STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445408	A. BUILDING _____ B. WING _____	07/10/2012

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SODDY-DAISY HEALTH CARE CENTER	701 SEQUOYAH ROAD SODDY-DAISY, TN 37379

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.**

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on medical record review, review of facility investigation, review of facility nursing shift reports, review of facility policy, observation, and interview, the facility failed to notify the attending Physician and/or Resident's Responsible Party of a fall, and a [MEDICAL CONDITION] distal femur (broken left thigh bone near the knee) for one (#1) of eleven residents reviewed. The facility's failure to notify the attending physician of resident #1's fall resulted in a delay of identifying and treating the [MEDICAL CONDITION] distal femur (Actual Harm).

The findings included:

Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].

Medical record review of a Physician's progress note [DIAGNOSES REDACTED]" and "c/o (complaint of) of [MEDICAL CONDITION]." Continued review revealed, "...appears somewhat confused...(resident) reports fall...no record of any fall in nursing notes...pain in both legs...pt (patient) with NIDDM (Non-Insulin Dependent [MEDICAL CONDITION]), History of OA ([MEDICAL CONDITION]), Psychoses, ? (questionable) PMR (Polymyalgia Rheumatica-muscle pain and stiffness)...c/o numbness in feet..." Continued review revealed [DIAGNOSES REDACTED].

Medical record review of a Physician's Telephone Order dated June 23, 2012, revealed an order for [MEDICATION ORDERS REDACTED]

Medical record review of a Nurse's Note dated June 23, 2012, at 2:41 p.m., revealed the Physician evaluated the resident due to complaints of [MEDICAL CONDITION].

Medical record review of a Nurse's Note dated June 26, 2012, at 2:34 a.m., revealed, "Charting for 12:45 a.m. This nurse (Registered Nurse (RN) #1) called to eval (evaluate) resident d/t (due to) increased pain and Lt. (left) upper leg swelling. Resident cries out in severe pain when leg is touched or with any movement. This nurse in to check resident Lt. leg swelling and old yellowish green bruises noted to left knee. Resident is unable to move (resident's) leg and cries when staff attempts to move (resident's) leg. This nurse asked resident what happened and (resident) stated "I fell in the bathroom and they had to get me up." Resident has not been getting up...as per (resident's) normal. Called...(Physician) at 1:00 a.m., and new order to send to the ER (emergency room) for eval of Lt. leg. Also order noted to give [MEDICATION NAME] (for moderate to severe pain) 5 mg (milligrams) SQ (subcutaneous-under the skin)...2:30 a.m., Ambulance service here to transport resident to (hospital) ER..."

Continued review of the Nurse's Notes dated June 26, 2012, at 2:42 a.m., revealed, LPN #2 assessed resident's left leg, "...Old bruising and swelling of the left leg and knee noted. Resident c/o pain to left leg. Supervisor (RN #1) notified."

Medical record review of a (hospital) radiology report of the left hip, dated June 26, 2012, revealed the resident had a comminuted (splintered or crushed) displaced left distal one-third [MEDICAL CONDITION] fracture (a traumatic break in the bone above the knee in which the two ends of the fractured bone are separated and out of their normal positions).

Medical record review of a Nurse's Note dated June 27, 2012, revealed the resident returned to the facility from the hospital on June 27, 2012, at 1:25 p.m. with [DIAGNOSES REDACTED].

Review of a facility investigation dated June 26, 2012, at 8:30 a.m., completed by the Staff Development Coordinator (SDC) and Assistant Director of Nursing (ADON) revealed, "...RN Supervisor (RN #1) assessed resident d/t increased pain, left leg swelling and bruising noted to left knee. MD (Medical Doctor) notified and resident sent to ER for evaluation and tx (treatment). Upon investigation it was found that on 6:00 p.m. to 6:00 a.m., shift on Friday June 22, 2012, a CNA (Certified Nursing Assistant-#1) reported to charge nurse (LPN #1) that resident was found in the bathroom floor..." Continued review of the investigation revealed the resident's Physician was not notified of the resident's fall on June 22, 2012, until June 26, 2012, at 1:00 a.m.; the resident's Responsible Party was not notified until June 26, 2012, at 1:25 a.m.

Review of a written statement dated June 25-26, 2012, by RN #1 revealed RN #1 was notified by LPN #2 of resident's increased pain and swelling of the left upper leg. RN #1's statement revealed the resident's left leg was swollen, with old yellow bruising. "Resident stated (resident) fell in...bathroom [ROOM NUMBER]-3 (two to three) days ago...but no report of a fall...(Physician) was here and checked resident on June 23, 2012...(Physician's) note states that resident also reported to (Physician) that (resident) fell but there was no nurses' notes to support resident's c/o...(Physician) was called at 1:00 a.m., and wanted (resident) to go to the ER and that (resident's) leg may be broken..." (Resident) started crying and stated "yes, it's broken...I fell in my bathroom between the wall and the commode..." RN #1 asked the resident if someone helped (resident) up, and resident stated "it was two women." RN #1 informed the resident of pain medication to be administered, and the resident "started crying" and stated "thank you."

Review of a written statement dated June 25, 2012, (beginning of June 25-26, 2012, night shift from 6:00 p.m.-6:00 a.m.) by LPN #2 revealed the resident's left leg was painful and swollen above and around the knee.

