? . When the RN was asked who gave the order for Resident #7 to go to the orthopedic's office, the nurse replied the DON. Telephone interview with the Medical Director, attending physician, on 7/13/18 at 5:59 PM, revealed when asked did he know about the bilateral fractures of Resident #7, he replied .this is the first I've heard right now . Interview with the Administrator on 7/13/18 at 6:05 PM, at the 400 hall nurses' station, revealed when shown the nurses' notes of 11/16/17, of the results of the x-rays and the physician was not noted as being notified, and on 11/17/17 when the staff made an appointment with an orthopedic surgeon without a physician's orders [REDACTED].(DON) is not a Doctor .
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review, facility investigation review, and interview, the facility failed to prevent an avoidable accident for 1 resident (#7) of 6 residents reviewed for accidents, of 8 sampled residents. The facility's failure to prevent an avoidable accident resulted in a fall, in which Resident #7 sustained bilateral impacted knee fractures, and placed Resident #7 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The facility was cited F689 at a scope and severity of J, which constitutes Substandard Quality of Care (SQC). The Immediate Jeopardy (IJ) was effective [DATE] and is ongoing. The findings include: Medical record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident was coded 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Further review revealed the resident required extensive assistance of 2 staff for bed mobility (how resident moves to and from lying position, turns side to side). Medical record review of the Fall Risk Evaluation dated [DATE] revealed Resident #7 scored 16 (score of 10 or higher placed the resident at risk for falls). Medical record review of Resident #7's care plan reviewed and updated [DATE], revealed for the problem of self-care deficit, related to bedbound status, the resident's approach included .Bed mobility extensive assist of two . Medical record review of the Interdisciplinary Progress Notes dated [DATE] revealed Resident #7 required extensive assist of two persons for bed mobility. Medical record review of the Interdisciplinary Care Plan (used by the Certified Nursing Assistants), not dated, revealed Resident #7 was a two person assist for bed mobility. Review of the facility's incident report dated [DATE] at 6:45 AM, revealed Resident #7 .was noted to slide off air mattress on to the floor during a bed change. Resident did not strike her head. Head to toe assessment performed, no injury noted .Sister .Dr (physician) .notified. Two CNAs (Certified Nursing Assistants) will be needed to turn resident on air mattress to prevent further falls . Continued review revealed the resident was care planned and assessed as a 2 staff assist for bed mobility prior to the accident. Review of the facility's investigation revealed a written statement completed by CNA #8 dated [DATE], which stated .I was in the middle of changing patient sheets, when patient rolled over. She slid out of the bed and landed on her knees and fell toward her left side and did not hit her head . Medical record review of nurse's notes dated [DATE] at 11:00 AM, revealed the resident complained of bilateral hip and left shoulder pain and x-rays were ordered. Medical record review of the radiology report dated [DATE] revealed .Minimal to moderate [MEDICAL CONDITION] changes to the right hip .Moderate to severe [MEDICAL CONDITION] changes of the left hip . No fracture or dislocation of the left shoulder was present. Medical record review of the Fall Risk Evaluation dated [DATE] revealed Resident #7 scored 18 (score of 10 or higher placed the resident at risk for falls). Review of the 5 WHYs worksheet (a worksheet used to ask 5 why questions to determine the root cause of a problem and implement interventions to prevent recurrence) revealed the worksheet was incomplete for the resident's accident. Further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) review revealed Define the problem: Resident slid out of bed . Further review revealed 5 boxes on the worksheet under why is it happening? with an area to answer why it happened, followed by why is that? and then a space to continue answering until the root cause was found. Further review revealed only 1 of the 5 why boxes was completed with, Air mattress unstable on edge of bed and then an arrow drawn to the side stating, use two CNAs to change or reposition resident, an intervention that was already to be done. Medical record review of nurse's notes dated [DATE] at 12:10 PM, revealed the resident still had complaints of pain related to the fall. Medical record review of the Interdisciplinary Progress Notes dated [DATE] revealed, IDT (Interdisciplinary Team) clinical post fall [DATE], slide from air mattress during care. 0 (no) injurys (injuries) .foam noodles added to bed . Medical record review of the resident's care plan revealed on [DATE] .noodles to bed . had been added as an intervention for at risk for falls due to decrease in mobility. Medical record review of nurse's notes dated [DATE] at 12:30 PM, revealed Resident #7's bilateral knees were swollen and bruised. Further review revealed .on Dr.'s (physician) Board for today (indicating the resident was to be seen by the physician or Nurse Practitioner) . Medical record review of a physician's telephone order dated [DATE] at 1:30 PM, revealed an order for [REDACTED]. Medical record review of the radiology report dated [DATE] revealed .Impacted right knee fracture involving the distal femoral metaphysis .Impacted fracture (left) involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee) .Old internally fixated proximal tibial fracture . Continued review revealed the Director of Nursing (DON) was notified of the results of the x-ray on [DATE] at 9:10 PM, and the family was notified of the results at 9:20 PM. Medical record review of nurse's notes dated [DATE] revealed the bilateral knees remained bruised. Medical record review of the office History and Physical completed by the orthopedic physician dated [DATE] revealed Resident #7 was complaining of pain only in her knees and legs, but it was quite significant. Continued review revealed both knees were swollen and deformed with some flexion. Resident #7 had some mild ecchymosis (bruising) around the knees. Further review revealed Resident #7 had significant osteoporotic appearing bone with significant arthritis and previous tibial hardware in both legs. The resident had bilateral distal femur fractures. The resident was admitted to the hospital due to the severity of the knee fractures. Medical record review of the hospital Death Summary dated [DATE], revealed Resident #7 .sustained bilateral distal femur fractures. She was in extreme pain at the time of admission and was initially admitted .She was normally non ambulatory however the fractures were extremely painful and they were repaired for palliative reasons .Palliative Care was consulted to discuss goals of care with the patient's family due to her severe debility and multiple comorbidities . The resident expired [DATE]. Interview with the Administrator on [DATE], at 9:00 AM, in the Conference Room, confirmed Resident #7 had a fall in (MONTH) (YEAR). Continued interview with the Administrator revealed when asked if the resident was assisted by 1 or 2 people, the Administrator stated only one. When asked how many staff members were to assist the