STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395512	A. BUILDING _____ B. WING _____	09/18/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-SUNBURY	901 COURT STREET SUNBURY, PA 17801

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 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on review of select facility policies and procedures, closed clinical record review, and staff and resident interview, it was determined that the facility failed to thoroughly investigate a resident's serious bodily injury to rule out potential abuse for one of six residents reviewed (Resident CR1). Findings include: The facility policy entitled, 7 Step Abuse Policy, last reviewed without changes on (MONTH) 28, (YEAR), revealed that incidents are logged to review patterns and/or trends to be identified which may constitute abuse, neglect, or misappropriation. Serious injuries of unknown origin will be reported to the DOH (Department of Health) immediately by the Abuse Prevention Coordinator/designee via the electronic reporting system. The supervisor will initiate the investigation immediately by conducting interviews of staff, resident, and visitors who have reasonable likelihood of knowledge of the incident over the last 24 hours as well as record review and consultation by other disciplines and medical personnel. In the case of incidents of unknown origin, staff having contact with the resident in the past 72 hours will be interviewed. Signed written statements will be obtained to rule out abuse or to determine the cause of the injury. Any allegation of abuse and/or neglect will be reported to the Department of Health via the electronic reporting system and Office of Aging within 24 hours. Telephone interview with Resident CR1 on (MONTH) 19, (YEAR), at 8:45 AM revealed that during therapy exercises on (MONTH) 9, (YEAR), Resident CR1 was unable to complete a transfer from sitting in her wheelchair to standing between the parallel bars. Resident CR1 stated that she lowered herself to her wheelchair; however, she was in a bent position with her right arm holding onto the parallel bar. Resident CR1 was unable to utilize her left arm due to a previous fracture. Resident CR1 stated that she asked therapy staff to help her to a normal sitting position; however, was told, You can get up, go ahead and do it. Resident CR1 stated that she reiterated to the staff that she had no strength to perform the activity, but the staff, just left me hang. Resident CR1 stated that after some time of her repeating that she could not sit upright unassisted, a female therapy staff member (named by first name only) pulled her right arm from the parallel bar at which time she heard a pop, felt pain, and stated, Oh my God, you broke my arm. Interview with the Director of Nursing on (MONTH) 18, (YEAR), at 9:30 AM revealed that the facility had no investigations relating to Resident CR1 in (YEAR). Closed clinical record review for Resident CR1 revealed nursing documentation dated (MONTH) 9, (YEAR), at 11:54 AM indicating that Resident CR1 had complaints of pain in her right arm. Therapy reported hearing a cracking sound when Resident CR1 was working on pushing herself up. Resident CR1 was crying and worried about not being able to use both arms (as she currently had a fractured left arm). Staff made Resident CR1's physician aware and obtained new orders for a right humeral x-ray. Nursing documentation dated (MONTH) 9, (YEAR), at 2:39 PM, revealed that the results of the x-ray indicated a non-displaced acute [MEDICAL CONDITION] of the humerus. The documentation indicated that the facility obtained an orthopedic consult for 3:30 PM that day (February 9, (YEAR)). A physical therapy progress note dated (MONTH) 9, (YEAR), revealed that Resident CR1 requested the therapist to assist her to stand in parallel bars. Resident CR1 was unable to complete the stand and sat down in her wheelchair. While Resident CR1 attempted to use her right arm and lower extremities to scoot back in the wheelchair for appropriate position, an audible crack was heard from her right upper extremity. Interview with the Director of Nursing on (MONTH) 18, (YEAR), at 12:45 PM and 2:00 PM revealed that the facility had a one page incident report dated (MONTH) 17, (YEAR), at 2:53 PM (printed (MONTH) 18, (YEAR), at 9:44 AM) regarding a right humerus fracture that Resident CR1 sustained in the therapy gym on (MONTH) 9, (YEAR), at 10:30 AM. The interview confirmed that the facility had no evidence of a complete investigation of Resident CR1's fracture that would include witness statements. During an exit interview with Employee 1 (corporate regional educator), Employee 2 (business development specialist/administrator-in-training), Employee 3 (registered nurse unit manager), and the Director of Nursing, on (MONTH) 18, (YEAR), at 3:25 PM the facility provided a statement from an occupational therapy assistant dated (MONTH) 10, (YEAR), detailing the events of Resident CR1's fracture. The statement indicated that no therapy staff touched Resident CR1 at the time that her arm appeared to give out. The interview confirmed that the facility had no evidence that staff obtained Resident CR1's statement, or the statement from the other three therapists, regarding the details of the incident. The interview confirmed that the facility did not report Resident CR1's fracture to the local field office as required. The facility failed to identify, or thoroughly investigate, Resident CR1's incident by failing to obtain a statement from Resident CR1 following her fracture; thus, failing to identify the discrepancies in Resident CR1's statement (that staff removed her arm from the parallel bar causing the fracture) versus the one occupational therapist's statement (that indicated no staff touched Resident CR1). The facility failed to initiate an investigation timely based on the eight day delay from the date of the incident to the date of the incident report. 28 Pa. Code 201.18(e)(1) Management Previously cited 1/6/17 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(3) Nursing services Previously cited 1/6/17, 9/6/16, 2/5/16
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to implement interventions to prevent a resident accident, which resulted in serious injury (fractured left hip) for one of six residents reviewed (Resident 13).

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

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

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Findings include: The facility policy entitled, Falls Practice Guide, last reviewed without changes on (MONTH) 28, (YEAR), indicated that fall management focuses on minimizing fall risk factors and fall related injuries while continuing to promote the patient's quality of life. The center utilizes the APIE (Assess, Plan, Implement, and Evaluate) framework as a systematic method to identify risk, select interventions to reduce the risk, and monitor the effect on risk reduction. The comprehensive care plan approaches for fall interventions are clear, specific, and individualized for the patient's needs. Clinical record review for Resident 13 revealed nursing documentation dated (MONTH) 13, (YEAR), at 10:05 AM indicating that at 10:00 AM, staff notified the registered nurse of Resident 13's fall. Resident 13 was seated on the floor. Resident 13 sustained a superficial abrasion on her back measuring 1.5 cm (centimeters) by 1.5 cm. Review of the facility's investigation of Resident 13's fall on (MONTH) 13, (YEAR), revealed that the conclusions (interventions) developed by the facility to prevent recurrence of falls included to offer to walk with Resident 13 if the resident is becoming restless in her chair. Review of Resident 13's plan of care developed by the facility to address the resident falls dated (MONTH) 2, (YEAR), revealed that staff added the intervention to take Resident 13 for a walk if the resident becomes restless in her chair on (MONTH) 14, (YEAR). Nursing documentation dated (MONTH) 15, (YEAR), at 5:20 PM revealed that staff called the registered nurse to assess Resident 13 because she had fallen. The licensed practical nurse reported that Resident 13 stood from her wheelchair in the hallway and fell forward landing on her right side with her head against the molding on the corner of the closet. Review of the facility's investigation of Resident 13's fall on (MONTH) 15, (YEAR), revealed that the timeline of events indicated that Resident 13 was in the dining room for dinner at 4:30 PM and in her wheelchair at the nurse's station in the hallway at 5:00 PM. Information obtained during the investigation indicated that Resident 13 had become very agitated after supper, pushing away from the table and attempting to throw a dinner plate at a staff member. The investigation did not obtain any evidence to indicate that staff offered to walk with Resident 13 when they identified her agitation before her fall (as per her care planned intervention following her fall on (MONTH) 13, (YEAR)). The actions taken by the facility during the investigation to prevent recurrence of falls included to provide Resident 13 with a table with activities to keep her occupied when seated in the hallway instead of sitting in the hall with