Review of a written statement (no date) by CNA #1, revealed on June 22, 2012, CNA #1 walked into the resident's room and heard a banging noise. CNA #1 opened the resident's bathroom door, found the resident sitting on the bathroom floor, banging the garbage can on the floor. "I ran and got the nurse (LPN #1), we picked (resident) up and then put (resident) in the bed."

Review of a written statement (no date) by LPN #1, revealed, "About 6:20 p.m., (no date) assisted (resident) to BR (bathroom)...call light on. When assisting (resident) back to w/c (wheelchair) (resident's) left leg went outward when wt. (weight) put on it. I was on (R) (right) side of pt. During the transfer pt. stated "my leg popped" 6:25 p.m., after assisting pt back to bed removed pants to check leg saw a knot with [MEDICAL CONDITION] (L) (left) leg above knee at back. Ask pt about knot stated "that has been there" No discoloration noted ROM (range of motion) intact...Assisted pt with personal care due to stress incontinet (incontinence). 7:30 p.m.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157	(continued... from page 1) Pt. up to BR per self in w/c transferred self to and from bed with no assistance. Cont (continued) taking self to BR with no assistance till (until) 6:00 a.m..." Medical record review revealed no documentation the resident fell on [DATE]. Continued review revealed no documentation the Physician and/or the Responsible Party was notified of the resident falling on June 22, 2012, until June 26, 2012. Review of the nursing shift-to-shift reports dated June 22, 23, 24, and 25, 2012, revealed no documentation of the resident having a fall on June 22, 2012, or Physician and/or the Responsible Party notification of the resident falling on June 22, 2012. Review of the facility "Protocol: Post Fall" (no date), revealed, "1. Assess the resident and implement appropriate measure to provide immediate care. Neurological checks to be done for all unwitnessed falls...2. Nursing to complete...a. Fall Tracking Form. b. Incident Report, to include vital signs, with lying and standing blood pressure. Incident Report and accident/event management protocol to be completed per nurse...c. FSI- Fall Scene Investigation Report (used to identify the root cause analysis). d. Change of status review. e. Resident Event Documentation...f. Pain Assessment...6. Discuss findings...with the resident and the Responsible Party..." Review of the facility policy "Accidents and Incidents-Investigating and Reporting" dated October 01, 2011, revealed, "Policy: All accidents or incidents involving residents...occurring at our facilities must be investigated and reported to the Administrator. Purpose: To ensure the safety of all residents...General Guidelines: 1. Reporting of Accidents/Incidents: a...must be reported to the department supervisor as soon as the accident/incident is discovered...b. An Incident Report Form must be completed for all reported accidents or incidents. d. The nurse supervisor/charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided...3. Medical Attention:...e. If the incident involves a resident, immediately contact the physician and responsible party of the incident... " Observation of the resident in the presence of the SDC, in the resident's room, on June 27, 2012, at 9:20 p.m., confirmed the resident was lying on the bed, with an immobilizer on the resident's left lower extremity, extending from the mid-thigh to the upper ankle. Yellow bruising extended laterally, above the immobilizer. Continued observation of the resident, in the resident's room, on July 10, 2012, confirmed the immobilizer was present on the resident's left lower extremity; with continued observation confirming the resident had one large yellow bruise on the lateral left thigh, measuring 12.5 inches by 11.0 inches. Within the yellow bruising were three separate purple bruises; (1) the upper lateral measured 4.5 inches by 4.5 inches, (2) the mid-lateral measured 5.0 inches by 3.0 inches, and (3) the lower lateral measured 3.0 inches by 1.5 inches. Interview with the SDC on June 27, 2012, at 4:30 p.m., in the conference room, confirmed upon arriving to work at the facility on June 26, 2012, at approximately 5:45 a.m., RN #1 gave report to the SDC. RN #1 reported on June 26, 2012, sometime around midnight (couldn't recall the exact time), the resident had increased complaints of pain with swelling in the left thigh; the resident alleged to have fallen and was assisted up by two females. The Physician was notified (sometime around midnight on June 26, 2012) and ordered the resident to be sent to the ER for an evaluation. An x-ray of the left hip was completed on June 26, 2012, at the hospital, and confirmed the resident had a left [MEDICAL CONDITION] fracture. The resident's chart was retrieved and reviewed; the Physician's progress note [DIAGNOSES REDACTED]. No Incident Report had been completed; and the resident's chart revealed no documentation of a fall. Interview with LPN #1, in the presence of the Administrator, on June 27, 2012, at 5:45 p.m., in the conference room, confirmed LPN #1 intentionally gave false and misleading information during the facility's investigation of the resident's left [MEDICAL CONDITION] fracture. LPN #1 confirmed the resident did have an unwitnessed fall on June 22, 2012, and at approximately 6:20 p.m., CNA #1 notified LPN #1 the resident was on the floor in the bathroom. LPN #1 and CNA #1 went to the resident's room to assist the resident up from the floor. LPN #1 confirmed the resident was sitting on the buttocks, with the knees bent upward. As the resident was assisted up, the resident complained of pain in the right foot, and LPN #1 heard the resident's left leg pop. When the surveyor asked if pain medication had been administered or if the Physician was notified, LPN #1 confirmed, "No...I didn't give any pain medication...No, I didn't call the Doctor or the resident's Responsible Party (family)...I know better...I knew better then...I knew what to do, I just didn't do it..." Continued interview confirmed the Physician was not notified of the resident's fall, complaint of pain, or of the left leg popping. LPN #1 confirmed when the SDC called (LPN #1) on June 26, 2012, and asked about the resident's left [MEDICAL CONDITION] fracture, "I intentionally deceived (SDC); I lied to (SDC) and (Administrator)...The written statement I gave to (Administrator) was false...I knew it was untruthful...I did not call the Physician and did not follow the facility's policies and procedures...I knew what to do...the resident was in the floor and I didn't do what I was supposed to do...I failed to follow the protocol and it's the patient that suffered." Interview with CNA #1, on June 27, 2012, at 8:30 p.m., via telephone, confirmed the resident fell on [DATE], after supper (unsure of exact time). CNA #1 went into the resident's room and heard a noise coming from the bathroom. Upon entering the bathroom, CNA #1 confirmed the resident was sitting on the bathroom floor, with the right leg extended outward and the left leg bent up under (resident's) bottom (buttocks). CNA #1 went and got LPN #1 and they went back into the resident's bathroom, got the resident up and into a wheelchair, then put the resident to bed. CNA #1 confirmed the resident verbalized complaints of knee pain, but the resident did not identify which knee was hurting. Continued interview with CNA #1 confirmed LPN #1 did not assess the resident, "Once the resident was in bed, we (CNA #1 and LPN #1) left (resident's) room together." Interview with the resident's attending Physician (Medical Director) on June 27, 2012, at 7:35 p.m., in the conference room, confirmed on June 23, 2012, the resident told the Physician, (resident) had fallen (did not state when). The Physician evaluated the resident, saw no [MEDICAL CONDITION] or discoloration; the resident complained of back and bilateral (both) leg pain. The Physician confirmed the resident had chronic pain secondary to generalized Arthritis. Upon the resident reporting the fall, the Physician confirmed to review the resident's chart and there was no documentation of a fall. Continued interview confirmed the Physician was not notified of any fall occurring recently, or on June 22, 2012. The Physician confirmed, "I expect to be notified of all falls...If I had gotten this information on the fall, I would have focused my examination on the (resident's) leg." Continued interview confirmed the facility's failure to notify the Physician of resident #1's fall resulted in a delay of identifying and treating the [MEDICAL CONDITION] distal femur. C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .
F 0224	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility investigation, review of facility nursing shift reports, review of facility policy, observation, and interview, the facility failed to follow facility policies to provide the necessary services, and prevent neglect for one (#1) resident with a left femur fracture after a fall, of eleven residents reviewed. The facility's failure to follow policies and prevent neglect resulted in a three-day delay of treatment for [DIAGNOSES REDACTED]. The findings included:

