STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	08/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00415330 and IN00415942. Complaint IN00415330 - Federal deficiencies related to the allegations are cited at F622, F626, and F684. Complaint IN00415942 - Federal deficiencies related to the allegations are cited at F622, F626, and F684. Survey dates: August 17, 18, and 21, 2023 Facility number: 003624 Provider number: 155802 AIM number: 200429840 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 13 Medicaid: 30 Other: 15 Total: 58 These defieciences reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 31, 2023.	F 0000		
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to			

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

Mandy Lynch | Administrator | 09/30/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.			

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	§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable,			

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	and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility failed to honor a resident's request to be transferred to the hospital related to increased pain of a right femur fracture and without her signing a document saying the transfer was against medical advice (AMA) and without being informed her AMA transfer may result in the facility not allowing her to return for 1 of 3 residents reviewed for transfer and discharge (Resident B). Findings include: During a confidential phone interview, on 8/17/23 at 8:55 a.m., Resident B's friend indicated she had visited the resident on 8/15/23 at the facility. The resident informed her friend that she had a fractured right femur. She was unable to explain how the fracture happened. The friend indicated the facility had always called her with any condition changes until this one. She was not notified of the fracture. She observed the resident's external rotation to her right leg during this visit. The friend indicated the rotation had never been noted before. The friend had just been in the facility at the end of July 2023, and it was not seen at that time. During an interview, on 8/17/23 at 11:44 a.m., RN 3 indicated she was working day shift on the day of 7/30/23 and she noticed Resident B's right foot was rotated out. She had never noticed it before. She forgot to notify the oncoming night shift nurse, nor did she document any of her findings in the resident's medical record. She didn't notice any swelling or redness at that time. She messaged the night shift nurse at approximately	F 0622	The facility disagrees with the deficiency cited below. This individual was not involuntarily discharged or transferred. The resident's attending physician was not willing to provide an order for the transfer to the hospital because he believed the risks of sending the resident for treatment of an old fracture that was already healing outweighed the benefits of treatment and would not increase the resident's quality of life. Even though the hospital treated the fracture it did not improve the resident's ability to bear weight due to paralyzed lower extremities. The resident voluntarily left the facility against medical advice (AMA) and signed an acknowledgment that included our AMA policy, which states that residents who leave AMA may not be allowed to return. When the hospital was ready to discharge the resident, the resident's prior attending physician would not provide an order for the resident to return to the facility, hence we could not readmit the resident without orders from a physician. At the time the fracture was discovered, we also notified the resident's sister, who was the resident's designated representative at that time. We	08/30/2023

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	3:00 a.m. via text message about the resident's foot. The record lacked documentation related to the potential injury by the nurse. During an interview, on 8/17/23 at 2:45 p.m., Resident B indicated she had increased pain in her right leg related to a fracture and she wanted to be transferred to the hospital for further assistance. During an interview, on 8/17/23 at 3:00 p.m., the Administrator indicated Resident B was going to be sent out to the hospital against medical advice (AMA) because it was her request to be sent out to the hospital. She indicated the Medical Director did not feel her transfer was medically necessary. During an interview, on 8/18/23 at 3:15 p.m., the Administrator indicated staff understood Resident B was requesting and had the right to be seen in the emergency room due to pain and wanting a second opinion of her fracture, but the Medical Director said it was not necessary, the facility had her sign an against medical advice (AMA) form. Having the resident sign the AMA did not indicate the facility would not take her back. Her return would depend on rather the Medical Director wanted to continue caring for her. Resident B's record was reviewed on 8/17/23 at 10:50 a.m. The profile indicated the resident's diagnoses included, but were not limited to, quadriplegia (paralysis of all four limbs), respiratory failure unspecified with hypoxia (happens when you don't have enough oxygen in your blood, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures). The resident required a mechanical ventilator (type of breathing apparatus that provides mechanical ventilation by moving breathable air into and out of the lungs).		explained that the attending physician and orthopedic specialist wanted to wait for further X-ray results in the coming weeks. The resident representative and the patient agreed to that plan of care and did not want to seek treatment at the hospital. Notwithstanding, it is the policy of PHC to ensure residents' transfers will be conducted in accordance with resident rights, and physician's orders, and in such a manner as to maintain continuity of care of the resident. Corrective Action Taken Related to this Finding: The resident was discharged to the hospital per her request. Other residents with Potential to be Affected by this Finding will be Identified by: No other resident was affected. Measures and Systemic Changes put into place to assure deficient practices do not recur are as follows: All nursing Staff were educated at mandatory in-service on 8-29 and 8-30-23 regarding the transfer and discharge policy. All transfers and discharges will be authorized by the Administrator or Director of Nursing. Corrective Actions will be Monitored to Ensure Compliance by: DON/designee will audit resident transfers/discharges to ensure proper paperwork is	