resident the Administrator replied .2 . Telephone interview with the Nurse Practitioner (NP) on [DATE] at 9:25 AM, revealed she remembered Resident #7 had a fall. The NP stated she gave the order for the x-ray of the knees on [DATE] because the resident was still hurting. Telephone interview with CNA #8 on [DATE] at 10:55 AM, revealed she was making her last round around 6:45 AM on [DATE], and went to change Resident #7 when she noticed something on her sheet, so she decided she would change the sheet. CNA #8 stated the resident had always grabbed the hand rail to hold onto when she turned, but for some reason she did not get a grip on the hand rail. CNA #8 stated when she turned Resident #7 over to change the sheet, the resident fell to the floor and landed on her knees. CNA #8 stated she screamed for help and the nurse came in to assess the resident and then the staff put the resident back to bed. CNA #8 stated the resident was .shaking really bad and I couldn't even get her vital signs . CNA #8 stated the resident grabbed her knees after she fell . When CNA #8 was asked had she been turning Resident #7 by herself, the CNA responded she had always turned the resident by herself. When CNA #8 was asked how did she know if a resident was a 1 person or a 2 person assist for bed mobility or transfer, the CNA stated .by word of mouth .asked other CNAs . Interview with Registered Nurse (RN) #3 on [DATE] at 12:05 PM, in the Conference Room, revealed each nurses' station had a CNA binder book which had the Interdisciplinary Care Plans for the CNAs to follow, and included assistance needed for Activities of Daily Living (ADL). Interviews with 16 CNAs on [DATE] and [DATE] revealed all but 2 (CNA #8 and #11) knew about the CNA binders at each nurses' station and where to find the information needed for resident care. Interview with CNA #11 on [DATE] at 5:18 PM, at the 300 hall nurses' station, revealed he didn't use the care guides and didn't know anything about them. Interview with RN #2 on [DATE] at 11:30 AM, at a location outside the facility, revealed when she came to work on [DATE] for the 7:00 AM to 7:00 PM shift, she was informed Resident #7 rolled out of bed and had fallen to the floor. RN #2 stated she assessed the resident who complained of pain in the left shoulder and left hip, and obtained x-rays of the shoulder and hips. RN #2 stated the resident was in pain and would scream when moved or turned. Further interview with RN #2 revealed when she worked Sunday [DATE], the resident was still complaining of pain. Further interview with RN #2 confirmed the NP had not been made aware of the resident's complaints of knee pain until [DATE], when an order to obtain x-rays of the bilateral knees was given by the NP. Telephone interview with RN #4 on [DATE] at 1:00 PM, revealed the resident was alert with confusion at times. RN #4 stated on [DATE] the CNAs reported the resident would scream when she was turned. RN #4 stated she went in to talk with Resident #7 who stated her knees hurt her badly. RN #4 confirmed the resident was not seen by the physician or NP on [DATE] or [DATE]. Interview with CNA #4 on [DATE] at 10:50 AM, in the Resting Lounge, revealed when she turned the resident she would scream out in pain in her knees. The resident's knees were swollen and bruised. When she was working [DATE] and it was either [DATE] or [DATE] when she notified the nurse of the swelling and bruising of both knees of Resident #7. Telephone interview with the former DON (who was DON at time of the incident) on [DATE] at 10:15 AM, revealed he didn't remember anything about the incident. When asked if he was aware the resident was care planned for a 2 person assist during bed mobility, he replied she was a 2 person assist only for transfer from bed to chair. The former DON stated he did remember they implemented a practice change to deflate the air mattress before doing care and turning residents. Interview with the Regional Quality Specialist on [DATE] at 3:20 PM, in the Resting Lounge, revealed she was in the building at least monthly ,[DATE] days at a time. The duties of the Regional Quality Specialist included survey readiness, compliance, review of policies and procedures, and performance improvement plans. When asked when she became aware of the accident of [DATE], the Regional Quality Specialist stated on Monday [DATE] when she came into the facility. When the Regional Quality Specialist was asked what she would have expected when a CNA stated she was not aware of the CNA Care Guides which documented assistance needed for ADLs, the Regional Quality Specialist replied .would have expected all CNAs would have been in-serviced on the Care Guides . Interview with CNA #17 on [DATE] at 4:00 PM, in the upper 400 hall shower room, revealed when she took care of Resident #7 she observed the knees swollen and the resident told the CNA she had fallen out of bed. CNA #17 reported to RN #4 about the knees being swollen and pain on turning and was informed the RN had been instructed to add the resident to the doctor's board by the ADON. CNA #17 confirmed both knees were swollen and the resident complained of a lot of pain on [DATE]. Interview with CNA #18 on [DATE] at 4:15 PM, in the upper 400 hall shower room, revealed Resident #7's legs and knees were swollen and she .screamed . when turned and would say .Oh Please, Please, Please . begging during changing. The CNA further stated she asked nursing everyday if anything had been done for the resident, such as an x-ray and was told no. Interview with the Administrator on [DATE] at 8:10 AM, in the Resting Lounge, revealed the facility discussed falls during the morning meetings and reviewed the 24 hour reports. The facility conducted a Risk Management meeting weekly where they went through all falls for the week. The Administrator stated their process .now . during the risk meeting was to look at interventions to see if the intervention was appropriate, pulling each chart, reviewing the nursing notes and trying to do a better and thorough job. The Administrator confirmed they were not doing this in-depth meeting at the time of Resident #7's accident. The Administrator confirmed if they had been doing the type of risk meeting they were doing now, including reading the nurses notes, they would have been aware of the accident. They would have included a teachable moment for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) CNA regarding use of the Care Guides and provided more staff education. The Administrator further stated she could not say at the time of the incident that they read the accident reports out loud or discussed the interventions during the meetings but .We do now . When asked when they started doing the new process regarding incident reports the Administrator stated it was after [DATE] when the previous DON left. Telephone interview with the Medical Director on [DATE] at 5:59 PM, revealed, when asked did he know about the bilateral fractures of Resident #7, he replied .this is the first I've heard right now . The MD confirmed all fractures should be called to the physician or the person on call. Interview with the Administrator on [DATE] at 9:00 AM, in the Administrator' Office, confirmed she became aware of the fall and fractures for Resident #7 when Adult Protective Services (APS) came in (MONTH) of (YEAR). The Administrator confirmed the incident resulting in bilateral fractures involving Resident #7 was not discussed for implementation of a corrective action plan.