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F 0224	

(continued... from page 2)

Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED].

Medical record review of a Physician's progress note [DIAGNOSES REDACTED]" and "c/o (complaint of) of [MEDICAL CONDITION]." Continued review revealed, "...appears somewhat confused...(resident) reports fall...no record of any fall in nursing notes...pain in both legs...pt (patient) with NIDDM (Non-Insulin Dependent [MEDICAL CONDITION]), History of OA ([MEDICAL CONDITION]), Psychoses, ?
(questionable) PMR (Polymyalgia Rheumatica-muscle pain and stiffness)...c/o numbness in feet..." Continued review revealed [DIAGNOSES REDACTED].

Medical record review of a Physician's Telephone Order dated June 23, 2012, revealed an order for [MEDICATION ORDERS REDACTED]

Medical record review of a Nurse's Note dated June 23, 2012, at 2:41 p.m., revealed the Physician evaluated the resident due to complaints of [MEDICAL CONDITION].

Medical record review of a Nurse's Note dated June 26, 2012, at 2:34 a.m., revealed, "Charting for 12:45 a.m. This nurse (Registered Nurse (RN) #1) called to eval (evaluate) resident d/t (due to) increased pain and Lt. (left) upper leg swelling. Resident cries out in severe pain when leg is touched or with any movement. This nurse in to check resident Lt. leg swelling and old yellowish green bruises noted to left knee. Resident is unable to move (resident's) leg and cries when staff attempts to move (resident's) leg. This nurse asked resident what happened and (resident) stated "I fell in the bathroom and they had to get me up." Resident has not been getting up...as per (resident's) normal. Called...(Physician) at 1:00 a.m., and new order to send to the ER (emergency room) for eval of Lt. leg. Also order noted to give [MEDICATION NAME] (for moderate to severe pain) 5 mg (milligrams) SQ (subcutaneous-under the skin)...2:30 a.m., Ambulance service here to transport resident to (hospital) ER..."

Continued review of the Nurse's Notes dated June 26, 2012, at 2:42 a.m., revealed, LPN #2 assessed resident's left leg, "...Old bruising and swelling of the left leg and knee noted. Resident c/o pain to left leg. Supervisor (RN #1) notified."