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	Review of Medication Administration Record (MAR), indicated in the month of August 2023, Resident B had complained of pain at a scale of 5 or higher 9 out of 17 days reviewed and required as needed pain medication to be administered in addition to the resident's routine pain medication. Review of bed hold policy, dated 8/17/23, Resident B was given a bed hold policy and indicated the resident was being transferred to the hospital and was marked as a transfer or discharge was necessary to meet the resident's welfare and the resident's needs cannot be met in the facility. Review of transfer or discharge request for hearing form, indicated Resident B's name on the form, there was no date and no resident representative signature on the form. Review of an orthopedic note, dated 8/18/23 at 2:54 p.m., the Orthopedic doctor indicated he had reviewed an x-ray that was completed on 8/1/23. The x-ray indicated Resident B had a non-displaced, subacute (a condition between acute and chronic) to chronic (long term) appearing intertrochanteric hip fracture with evidence of healing. The orthopedic doctor recommended continued non-operative treatment as long as the resident was not having significant pain and was tolerating transfers and positioning. He was aware the resident had transferred to a local hospital per patient request. A review of the hospital records included a Computerized Tomography (CT) of the low right extremity from the hospital, dated 8/17/23. The CT indicated Resident B had a subacute to chronic non healed comminuted (a bone that is broken in at least 2 places) right femur intertrochanteric		completed. Conducting audits 5x per week times 4 weeks, then 3 x per week x 4 weeks, then 2 x per week x 4 weeks, then 1 x per week x 3 months. The outcome of the audit will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

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	fracture. A hospital note included an Orthopedic physician consultation note, dated 8/18/23. They were consulted due to Resident B's fracture. The orthopedic doctor at the hospital indicated the resident had a subacute fracture to the right proximal (situated nearer the center of the body or the point of attachment) femur, likely 2 to 6 weeks old. The physician planned to take Resident B to the operating room on 8/19/23 for a gamma nail (used to treat proximal femoral fractures) and fracture fixation (stabilize extremely misaligned broken bones by re-setting). Review of Operative note, dated 8/19/23, indicated Resident B had a preoperative diagnosis of an unstable fracture of the right proximal femur. The operation was an open reduction and internal fixation (put pieces of a broken bone into place using surgery) of the right proximal femur with 120-degree Stryker gamma nail with proximal distal interlocking (metallic implants used for the repair of traumatic long bone fractures) and a long leg splint. During a phone interview, on 8/22/23 at 9:45 a.m., the Case Manager from the hospital indicated the resident wanted transferred to the hospital for a second opinion on her fractured leg. The resident's injury did require surgical intervention while she was at the hospital. Her surgery was performed on 8/19/23. Cross reference F626 and F684. On 8/18/23 at 1:15 p.m., the Administrator provided a document, with a revised date of 1/15/23, titled, "Transfer and Discharge," and indicated it was the policy currently being used			

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	by the facility. The policy indicated, "...2. Resident or resident representative(s), if known have the right to participate in decisions regarding transfers or discharge and to request or agree to transfers with in the facility or to another facility or home ... 5. The state mandated notice must be given to the resident or resident representative at least 30 days before the transfer or discharge ...14. In the event of an emergency transfer, the state form shall be sent with the resident to the hospital for a resident review as soon as possible and provided to other required individuals ...." This Federal tag relates to Complaints IN00415330 and IN00415942. 3.1-12(a)(6)(B)			
F 0626 SS=D Bldg. 00	483.15(e)(1)(2) Permitting Residents to Return to Facility §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an			

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	expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. Based on interview and record review, the facility failed to accept a resident back from the hospital without a 30-day discharge notice for 1 of 3 residents reviewed for transfer and discharge (Resident B). Findings include: During an interview, on 8/17/23 at 2:45 p.m., Resident B indicated she had increased pain in her right leg related to a fracture and she wanted to be transferred to the hospital for further assistance. Cross reference F622 and F684. During an interview, on 8/17/23 at 3:00 p.m., the Administrator indicated Resident B was going to be sent out to the hospital against medical advice (AMA) because it was her request to be sent out. The Medical Director did not feel her transfer was medically necessary. During an interview, on 8/17/23 at 4:05 p.m., Resident B's emergency contact individual	F 0626	It is the policy of PHC to ensure residents' transfers will be conducted in accordance with resident rights, and physician's orders, and in such a manner as to maintain continuity of care of the resident. Corrective Action Taken Related to this Finding: For any facility-initiated transfers/discharges, residents will be permitted to return to the facility. Other residents with Potential to be Affected by this Finding will be Identified by: No other resident was affected. Measures and Systemic Changes put into place to assure deficient practices do not recur are as follows: All nursing Staff were educated at mandatory in-service on 8-29 and 8-30-23 regarding the transfer and	08/30/2023