F 0697 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review, facility investigation review, interview, and observation, the facility failed to ensure pain management was provided to 1 resident (#7) of 6 residents reviewed for accidents, after a fall which resulted in bilateral impacted knee fractures. The facility's failure to identify the cause of pain and provide interventions placed Resident #7 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The facility was cited F697 at a scope and severity of J, which constitutes Substandard Quality of Care (SQC). The Immediate Jeopardy (IJ) was effective [DATE] and is ongoing. The findings include: Medical record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of a Rheumatology Consultation dated [DATE] revealed .has symptoms of chronic widespread pain. She is exquisitely sensitive to any sort of palpation of her extremities, particularly her lower extremities .would put her under pain amplificatio[DIAGNOSES REDACTED] . Medical record review of the Medication Administration Record [REDACTED]. Medical record review of psychiatric recommendations and progress notes dated [DATE] revealed Resident #7 complained of pain as a 10 (extreme pain) on a scale of 1 to 10. Medical record review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident was coded 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Medical record review of Resident #7's MAR for (MONTH) (YEAR) revealed the resident had a pain assessment completed every shift (7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM) and the resident's pain was 0 every day until [DATE], after the resident was diagnosed with [REDACTED]. Review of the facility's incident report dated [DATE] at 6:45 AM, revealed Resident #7 .was noted to slide off air mattress on to the floor during a bed change. Review of the facility's investigation revealed a written statement completed by Certified Nursing Assistant (CNA) #8 dated [DATE], which stated .I was in the middle of changing patient sheets, when patient rolled over. She slid out of the bed and landed on her knees . Medical record review of the MAR indicated [REDACTED]. Medical record review of the (MONTH) MAR indicated [REDACTED]. Medical record review of Resident #7's (MONTH) (YEAR) MAR indicated [REDACTED]. Medical record review of nurse's notes dated [DATE] at 11:00 AM, revealed the resident complained of bilateral hip and left shoulder pain and x-rays were ordered. Medical record review of the radiology report dated [DATE] revealed no fracture or dislocation of the shoulder or hips was present. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of nurse's notes dated [DATE] at 12:10 PM, revealed Resident #7 still had complaints of pain related to the fall. Continued review revealed pain medication was given as ordered. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of nurse's notes dated [DATE] at 12:30 PM, revealed Resident #7's bilateral knees were swollen and bruised. Further review revealed .on Dr.'s (physician) Board for today (indicating the resident needed to be seen by the physician or the Nurse Practitioner) . Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of the (MONTH) MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of a physician's telephone order dated [DATE] at 1:30 PM, revealed an order for [REDACTED]. Medical record review of the radiology report dated [DATE] revealed .Impacted right knee fracture involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee) .Impacted fracture (left) involving the distal femoral metaphysis .Old internally fixated proximal tibial fracture . Continued review revealed the Director of Nursing (DON) was notified of the results of the x-ray on [DATE] at 9:10 PM. Review of the radiology report and nursing notes revealed no documentation the physician was notified. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of the (MONTH) (YEAR) MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of Resident #7's MAR indicated [REDACTED]. Medical record review of the (MONTH) (YEAR) MAR indicated [REDACTED]. Medical record review of the office History and Physical completed by the orthopedic physician dated [DATE] revealed Resident #7 was complaining of pain only in her knees and legs, but it was quite significant. The resident had bilateral distal femur fractures. The resident was admitted to the hospital due to the severity of the knee fractures. Medical record review of the hospital Death Summary dated [DATE], revealed Resident #7 .sustained bilateral distal femur fractures. She was in extreme pain at the time of admission and was initially admitted .the fractures were extremely painful and they were repaired for palliative reasons .Palliative Care was consulted to discuss goals of care with the patient's family due to her severe debility and multiple comorbidities . The resident expired [DATE]. Telephone interview with the Nurse Practitioner (NP) on [DATE] at 9:25 AM, revealed she remembered she gave the order for the x-ray of the knees on [DATE] because the resident was still having pain. Telephone interview with CNA #8 on [DATE] at 10:55 AM, revealed she was making her last round around 6:45 AM on [DATE], and went in to change the resident's bed sheet. CNA #8 stated when she turned Resident #7 over to change the sheet, the resident fell to the floor and landed on her knees. CNA #8 stated she screamed for help and the nurse came in to assess the resident and then they put the resident back to bed. CNA #8 stated the resident was .shaking really bad and I couldn't even get her vital signs . CNA #8 stated the resident grabbed her knees after she fell . Interview with Registered Nurse (RN) #2 on [DATE] at 11:30 AM, at a location outside the facility, revealed when she came in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0697 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 8) [DATE] (for the 7:00 AM to 7:00 PM shift) she was told Resident #7 rolled out of bed and had fallen to the floor. RN #2 stated she assessed the resident in the resident's room who complained of pain in the left shoulder and left hip. RN #2 stated the resident was in pain and would scream when moved or turned. Further interview with RN #2 revealed when she worked Sunday [DATE], the resident was still complaining of pain and she gave the resident pain medication to try to keep her comfortable. RN #2 further stated she knew Resident #7 was in pain. Continued interview with RN #2 revealed she was not working [DATE], [DATE], and [DATE]. RN #2 stated on [DATE] when she returned to work the resident still had not been seen by