Medical record review of a (hospital) radiology report of the left hip, dated June 26, 2012, revealed the resident had a comminuted (splintered or crushed) displaced left distal one-third [MEDICAL CONDITION] fracture (a traumatic break in the bone above the knee in which the two ends of the fractured bone are separated and out of their normal positions).

Medical record review of a Nurse's Note dated June 27, 2012, revealed the resident returned to the facility from the hospital on June 27, 2012, at 1:25 p.m. with [DIAGNOSES REDACTED].

Review of a facility investigation dated June 26, 2012, at 8:30 a.m., completed by the Staff Development Coordinator (SDC) and Assistant Director of Nursing (ADON) revealed, "...RN Supervisor (RN #1) assessed resident d/t increased pain, left leg swelling and bruising noted to left knee. MD (Medical Doctor) notified and resident sent to ER for evaluation and tx (treatment). Upon investigation it was found that on 6:00 p.m. to 6:00 a.m., shift on Friday June 22, 2012, a CNA (Certified Nursing Assistant) reported to charge nurse (LPN #1) that resident was found in the bathroom floor..." Continued review of the investigation revealed the resident's Physician was not notified of the resident's fall on June 22, 2012, until June 26, 2012, at 1:00 a.m.

Review of a written statement dated June 25-26, 2012, by RN #1 revealed RN #1 was notified by LPN #2 of resident's increased pain and swelling of the left upper leg. RN #1's statement revealed the resident's left leg was swollen, with old yellow bruising. "Resident stated (resident) fell in...bathroom [ROOM NUMBER]-3 (two to three) days ago...but no report of a fall...(Physician) was here and checked resident on June 23, 2012...(Physician's) note states that resident also reported to (Physician) that (resident) fell but there was no nurses' notes to support resident's c/o...(Physician) was called at 1:00 a.m., and wanted (resident) to go to the ER and that (resident's) leg may be broken..." (Resident) started crying and stated "yes, it's broken...I fell in my bathroom between the wall and the commode..." RN #1 asked the resident if someone helped (resident) up, and resident stated "it was two women." RN #1 informed the resident of pain medication to be administered, and the resident "started crying" and stated "thank you."

Review of a written statement dated June 25, 2012, (beginning of June 25-26, 2012, night shift from 6:00 p.m.-6:00 a.m.) by LPN #2 revealed the resident's left leg was painful and swollen above and around the knee.

Review of a written statement (no date) by CNA #1, revealed on June 22, 2012, CNA #1 walked into the resident's room and heard a banging noise. CNA #1 opened the resident's bathroom door, found the resident sitting on the bathroom floor, banging the garbage can on the floor. "I ran and got the nurse (LPN #1), we picked (resident) up and then put (resident) in the bed."

Review of a written statement (no date) by LPN #1, revealed, "About 6:20 p.m., (no date) assisted (resident) to BR (bathroom)...call light on. When assisting (resident) back to w/c (wheelchair) (resident's) left leg went outward when wt. (weight) put on it. I was on (R) (right) side of pt. During the transfer pt. stated "my leg popped" 6:25 p.m., after assisting pt back to bed removed pants to check leg saw a knot with [MEDICAL CONDITION] (L) (left) leg above knee at back. Ask pt about knot stated "that has been there" No discoloration noted ROM (range of motion) intact...Assisted pt with personal care due to stress incontinet (incontinence). 7:30 p.m. Pt. up to BR per self in w/c transferred self to and from bed with no assistance. Cont (continued) taking self to BR with no assistance till (until) 6:00 a.m..."

Medical record review revealed no documentation the resident fell on [DATE]. Continued review revealed no documentation of the resident being assessed for injury or change in condition (no vital signs, no pain assessment, no neurological assessment, and no body systems assessment) on June 22, 2012; continued review revealed no documentation the Physician was notified of the resident falling on June 22, 2012, until June 26, 2012.

Review of the nursing shift-to-shift reports dated June 22, 23, 24, and 25, 2012, revealed no documentation of the resident having a fall on June 22, 2012, or Physician notification of the resident falling on June 22, 2012.

Review of the facility "Protocol: Post Fall" (no date), revealed, "1. Assess the resident and implement appropriate measure to provide immediate care. Neurological checks to be done for all unwitnessed falls...2. Nursing to complete... a. Fall Tracking Form. b. Incident Report, to include vital signs, with lying and standing blood pressure. Incident Report and accident/event management protocol to be completed per nurse...c. FSI- Fall Scene Investigation Report (used to identify the root cause analysis). d. Change of status review. e. Resident Event Documentation...f. Pain Assessment...6. Discuss findings...with the resident and family..."

Review of the facility "Procedure: Post Fall" (no date), revealed, "...3...Obtain blood pressure and pulse while resident is on the ground. Leave blood pressure cuff on resident. If resident is able to stand, do so and obtain blood pressure immediately. Do not wait for blood pressure to stabilize. If not, place in chair and obtain blood pressure. 4. Do neurochecks for all unwitnessed falls...7. Nursing to complete...Fall Tracking Form; Incident Report, to include vital signs, with lying and standing blood pressure...Incident Report and Accident/Event Management Protocol to be completed per nurse...; FSI-Fall Scene Investigation Report...; Pain Assessment..."