nothing to do. Review of Resident 13's plan of care developed by the facility to address her falls dated (MONTH) 2, (YEAR), revealed that staff did not add the intervention to provide Resident 13 with activities to keep her occupied when she is sitting in the hallway for observation and safety until (MONTH) 30, (YEAR). Nursing documentation dated (MONTH) 18, (YEAR), at 7:45 PM revealed that staff called the registered nurse to the unit where she noted Resident 13 lying on the floor face down. Resident 13 sustained a contusion (bruise, collection of blood that seeped from blood vessels under the skin) above her right eye. Review of the facility's investigation of Resident 13's fall on (MONTH) 18, (YEAR), indicated that at 7:30 PM staff noted Resident 13 sitting in the hall in her wheelchair. At 7:45 PM, staff noted Resident 13 stand, attempt to reach back to wheelchair to sit down, and fall forward onto the floor. The investigation did not indicate any evidence that staff provided activities to keep Resident 13 occupied while sitting in the hallway. Actions taken by the staff following Resident 13's fall included giving her a doll to play with while she was in the hallway for supervision. The investigation indicated that the new intervention implemented to prevent recurrence was, .when becoming restless in w/c (wheelchair) take resident for a walk . The investigation failed to identify that this intervention was already a part of Resident 13's plan of care as of (MONTH) 14, (YEAR). Nursing documentation dated (MONTH) 30, (YEAR), at 1:20 PM revealed that Resident 13 was seated in her wheelchair in the hallway and staff observed her stand from the wheelchair, take a few steps to her right, and fall with her right side against a room doorway with her legs flexed. Resident 13 complained of slight discomfort when she lifted her left leg, but had displayed this discomfort at times prior to the fall. Nursing documentation dated (MONTH) 30, (YEAR), at 1:48 PM revealed that following the fall, staff took Resident 13 to the bathroom where they noted her to be incontinent of a small amount of urine and she also voided in the toilet at that time. Review of the facility's investigation into Resident 13's fall on (MONTH) 30, (YEAR), at 1:20 PM revealed that the timeline of events indicated the following: 10:28 AM toileted in bathroom 11:15 AM - 1:00 PM in the dining room for lunch and socializing 1:00 PM - 1:20 PM in the hallway at the nurse's station in her wheelchair 1:20 PM stood up by herself and fell The information obtained during the investigation determined that staff did not toilet Resident 13 after lunch per her toileting schedule. The actions taken during the investigation to prevent fall recurrence included providing activities to keep Resident 13 busy when she was seated in the hallway. The investigation failed to identify that this intervention was appropriate for Resident 13 after her fall on (MONTH) 15, (YEAR). The investigation did not obtain any evidence to indicate that staff provided activities to keep Resident 13 occupied while sitting in the hallway at the time of her fall. Review of Resident 13's plan of care to address her urinary and bowel incontinence (initiated (MONTH) 1, (YEAR)) confirmed that interventions included toileting after meals. Nursing documentation dated (MONTH) 1, (YEAR), at 12:32 PM revealed that staff reported Resident 13 complained of severe pain in her lower back and hips when they transferred her back to bed after lunch. Nursing documentation dated (MONTH) 1, (YEAR), at 6:21 PM revealed that staff obtained a physician's orders [REDACTED]. An X-ray report dated (MONTH) 1, (YEAR), concluded that the study results were suspicious of a minimally displaced fracture of the sub capital left femoral neck (left hip fracture). Nursing documentation dated (MONTH) 2, (YEAR), at 12:35 AM revealed that staff received the X-ray report and obtained a physician's orders [REDACTED]. Nursing documentation dated (MONTH) 2, (YEAR), at 1:03 PM revealed that the emergency room nurse informed the staff that Resident 13 was admitted with the [DIAGNOSES REDACTED]. Interview with the Director of Nursing on (MONTH) 18, (YEAR), at 2:00 PM reviewed the findings above. The interview confirmed that the facility had no further evidence that staff implemented interventions included in Resident 13's plan of care to prevent recurrent falls resulting in a hip fracture. 483.25(d)(1)(2)(n)(1)-(3) Free of Accident Hazards/supervision/devices Previously cited deficiency 1/6/17, 2/5/16 28 Pa. Code 211.12(d)(1)(5) Nursing services Previously cited 1/6/17, 9/6/16, 7/27/16, 2/5/16