the Nurse Practitioner or the physician, but stated the NP was at the nurses' station so she asked if she could get x-rays of the knees of Resident #7. The nurse further revealed when she read the report on [DATE] from the bilateral knee x-rays she scheduled an appointment with an orthopedic surgeon for [DATE]. Further interview with RN #2 confirmed the NP had not been made aware of the resident's complaints of knee pain until [DATE]. Telephone interview with RN #4 on [DATE] at 1:00 PM, revealed the resident was alert with confusion at times. RN #4 stated Resident #7 was not a complainer and usually would not volunteer to tell you she was hurting. RN #4 stated on [DATE] the resident was in so much pain the CNAs reported the resident would scream when she was turned. RN #4 stated she went in to talk with Resident #7 who stated her knees hurt her badly. RN #4 stated both knees were swollen and black and blue. RN #4 stated at this time there was a sign posted at the nurse's station to notify the supervisor before calling the physician or NP so she went to the Assistant Director of Nursing (ADON) and reported the resident was in severe pain. RN #4 stated the ADON said they had done x-rays and they were all negative. RN #4 then replied .no, we have not x-rayed the knees . The ADON replied it was too late to call the physician and just place it on the Dr.'s Board (which is used to list residents who need to be seen by the physician or NP on the next visit) for the resident to be seen the next day. RN #4 stated on [DATE] she saw the physician and the NP in the facility but they never came to the floor to see Resident #7 and when she reminded the ADON Resident #7 needed to be seen, the ADON replied to her the physician and NP were not seeing residents that day. RN #4 confirmed the resident was not seen by the physician or NP on [DATE] or [DATE] when she was on duty. RN #4 further revealed Resident #4 was never a good eater, but after the incident the resident was not eating as much and the resident was in a lot of pain. RN #4 further confirmed she administered the resident pain medications that had been previously prescribed as much as possible to keep her comfortable. Interview with the Restorative Aide on [DATE] at 9:50 AM, in the Resting Lounge, revealed she had worked with Resident #7 multiple times doing Range of Motion (ROM). The Restorative Aide stated after the fall on [DATE] the resident didn't want her to do ROM on her legs at all because of the pain. The Restorative Aide stated the resident told her she had a fall and was in .so much pain . The Restorative Aide further stated the resident was also moaning and her complaint of pain was different from her normal baseline and .enough to get my attention . Interview with CNA #4 on [DATE] at 10:50 AM, in the Resting Lounge, revealed Resident #7 was never really one to complain of pain but would close her eyes and crunch up her face. CNA #4 stated before the fall when she would turn the resident, the resident would complain of pain, and maybe even more on rainy or cold days. But after the fall, the resident was in a lot of pain all the time. CNA #4 stated when she turned the resident, she would scream out in pain in her knees. The resident's knees were swollen and bruised. When asked if the complaint of pain was different after the fall the CNA replied .absolutely . CNA #4 stated the resident was screaming with intense pain especially on turning. CNA #4 stated the nurses told the CNAs they had been instructed to put the resident on the doctor's board and the pain could wait until the physician came. CNA #4 stated she felt the nurses on the floor and the CNAs did everything they could do but the lady .laid there several days in pain . Telephone interview with the former DON (who was DON at time of the accident) on [DATE] at 10:15 AM, confirmed he was notified several days after the fall the resident was having a lot of pain. During observation and interview with RN #4 on [DATE] at 12:10 PM, in the Resting Lounge, RN #4 presented a copy of the physician board sheet which revealed a notation dated [DATE] for Resident #7 XXX,[DATE] S/P (status [REDACTED]. RN #4 confirmed she saw a big change in Resident #4 after the fall where she didn't eat as well and she didn't want to be changed because of the pain. Interview with the Regional Quality Specialist on [DATE] at 3:20 PM, in the Resting Lounge, revealed she was in the building at least monthly ,[DATE] days at a time. When asked what she would have expected the nursing staff to do when the resident continued to complain of pain the Regional Quality Specialist replied .would have expected a call placed to the provider . Telephone interview with the attending physician (Medical Doctor) on [DATE] at 3:45 PM, revealed when asked what he would have expected the nursing staff to do for any increased pain, the MD stated he would expect to be called for any changes. The MD further confirmed he did not remember the facility calling him for any changes to Resident #7. Interview with CNA #17 on [DATE] at 4:00 PM, in the upper 400 hall shower room, revealed when she took care of Resident #7 she observed the knees swollen and the resident told the CNA she had fallen out of bed. CNA #17 reported to RN #4 about the resident's pain on turning and was informed the RN had been instructed to put it on the doctor's board by the ADON. CNA #17 confirmed the resident complained of a lot of pain on [DATE]. CNA #17 asked nursing again on [DATE] and was told the doctor had still not seen the resident. Interview with CNA #18 on [DATE] at 4:15 PM, in the upper 400 hall shower room, revealed Resident #7's legs and knees were swollen and she .screamed . when turned and would say .Oh Please, Please, Please . begging during changing. The CNA further stated she asked nursing everyday if anything had been done for the resident, and was told no. Interview with RN #2 on [DATE] at 5:45 PM, at the 400 hall nurses' station, revealed when she left on [DATE] the results of the x-rays of the bilateral knees for Resident #7 had not returned. She returned to work on [DATE], read the x-ray results, was in contact with the DON per text messaging, and an appointment was made for [DATE]. When RN #2 was asked how Resident #7 was during [DATE] until the doctor appointment on [DATE], the RN replied the same. RN #2 stated they (nursing) kept the resident comfortable with the [MEDICATION NAME], and [MEDICATION NAME] the resident was prescribed prior to the fall. In summary, Resident #7 experienced an avoidable accident on [DATE]. From [DATE] until [DATE] Resident #7 experienced significant increase in pain from her baseline level. On [DATE] an x-ray was completed on the bilateral knees indicating bilateral knee fractures. Resident #7 was not seen by a physician at the facility from [DATE] through [DATE], when she was sent out to see an orthopedic physician, and the facility failed to provide interventions to address the cause of newly increased pain, bilateral leg fractures from a fall on [DATE]. Resident #7 was admitted to the hospital from the orthopedic physician's office for repair of the fractures and palliative care. The resident expired on [DATE].