Review of the facility policy "Accidents and Incidents-Investigating and Reporting" dated October 01, 2011, revealed, "Policy: All accidents or incidents involving residents...occurring at our facilities must be investigated and reported to the Administrator. Purpose: To ensure the safety of all residents...General Guidelines: 1. Reporting of Accidents/Incidents: a...must be reported to the department supervisor as soon as the accident/incident is discovered...b. An Incident Report Form must be completed for all reported accidents or incidents. d. The nurse supervisor/charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided...3. Medical Attention:...e. If the incident involves a resident, immediately contact the physician and responsible party of the incident...Steps in the Procedure: 1. The Incident Report...a. The nurse supervisor/charge nurse and/or the department director or supervisor shall:...3. Use information obtained during the investigation to complete the Incident Report

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F 0224	

(continued... from page 3)

Form; and 4. Complete the assessment of the resident...complete the information required and give a full description of the occurrence. Record time of incident, and describe exactly what occurred or was observed..."

Review of the facility policy "Charting and Documentation: Nurse's Notes" pages one through three, revealed, "Policy: To maintain a complete account of the resident's care...Purpose: To ensure that all services provided to the resident or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. General Guidelines:...3. All incidents, accidents, or changes in the resident's condition must be recorded..."

Review of the facility policy "Pain Management" (no date), revealed, "Policy:...Any resident who experiences pain will be reviewed and a plan will be established to treat his or her pain...Purpose(s): 1. To ensure the physical and psychological well being of the resident. 2. To maintain optimum functional ability. Guiding Principles: In the long-term care setting, the comfort and well-being of the individual resident should always be paramount (of chief concern or importance). This principle is the foundation for effective management of pain. Adequate pain management should be sought in each case. Individualized care...ensures that pain management is tailored to each resident's needs, circumstances, conditions, and risk factors. Members of the interdisciplinary care team have a responsibility to advocate for resident comfort...Procedure(s):...B. Process 1. Pain will be reviewed/scored using a numeric 0-10 (zero to ten) scale...Alternate scales may be used...The type of scale used, if different than policy, must be documented...3. Every resident will be regularly and systematically reviewed for pain...b. With any change in resident condition...new onset complaints of pain...To maintain a complete account of the resident's care...Purpose: To ensure that all services provided to the resident or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. General Guidelines:...3. All incidents, accidents, or changes in the resident's condition must be recorded..."

Observation of the resident in the presence of the SDC, in the resident's room, on June 27, 2012, at 9:20 p.m., confirmed the resident was lying on the bed, very confused and verbalized a nonsensical conversation with the surveyor. The SDC confirmed the resident was not typically confused to this degree. Continued observation confirmed an immobilizer was on the resident's left lower extremity, extending from the mid-thigh to the upper ankle. Yellow bruising extended laterally, above the immobilizer. The resident expressed complaints of pain "Oh, oh, oh...that hurts..." with the slightest touch and/or movement during care per nursing staff.

Continued observation of the resident, in the resident's room, on July 10, 2012, confirmed the immobilizer was present on the resident's left lower extremity; with continued observation confirming the resident had one large yellow bruise on the lateral left thigh, measuring 12.5 inches by 11.0 inches. Within the yellow bruising were three separate purple bruises; (1) the upper lateral measured 4.5 inches by 4.5 inches, (2) the mid-lateral measured 5.0 inches by 3.0 inches, and (3) the lower lateral measured 3.0 inches by 1.5 inches.

Interview with the SDC on June 27, 2012, at 4:30 p.m., in the conference room, confirmed upon arriving to work at the facility on June 26, 2012, at approximately 5:45 a.m., RN #1 gave report to the SDC. RN #1 reported on June 26, 2012, sometime around midnight (couldn't recall the exact time), the resident had increased complaints of pain with swelling in the left thigh; the resident alleged to have fallen and was assisted up by two females. The physician was notified (sometime around midnight) and ordered the resident to be sent to the ER for an evaluation. An x-ray of the left hip was completed on June 26, 2012, at the hospital, and confirmed the resident had a left [MEDICAL CONDITION] fracture. The SDC confirmed, on June 26, 2012, at approximately 8:45 a.m., to report RN #1's findings regarding the resident in the facility's morning clinical meeting. An investigation was initiated immediately, to determine the cause of the fracture. The resident's chart was retrieved and reviewed; the physician's note dated June 23, 2012, was reviewed, which included complaints of [MEDICAL CONDITION] and allegations of a fall. No Incident Report had been completed; and the resident's chart revealed no documentation of a fall.

Nursing assignment schedules from June 21-25, 2012, were reviewed and interviews began. The SDC's interview with CNA #1 revealed CNA #1 found the resident on the floor banging on a garbage can on June 22, 2012, after supper; CNA #1 left the resident's room and immediately notified LPN #1 for assistance; together, CNA #1 and LPN #1 went back to the resident's room, got the resident out of the floor, and put the resident in the bed. The SDC called LPN #1 after completing the interview with CNA #1. The SDC asked LPN #1 "Do you know anything that may have happened to (resident)?" LPN #1 denied knowing anything. The SDC continued questioning "Are you sure you don't know anything that happened to the resident on Friday or Saturday night (June 22 or 23, 2012)?" LPN #1 revealed to remember providing assistance to (resident), who "began to go down and LPN #1 caught (resident) and put (resident) in the wheelchair." The SDC confirmed this was the only information provided or revealed by LPN #1.

Interview with LPN #1, in the presence of the Administrator, on June 27, 2012, at 5:45 p.m., in the conference room, confirmed LPN #1 intentionally gave false and misleading information during the facility's investigation of the resident's left [MEDICAL CONDITION] fracture. LPN #1 confirmed the resident did have an unwitnessed fall on June 22, 2012, and at approximately 6:20 p.m., CNA #1 notified LPN #1 the resident was on the floor in the bathroom. LPN #1 and CNA #1 went to the resident's room to assist the resident up from the floor. LPN #1 confirmed the resident was sitting on the buttocks, with the knees bent upward. As the resident was assisted up, the resident complained of pain in the right foot, and LPN #1 heard the resident's left leg pop. When the surveyor asked if pain medication had been administered or if the Physician was notified, LPN #1 confirmed, "No...I didn't give any pain medication...No, I didn't call the Doctor...I know better...I knew better then...I knew what to do, I just didn't do it..." Continued interview confirmed the Physician was not notified of the resident's fall, complaint of pain, or of the left leg popping. LPN #1 confirmed when the SDC called (LPN #1) on June 26, 2012, and asked about the resident's left [MEDICAL CONDITION] fracture, "I intentionally deceived (SDC); I lied to (SDC) and (Administrator)...The written statement I gave to (Administrator) was false...I knew it was untruthful...I did not call the Physician and did not follow the facility's policies and procedures...I knew what to do...the resident was in the floor and I didn't do what I was supposed to do...I failed to follow the protocol and it's the patient that suffered."

Interview with CNA #1, on June 27, 2012, at 8:30 p.m., via telephone, confirmed the resident fell on [DATE], after supper (unsure of exact time). CNA #1 went into the resident's room and heard a noise coming from the bathroom. Upon entering the bathroom, CNA #1 confirmed the resident was sitting on the bathroom floor, with the right leg extended outward and the left leg bent up under (resident's) bottom (buttocks). CNA #1 went and got LPN #1 and they went back into the resident's bathroom, got the resident up and into a wheelchair, then put the resident to bed. CNA #1 confirmed the resident verbalized complaints of knee pain, but the resident did not identify which knee was hurting. Continued interview with CNA #1 confirmed LPN #1 did not assess the resident, "Once the resident was in bed, we (CNA #1 and LPN #1) left (resident's) room together."

Interview with the resident's attending Physician (Medical Director) on June 27, 2012, at 7:35 p.m., in the conference room confirmed, on June 23, 2012, the resident told the Physician, (resident) had fallen (did not state when). The Physician evaluated the resident, saw no [MEDICAL CONDITION] or discoloration; the resident complained of back and bilateral (both) leg pain. The Physician confirmed the resident had chronic pain secondary to generalized Arthritis. Upon the resident reporting the fall, the Physician confirmed to review the resident's chart and there was no documentation of a fall. Continued interview confirmed the Physician was not notified of any fall occurring recently, or on June 22, 2012. The Physician confirmed, "I expect to be notified of all falls...If I had gotten this information on the fall, I would have focused my examination on the (resident's) leg." The Physician confirmed the nurse's failure to follow facility policies and failure to provide pain management for resident #1 resulted in a delay of treatment and complaints of pain without treatment.

Interview with the Administrator on June 27, 2012, at 9:00 p.m., and July 10, 2012, at 6:00 p.m., in the conference room, confirmed LPN #1 failed to follow facility policies, failed to report the resident's fall on June 22, 2012, failed to provide accurate information (both verbally and written) during a facility investigation to determine the cause of a resident with a fractured left femur, failed to provide the necessary services to prevent a three-day delay in treatment for [DIAGNOSES REDACTED]'s complaint of pain. Continued interview confirmed LPN #1 was suspended on June 27, 2012, and remained on suspension until terminated on July 3, 2012. Continued interview confirmed the facility's failure resulted in neglect of resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445408	A. BUILDING _____ B. WING _____	07/10/2012

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SODDY-DAISY HEALTH CARE CENTER	701 SEQUOYAH ROAD SODDY-DAISY, TN 37379