F 0777 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review, review a facility incident report, interview, and observation, the facility failed to obtain an order by the physician or Nurse Practitioner (NP) prior to obtaining x-rays and failed to promptly notify the ordering physician or NP the results of the x-rays, for 1 resident (#7) of 8 sampled residents. Failure to obtain a physician's orders [REDACTED].#7 experiencing pain, and placed Resident #7 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The Immediate Jeopardy (IJ) was effective 11/11/17 and is ongoing. The findings include: Medical record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the facility's incident report dated 11/11/17 at 6:45 AM, revealed Resident #7 .was noted to slide off air mattress on to the floor during a bed change .no injury noted . Medical record review of nurse's notes dated 11/11/17 at 11:00 AM, revealed the resident complained of bilateral hip and left shoulder pain and x-rays had been ordered. Medical record review of a telephone order dated 11/11/17, at 10:45 AM, revealed Bilateral hips & (and) L (left) shoulder x-ray .fall .VORB (verbal order read back) (name of the Director of Nursing). Continued review of the order revealed the order was a verbal order written by a Registered Nurse and given by the Director of Nursing (DON). Further review revealed the order was signed by the Nurse Practitioner (NP) on 11/16/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0777 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) Medical record review of the radiology report for the shoulder and hip x-rays dated 11/11/17 revealed no fracture or dislocation. Medical record review of a physician's telephone order dated 11/16/17 at 1:30 PM, revealed a verbal order from the NP for x-ray of bilateral knees. Medical record review of the radiology report dated 11/16/17 revealed .Impacted right knee fracture involving the distal femoral metaphysis .Impacted fracture (left) involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee) .Old internally fixated proximal tibial fracture . Medical record review of a nursing progress note dated 11/16/17 revealed the DON was notified of the results of the x-ray on 11/16/17 at 9:10 PM, and the family was notified of the results at 9:20 PM. Further review of the radiology report and nursing notes revealed no documentation the physician or NP were notified of the results of the radiology report indicating the resident had fractures. Telephone interview with the Nurse Practitioner (NP) on 7/10/18 at 9:25 AM, revealed she remembered giving the order for the x-ray of the knees on 11/16/17 because the resident was still hurting. Interview with RN #2 on 7/10/18 at 11:30 AM, at a location outside the facility, revealed when she came to work 11/11/17 for the 7:00 AM to 7:00 PM shift she was told Resident #7 rolled out of bed and had fallen to the floor. RN #2 stated she assessed the resident who complained of pain in the left shoulder and left hip, so she texted the DON at 9:30 AM and was given verbal permission to obtain x-rays of the shoulder and bilateral hips from the DON. Continued interview with RN #2 revealed she was not working 11/13/17, 11/14/17, and 11/15/17. RN #2 stated on 11/16/17, when she returned to work, the resident still had not been seen by the NP or the physician, but the NP was at the nurses' station so she asked the NP if she could get x-rays of the knees of Resident #7. Telephone interview with the former DON (who was DON at time of the incident) on 7/11/18 at 10:15 AM, revealed he did remember several days after the fall, when he was made aware the resident was having a lot of pain and her knees were swollen and bruised, he instructed the nurses to get x-rays. Observation and interview with RN #4 on 7/11/18 at 12:10 PM, in the Resting Lounge, revealed she presented a sign she stated she took down from the nurses station which read .Staff are never to call Dr. (Medical Doctor) or his NP until contact has been made with the on-call Nurse Mgr. (manager). If you have questions about this see (DON) or (ADON). The DON's name was typed on the bottom. Continued interview with RN #4 revealed the nurses were to call management first. Telephone interview with the attending physician on 7/11/18 at 3:45 PM, revealed he did not remember the facility calling him for any changes to Resident #7 or for any further orders. Interview with RN #2 on 7/13/18 at 5:45 PM, at the 400 hall nurses' station, revealed when she left work on 11/16/17, the results of the x-rays of the bilateral knees for Resident #7 had not returned. RN #2 stated when she returned to work on 11/17/18, she read the x-ray results and was in contact with the DON per text messaging. Further interview revealed she did not contact the physician or the NP with the results. Telephone interview with the Medical Director, who was the resident's attending physician, on 7/13/18 at 5:59 PM, revealed when asked did he know about the bilateral fractures of Resident #7 he replied .this is the first I've heard right now . When asked if he would have expected to be notified, the physician replied all fractures should be called to the physician or the person on call. Interview with the Administrator on 7/13/18 at 6:05 PM, at the 400 hall nurses' station, revealed when shown the nurses' notes dated 11/16/17, with the results of the knee x-rays, the Administrator confirmed the physician was not noted as being notified. Telephone interview with the NP on 7/13/18 at 9:11 PM, revealed the NP had researched her notes related to Resident #7 and found no notation of being notified of the results of bilateral knee x-rays. Interview with the Administrator on 7/14/18 at 9:00 AM, in the Administrator's Office, confirmed during review of nursing notes for 11/16/17 and 11/17/17, the Administrator did not see any documentation the physician or NP had been notified of the results of the bilateral knee x-rays. The Administrator replied .don't see anything .
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on facility policy review, facility investigation review, interview, and observation, the Administrator failed to ensure facility policies were implemented, physicians were notified timely of changes in condition, and residents were free from neglect, avoidable accidents, and pain. The Administrator's failure resulted in a resident having an avoidable accident and a delay in receiving services and treatment after a fall with fractures, with Resident #7 experiencing intense pain, and placing Resident #7 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The Immediate Jeopardy (IJ) was effective [DATE] and is ongoing. The findings include: Review of the facility's policy Change in a Resident's Condition or Status dated [DATE] revealed .1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician and the resident's representative when there has been .d. A significant change in the resident's physical/emotional/mental condition; that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications .2. A significant change of condition is a decline or improvement in the resident's status . Review of the facility's policy titled Abuse Prevention/Reporting Policy and Procedure dated (YEAR) revealed .7. Neglect: the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress . Medical record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident was coded 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Further review revealed the resident required extensive assistance of 2 staff for bed mobility (how resident moves to and from lying position, turns side to side) Review of the facility's incident report and investigation dated [DATE] at 6:45 AM, revealed Certified Nursing Assistant (CNA) #8 was changing Resident #7's bed linen without assistance of a second staff person, and Resident #7 fell in the floor landing on her knees. Medical record review of the resident's nursing notes and Medication Administration Record [REDACTED]. Further review revealed the physician nor Nurse Practitioner (NP) was notified of the resident having pain, bruising or swelling in her knees and was not assessed at any time after the fall by the physician or NP. Medical record review of a physician's telephone order dated [DATE] at 1:30 PM, revealed an order for [REDACTED]. Medical record review of the radiology report dated [DATE] revealed .Impacted right knee fracture involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee) .Impacted fracture (left) involving the distal femoral metaphysis .Old internally fixated proximal tibial fracture . Medical record review of nursing notes, radiology reports, and physician's orders revealed the Director of Nursing (DON) was notified of the results of the x-ray on [DATE] at 9:10 PM, and the family was notified of the results at 9:20 PM, but there was no documentation the physician or NP was notified of the results. Further review revealed Registered Nurse (RN) arranged an appointment with an orthopedic physician for [DATE] and there was no physician's order for the orthopedic consult. Medical record review of the nursing notes and MAR for [DATE] through [DATE] revealed the resident continued to experience pain, swelling, and bruising in her knees and legs. Further review revealed no documentation the physician or NP was notified of the pain or results of the x-rays, and no documentation the resident was assessed by the physician or NP. Medical record review of the office History and Physical completed by the orthopedic physician dated [DATE] revealed Resident #7 was complaining of pain only in her knees and legs, but it is quite significant. Continued review revealed both knees were swollen and deformed with some flexion. Resident #7 had some mild ecchymosis (bruising) around the knees. The resident had bilateral distal femur fractures. The resident was admitted to the hospital due to the severity of the knee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) fractures. Medical record review of the hospital Death Summary by the orthopedic surgeon dated [DATE] revealed Resident #7 .sustained bilateral distal femur fractures. She was in extreme pain at the time of admission and was initially admitted .She was normally non ambulatory however the fractures were extremely painful and they were repaired for palliative reasons .Palliative Care was consulted to discuss goals of care with the patient's family due to her severe debility and multiple comorbidities . The resident expired [DATE]. Interviews with CNA #8, RN #2, RN #4, CNA #4 during investigation [DATE] - [DATE] revealed the resident continued to complain of severe pain and staff reported the resident's condition to the DON and Assistant Director of Nursing (ADON), who failed to ensure the physician or NP was notified of the resident's condition and assessed the resident. Staff interviews revealed the physician and NP were not notified of the resident's pain or results of the x-rays indicating the resident had bilateral fractures, and the physician and NP did not assess the resident. Telephone interview with the former DON (who was DON at time of the incident) on [DATE] at 10:15 AM, revealed he didn't remember anything about Resident #7's accident. Continued interview with the DON revealed he did remember several days after Resident #7's fall when he was made aware the resident was having a lot of pain. Observation and interview with RN #4 on [DATE] at 12:10 PM, in the Resting Lounge, revealed she presented a sign she stated she took down from the nurses station which read .Staff are never to call Dr. (Medical Director) or his NP until contact has been made with the on-call Nurse Mgr. (manager). If you have questions about this see (DON) or (ADON). The DON's name was typed on the bottom. RN #4 also presented a copy of the physician board sheet which revealed a notation dated [DATE] for Resident #7 XXX,[DATE] S/P (status [REDACTED]. Continued interview with RN #4 revealed the nurses were to call management first. Telephone interview with the attending physician on [DATE] at 3:45 PM, revealed when asked what he