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 0224	(continued... from page 4) C/O #**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .
F 0309	**Provide necessary care and services to maintain the highest well being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility investigation, review of facility nursing shift reports, review of facility policy, observation, and interview, the facility failed to follow facility policies in a timely manner, resulting in a delay of treatment for [DIAGNOSES REDACTED]. The facility's failure to follow policies and failure to provide pain management for resident #1 resulted in a delay of treatment and complaints of pain without treatment (Actual Harm). The findings included: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a Physician's progress note [DIAGNOSES REDACTED]." Continued review revealed, "...appears somewhat confused...(resident) reports fall...no record of any fall in nursing notes...pain in both legs...pt (patient) with NIDDM (Non-Insulin Dependent [MEDICAL CONDITION]), History of OA ([MEDICAL CONDITION]), Psychoses, ? (questionable) PMR (Polymyalgia Rheumatica-muscle pain and stiffness)...c/o numbness in feet..." Continued review revealed [DIAGNOSES REDACTED]. Medical record review of a Physician's Telephone Order dated June 23, 2012, revealed an order for [MEDICATION ORDERS REDACTED] Medical record review of a Nurse's Note dated June 23, 2012, at 2:41 p.m., revealed the Physician evaluated the resident due to complaints of [MEDICAL CONDITION]. Medical record review of a Nurse's Note dated June 25, 2012, at 7:04 p.m., revealed, "In bed all day. C/O (complaining of) pain in the left knee..." Medical record review of a Nurse's Note dated June 26, 2012, at 2:34 a.m., revealed, "Charting for 12:45 a.m. This nurse (Registered Nurse (RN) #1) called to eval (evaluate) resident d/t (due to) increased pain and Lt. (left) upper leg swelling. Resident cries out in severe pain when leg is touched or with any movement. This nurse in to check resident Lt. leg swelling and old yellowish green bruises noted to left knee. Resident is unable to move (resident's) leg and cries when staff attempts to move (resident's) leg. This nurse asked resident what happened and (resident) stated "I fell in the bathroom and they had to get me up." Resident has not been getting up...as per (resident's) normal. Called...(Physician) at 1:00 a.m., and new order to send to the ER (emergency room) for eval of Lt. leg. Also order noted to give [MEDICATION NAME] (for moderate to severe pain) 5 mg (milligrams) SQ (subcutaneous-under the skin)...2:30 a.m., Ambulance service here to transport resident to (hospital) ER..." Continued review of the Nurse's Notes dated June 26, 2012, at 2:42 a.m., revealed, LPN #2 assessed resident's left leg, "Nurse on day shift reported to this nurse of increased pain...Old bruising and swelling of the left leg and knee noted. Resident c/o pain to left leg. Supervisor (RN #1) notified." Medical record review of a (hospital) radiology report of the left hip, dated June 26, 2012, revealed the resident had a comminuted (splintered or crushed) displaced left distal one-third [MEDICAL CONDITION] fracture (a traumatic break in the bone above the knee in which the two ends of the fractured bone are separated and out of their normal positions). Medical record review of a Nurse's Note dated June 27, 2012, revealed the resident returned to the facility from the hospital on June 27, 2012, at 1:25 p.m. with [DIAGNOSES REDACTED]. Review of a facility investigation dated June 26, 2012, at 8:30 a.m., completed by the Staff Development Coordinator (SDC) and Assistant Director of Nursing (ADON) revealed, "...RN Supervisor (RN #1) assessed resident d/t increased pain, left leg swelling and bruising noted to left knee. MD (Medical Doctor) notified and resident sent to ER for evaluation and tx (treatment). Upon investigation it was found that on 6:00 p.m. to 6:00 a.m., shift on Friday June 22, 2012, a CNA (Certified Nursing Assistant) reported to charge nurse (LPN #1) that resident was found in the bathroom floor..." Continued review of the investigation revealed the resident's Physician was not notified of the resident's fall on June 22, 2012, until June 26, 2012, at 1:00 a.m.; the resident's family was not notified until June 26, 2012, at 1:25 a.m. Review of a written statement dated June 25-26, 2012, by RN #1 revealed RN #1 was notified by LPN #2 of resident's increased pain and swelling of the left upper leg. RN #1's statement revealed the resident's left leg was swollen, with old yellow bruising. "Resident stated (resident) fell in...bathroom [ROOM NUMBER]-3 (two to three) days ago...but no report of a fall...(Physician) was here and checked resident on June 23, 2012...(Physician's) note states that resident also reported to (Physician) that (resident) fell but there was no nurses' notes to support resident's c/o...(Physician) was called at 1:00 a.m., and wanted (resident) to go to the ER and that (resident's) leg may be broken..." (Resident) started crying and stated "yes, it's broken...I fell in my bathroom between the wall and the commode..." RN #1 asked the resident if someone helped (resident) up, and resident stated "it was two women." RN #1 informed the resident of pain medication to be administered, and the resident "started crying" and stated "thank you." Review of a written statement dated June 25, 2012, (beginning of June 25-26, 2012, night shift from 6:00 p.m.-6:00 a.m.) by LPN #2 revealed the resident's left leg was painful and swollen above and around the knee. Review of a written statement (no date) by CNA #1, revealed on June 22, 2012, CNA #1 walked into the resident's room and heard a banging noise. CNA #1 opened the resident's bathroom door, found the resident sitting on the bathroom floor, banging the garbage can on the floor. "I ran and got the nurse (LPN #1), we picked (resident) up and then put (resident) in the bed." Review of a written statement (no date) by LPN #1, revealed, "About 6:20 p.m., (no date) assisted (resident) to BR (bathroom)...call light on. When assisting (resident) back to w/c (wheelchair) (resident's) left leg went outward when wt. (weight) put on it. I was on (R) (right) side of pt. During the transfer pt. stated "my leg popped" 6:25 p.m., after assisting pt back to bed removed pants to check leg saw a knot with [MEDICAL CONDITION] (L) (left) leg above knee at back. Ask pt about knot stated "that has been there" No discoloration noted ROM (range of motion) intact...Assisted pt with personal care due to stress incontinet (incontinence). 7:30 p.m. Pt. up to BR per self in w/c transferred self to and from bed with no assistance. Cont (continued) taking self to BR with no assistance till (until) 6:00 a.m..." Medical record review revealed no documentation the resident fell on [DATE]. Continued review revealed no documentation of the resident being assessed for injury or change in condition (no vital signs, no pain assessment, no neurological assessment, and no body systems assessment) on June 22, 2012; continued review revealed no documentation the Physician was notified of the resident falling on June 22, 2012, until June 26, 2012. Review of the nursing shift-to-shift reports dated June 22, 23, 24, and 25, 2012, revealed no documentation of the resident having a fall on June 22, 2012, or Physician notification of the resident falling on June 22, 2012. Review of the facility "Procedure: Post Fall" (no date), revealed, "...4. Do neurochecks for all unwitnessed falls...7. Nursing to complete...Fall Tracking Form; Incident Report, to include vital signs, with lying and standing blood pressure...Incident Report and