would have expected the nursing staff to do for any change in resident status including increased pain or swelling and bruising of both knees, the physician stated he would expect to be called for any changes. The MD further confirmed he did not remember the facility calling him for any changes to Resident #7. Interview with the Administrator on [DATE] at 8:10 AM, in the Resting Lounge, revealed she had not seen the sign hanging at the nursing station to call the nurse supervisor before calling the physician or NP. Telephone interview with the Medical Director, who was the resident's attending physician, on [DATE] at 5:59 PM, revealed when asked when did he know about the bilateral fractures of Resident #7, he replied .this is the first I've heard right now . When asked if he would have expected to be notified, the physician replied all fractures should be called to the physician or the person on call. Interview with the Administrator on [DATE] at 9:00 AM, in the Administrator' Office, confirmed during observation of nursing notes for [DATE] and [DATE] the Administrator did not see any documentation the physician or NP had been notified of the results of the bilateral knee x-rays. The Administrator replied .don't see anything . When asked when she became aware of the fall and fractures related to Resident #7, the Administrator replied when Adult Protective Services (APS) came in (MONTH) of (YEAR). The Administrator stated she didn't remember if she was present or not at the facility for the morning meeting when the fall should have been discussed, but at the time of the fall they were not reading the incidents out loud and the assumption was the DON was looking at all nursing notes of residents with falls. Continued interview with the Administrator confirmed, when asked if the documentation showed the physician or the NP had been made aware of the results of the bilateral knee x-rays, the Administrator shook her head back and forth and said .no . Further interview with the Administrator revealed QA meetings were conducted on [DATE] and [DATE] at which time only number of incidents and location of the incidents were presented. Continued interview revealed no fractures were reported during these meetings.
F 0837 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on medical record review, facility investigation review, observation, and interviews, the governing body failed to ensure implemention of policies regarding the management and operation of the facility. The governing body's failure placed 1 resident (#7) of 6 residents of 8 residents reviewed for accidents and incidents in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Immediate Jeopardy (IJ) was effective [DATE] and is ongoing. The findings include: Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Minimum Data Set ((MDS) dated [DATE] revealed the resident required extensive assist of 2 staff for bed mobility which include turning from side to side. Medical record review of the care plan updated [DATE] revealed Resident #7 required extensive assistance of 2 for bed mobility. During the survey conducted [DATE] - [DATE], investigation revealed on [DATE] at 6:45 AM, Resident #7 was turned in bed by 1 Certified Nursing Assistant (CNA), instead of 2 CNAs as required, and the resident fell to the floor, landing on her knees. The nurse gave the resident Tylenol for knee pain. X-rays were completed on [DATE] of bilateral hips and left shoulder. The results of the x-rays were negative. Resident #7 continued to complain of pain, especially on turning. Interview with Registered Nurse (RN) #4 on [DATE] revealed on [DATE] Resident #7 was in so much pain the CNAs reported the resident would scream when she was turned. RN #4 assessed Resident #7 and found both knees to be swollen and bruised. According to RN #4 on [DATE] a sign was posted at the nurses station to call the supervisor before calling the physician or the Nurse Practitioner (NP), so RN #4 reported to the Assistant Director of Nursing (ADON) who instructed the nurse to place a note on the Dr's Board (list for physician or NP know the residents needed to be seen the next visit). The physician and the NP were in the facility on [DATE] but did not see Resident #7. Resident #7 continued to have pain on turning from [DATE] until on [DATE], when RN #2 approached the NP, who was at the nursing station and bilateral knee x-rays were ordered. Results of the bilateral knee x-rays revealed bilateral knee fracture involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee). Neither the physician nor the NP were notified of the results of the bilateral knee x-rays. The Director of Nursing (DON) instructed RN #2 by text messaging to make an orthopedic physician's appointment without a physician's orders [REDACTED]. Resident #7 expired on [DATE]. Interview with the Regional Quality Specialist on [DATE] revealed she was in the facility monthly at least ,[DATE] days at a time. Continued interview with the Regional Quality Specialist revealed her duties while in the facility included survey readiness, compliance of policies and procedures, system breakdown, and performance improvement plans. Further interview revealed the Regional Quality Specialist was unaware of the sign hanging at the nurses' station not to call the physician or NP before calling the nursing supervisor. Continued interview revealed the Regional Quality Specialist was to be notified of all fractures but was unaware of the fractures to Resident #7 until [DATE]. When the Regional Quality Specialist was asked what she would have expected the nursing staff to do when the resident continued to complain of pain and especially with the knees swollen and bruised, the Regional Quality Specialist replied she .would have expected a call placed to the provider . When the Regional Quality Specialist was asked what she would have expected when a CNA stated she was not aware of the CNA Care Guides which documented assistance needed for Activities of Daily Living, the Regional Quality Specialist replied .would have expected all CNAs would have been in-serviced on the Care Guides .