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0309	

(continued... from page 5)
Accident/Event Management Protocol to be completed per nurse...; Pain Assessment..."

Review of the facility policy "Accidents and Incidents-Investigating and Reporting" dated October 01, 2011, revealed, "Policy: All accidents or incidents involving residents...occurring at our facilities must be investigated and reported...as soon as the accident/incident is discovered...b. An Incident Report Form must be completed for all reported accidents or incidents. 3. Medical Attention:...e. If the incident involves a resident, immediately contact the physician and responsible party of the incident..."

Review of the facility policy "Pain Management" (no date), revealed, "Policy:...Any resident who experiences pain will be reviewed and a plan will be established to treat his or her pain...Purpose(s): 1. To ensure the physical and psychological well being of the resident. Guiding Principles:...Members of the interdisciplinary care team have a responsibility to advocate for resident comfort...Procedure(s):...B. Process 1. Pain will be reviewed/scored using a numeric 0-10 (zero to ten) scale...Alternate scales may be used...The type of scale used, if different than policy, must be documented...3. Every resident will be regularly and systematically reviewed for pain...b. With any change in resident condition...new onset complaints of pain...To maintain a complete account of the resident's care...Purpose: To ensure that all services provided to the resident or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. General Guidelines:...3. All incidents, accidents, or changes in the resident's condition must be recorded..."

Observation of the resident in the presence of the SDC, in the resident's room, on June 27, 2012, at 9:20 p.m., confirmed the resident was lying on the bed, very confused and verbalized a nonsensical conversation with the surveyor. The SDC confirmed the resident was not typically confused to this degree. Continued observation confirmed an immobilizer was on the resident's left lower extremity, extending from the mid-thigh to the upper ankle. Yellow bruising extended laterally, above the immobilizer. The resident expressed complaints of pain "Oh, oh, oh...that hurts..." with the slightest touch and/or movement during care per nursing staff.

Continued observation of the resident, in the resident's room, on July 10, 2012, confirmed the immobilizer was present on the resident's left lower extremity; with continued observation confirming the resident had one large yellow bruise on the lateral left thigh, measuring 12.5 inches by 11.0 inches. Within the yellow bruising were three separate purple bruises; (1) the upper lateral measured 4.5 inches by 4.5 inches, (2) the mid-lateral measured 5.0 inches by 3.0 inches, and (3) the lower lateral measured 3.0 inches by 1.5 inches.

Interview with the SDC on June 27, 2012, at 4:30 p.m., in the conference room, confirmed upon arriving to work at the facility on June 26, 2012, at approximately 5:45 a.m., RN #1 gave report to the SDC. RN #1 reported on June 26, 2012, sometime around midnight (couldn't recall the exact time), the resident had increased complaints of pain with swelling in the left thigh; the resident alleged to have fallen and was assisted up by two females. The physician was notified (sometime around midnight) and ordered the resident to be sent to the ER for an evaluation. An x-ray of the left hip was completed on June 26, 2012, at the hospital, and confirmed the resident had a left [MEDICAL CONDITION] fracture. The SDC confirmed, on June 26, 2012, at approximately 8:45 a.m., to report RN #1's findings regarding the resident in the facility's morning clinical meeting. An investigation was initiated immediately, to determine the cause of the fracture. The resident's chart was retrieved and reviewed; the physician's note dated June 23, 2012, was reviewed, which included complaints of [MEDICAL CONDITION] and allegations of a fall. No Incident Report had been completed; and the resident's chart revealed no documentation of a fall. Nursing assignment schedules from June 21-25, 2012, were reviewed and interviews began. The SDC's interview with CNA #1 revealed CNA #1 found the resident on the floor banging on a garbage can on June 22, 2012, after supper; CNA #1 left the resident's room and immediately notified LPN #1 for assistance; together, CNA #1 and LPN #1 went back to the resident's room, got the resident out of the floor, and put the resident in the bed. The SDC called LPN #1 after completing the interview with CNA #1. The SDC asked LPN #1 "Do you know anything that may have happened to (resident)?" LPN #1 denied knowing anything. The SDC continued questioning "Are you sure you don't know anything that happened to the resident on Friday or Saturday night (June 22 or 23, 2012)?" LPN #1 revealed to remember providing assistance to (resident), who "began to go down and LPN #1 caught (resident) and put (resident) in the wheelchair." The SDC confirmed this was the only information provided or revealed by LPN #1.

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