F 0867 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** >

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445114	A. BUILDING _____ B. WING _____	07/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMORELAND HEALTH AND REHABILITATION CENTER	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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 0867 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) Based on facility policy review, review of facility investigation, review of Quality Assurance and Performance Improvement (QAPI) meeting documentation, and interview, the QAPI committee failed to identify and correct quality deficiencies resulting in an avoidable accident where Resident #7 rolled out of bed during care and received bilateral leg fractures that were not identified for 5 days and the resident was not assessed and treated by a physician for another 4 days after x-ray results. The QAPI's failure placed 1 resident (#7) of residents reviewed in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The Immediate Jeopardy (IJ) was effective on [DATE] and is ongoing. The findings include: Review of the facility's policy titled Abuse Prevention/Reporting Policy and Procedure dated (YEAR) revealed .7. Neglect: the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress . Review of the facility's policy titled Change in a Resident's Condition or Status dated [DATE] revealed .1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician and the resident's representative when there has been .d. A significant change in the resident's physical/emotional/mental condition; that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications .2. A significant change of condition is a decline or improvement in the resident's status . Medical record review revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed the resident was coded 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Further review revealed the resident required extensive assistance of 2 staff for bed mobility (how resident moves to and from lying position, turns side to side). Review of the facility's incident report dated [DATE] at 6:45 AM, revealed Resident #7 .was noted to slide off air mattress on to the floor during a bed change .Two Certified Nursing Assistants (CNAs) will be needed to turn resident on air mattress to prevent further falls . Further review revealed Resident #7 required 2 person assist with bed mobility prior to the incident. Review of the facility's investigation revealed a written statement completed by CNA #8 dated [DATE], which stated .I was in the middle of changing patient sheets, when patient rolled over. She slid out of the bed and landed on her knees and fell toward her left side and did not hit her head . Medical record review of a physician's telephone order dated [DATE] at 1:30 PM, revealed an order for [REDACTED]. Medical record review of the radiology report dated [DATE] revealed .Impacted right knee fracture involving the distal femoral metaphysis .Impacted fracture (left) involving the distal femoral metaphysis (fracture in the area where the long bone femur of the upper leg meets the knee) .Old internally fixated proximal tibial fracture . Medical record review of the office History and Physical completed by the orthopedic physician dated [DATE] revealed Resident #7 was complaining of pain only in her knees and legs, but it was quite significant. Continued review revealed both knees were swollen and deformed with some flexion. Resident #7 had some mild ecchymosis (bruising) around the knees. The resident had bilateral distal femur fractures and was admitted to the hospital due to the severity of the knee fractures. Medical record review of the hospital Death Summary dated [DATE] revealed Resident #7 .sustained bilateral distal femur fractures. She was in extreme pain at the time of admission and was initially admitted .She was normally non ambulatory however the fractures were extremely painful and they were repaired for palliative reasons .Palliative Care was consulted to discuss goals of care with the patient's family due to her severe debility and multiple comorbidities . The resident expired [DATE]. Interview with the Administrator on [DATE] at 8:10 AM, in the Resting Lounge, revealed the facility conducted Quality Assurance meetings monthly with the Administrator, Director of Nursing (DON), Staff Development Coordinator, Medical Director, Dietary Manager, Social Services, Activities, Infection Control Director, Rehab Director, Human Resources, Medical Records Director, Registered Dietician, MDS Coordinator, Maintenance Director, a CNA, a Nurse, Respiratory Therapist, Wound Care Nurse, and Pharmacy Consultant (at least quarterly). The Administrator stated they go through each department, investigations, customer satisfaction, family satisfaction, revised policies, discharges, falls, and trends. The Administrator stated they discussed falls during the morning meetings and reviewed the 24 hour reports. The facility conducted a Risk Management meeting weekly where they go through all falls for the week. The Administrator stated .now . during the risk meeting they were looking at interventions to see if the intervention was appropriate, pulling each chart, reviewing the nursing notes, and trying to do a better and through job. The Administrator stated they were not doing this in-depth meeting when the previous DON was at the facility at the time of Resident #7's fall. The Administrator confirmed if they had been doing the type of risk meeting they were doing now, including reading the nurses notes, they would have been aware of the accident and the days following the accident, including the resident's continued complaints of pain with the swelling and bruising of both knees. Further interview with the Administrator confirmed if they had been doing the new process at the time of the incident they would have also included a teachable moment for the CNA regarding use of the Care Guides and provided more staff education. The Administrator further stated she was not sure at the time if they read the incident reports out loud or discussed the interventions during the meetings but .We do now . When asked when the new process for reviewing incidents started the Administrator replied after [DATE] when the prior DON left. The Administrator stated we review verbally now, including nursing notes for days after an incident, but the previous DON did not see the value in doing this process. Telephone interview with the Medical Director on [DATE] at 5:59 PM, revealed when asked did he know about the bilateral fractures of Resident #7, he replied .this is the first I've heard right now . Interview with the Administrator on [DATE] at 9:00 AM, in the Administrator's Office, revealed when asked when she became aware of the fall and fractures related to Resident #7, the Administrator replied when Adult Protective Services came in (MONTH) of (YEAR). The Administrator stated she didn't remember if she was present or not at the facility for the morning meeting when the fall should have been discussed, but at the time of the fall they were not reading the incidents out loud, and the assumption was the DON was looking at all nursing notes of residents with falls. Continued interview revealed the facility conducted QA meetings on [DATE] and [DATE], at which time only numbers and locations of accidents and incidents was presented. Further interview confirmed no fractures were reported to the committee at either committee meeting and the facility had not made any type of systemic correction or performance improvement related to the events involving Resident #7 on [DATE].