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	indicated she was not made aware of the resident not being allowed to return to facility once discharged from the hospital by any facility personnel when the resident was sent to the hospital per the resident's request. During an interview, on 8/18/23 at 3:15 p.m., the Administrator indicated staff understood Resident B was requesting and had the right to be seen in the emergency room due to pain. Having the resident sign the AMA did not indicate the facility would not take her back. Her return would depend on if the medical director wanted to continue caring for her. Resident B's record was reviewed on 8/17/23 at 10:50 a.m. The profile indicated the resident's diagnoses included, but were not limited to, quadriplegia (paralysis of all four limbs), respiratory failure unspecified with hypoxia (happens when you don't have enough oxygen in your blood, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures). The resident required a mechanical ventilator (type of breathing apparatus that provides mechanical ventilation by moving breathable air into and out of the lungs). Review of x-ray report completed on 8/1/23 at 4:55 p.m. The report indicated Resident B had an "old or healing" intertrochanteric right femoral fracture. Review of bed hold policy, dated 8/17/23, Resident B was given a bed hold policy and indicated the resident was being transferred to the hospital and was marked as a transfer or discharge was necessary to meet the resident's welfare and the resident's needs cannot be met in the facility. Review of transfer or discharge request for		discharge policy. All transfers and discharges will be authorized by the Administrator or Director of Nursing. Corrective Actions will be Monitored to Ensure Compliance by: DON/designee will audit resident transfers/discharges to ensure proper paperwork is completed. Conducting audits 5x per week times 4 weeks, then 3 x per week x 4 weeks, then 2 x per week x 4 weeks, then 1 x per week x 3 months. The outcome of the audit will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

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	hearing form, indicated Resident B's name on the form, there was no date and no resident representative signature on the form. Review of case management note from the hospital, dated 8/18/23 at 4:35 p.m., indicated the Case Manager spoke with Administrator from the long-term care facility and she indicated Resident B had signed an AMA form to come to the emergency room for evaluation and treatment. The Administrator indicated the Medical Director did not feel as though the patient needed to come to the hospital and her needs could be met at the facility. The Administrator did not provide the Case Manager with an answer on rather the resident could return to the facility post discharge. Review of physician progress note, dated 8/18/23 at 7:01 p.m., the Medical Director indicated the patient was transferred to the hospital against medical advice. Given the facility policy and the resident's non-compliant behavior, the Medical Director deemed it was necessary to deny readmittance to the facility. During an interview, on 8/21/23 at 9:00 a.m., the Administrator indicated she would be surprised if the resident wanted to return to their facility since she "wasn't happy here." She indicated the Medical Director was not keen on the idea of the resident returning to the facility from the hospital. During a phone interview, on 8/22/23 at 9:45 a.m., the Case manager from the hospital indicated the Administrator from the long-term care facility had denied Resident B's re-admittance back to the facility from the hospital. The case manager indicated she was not provided a 30-day discharge notice from the facility for the resident.			

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	She indicated the resident was not aware that signing an AMA form meant she couldn't return to the facility. The resident wanted transferred to the hospital for a second opinion. The case manager indicated her injury did require surgical intervention while she was at the hospital. Her surgery was performed on 8/19/23. On 8/18/23 at 1:15 p.m., the ADM provided a document, with a revised date of 1/15/23, titled, "Transfer and Discharge," and indicated it was the policy currently being used by the facility. The policy indicated," ...2. Resident or resident representative(s), if known have the right to participate in decisions regarding transfers or discharge and to request or agree to transfers with in the facility or to another facility or home ... 5. The state mandated notice must be given to the resident or resident representative at least 30 days before the transfer or discharge ...14. In the event of an emergency transfer, the state form shall be sent with the resident to the hospital for a resident review as soon as possible and provided to other required individuals ...." This Federal tag relates to Complaints IN00415330 and IN00415942. 3.1-12(a)(26)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

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	comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to assess and document a baseline for a new injury, failed to report an unknown injury for orders and treatment, and failed to follow up timely on an external rotation of the right leg resulting in the delay of care for 1 of 3 residents reviewed for quality of care (Resident B). Findings include: During a confidential phone interview, on 8/17/23 at 8:55 a.m., Resident B's friend indicated she had visited the resident on 8/15/23 at the facility. The resident informed her friend that she had a fractured right femur. She was unable to explain how the fracture happened. The friend indicated the facility had always called her with any condition changes until this one. She was not notified of the fracture. She observed the resident's external rotation to her right leg during this visit. The friend indicated the rotation had never been noted before. The friend had just been in the facility at the end of July 2023, and it was not seen at that time. During an interview, on 8/17/23 at 11:44 a.m., RN 3 indicated she was working day shift on the day of 7/30/23 and she noticed Resident B's right foot was rotated out. She had never noticed it before. She forgot to notify the oncoming night shift nurse, nor did she document any of her findings in the resident's medical record. She didn't notice any swelling or redness at that time. She messaged the night shift nurse at approximately 3:00 a.m. via text message about the resident's foot. The record lacked documentation related to the potential injury by the nurse.	F 0684	It is the policy of PHC to ensure residents receive comprehensive assessment and appropriate treatment timely. Corrective Action Taken Related to this Findings: On 8-29-23, the IDT consisting of, Director of Nursing, Unit Managers, Director of Quality, Social Services, and therapy reviewed all orders and treatments. Other residents with Potential to be Affected by this Finding will be Identified by: On 8-29-23, the IDT reviewed all residents' care plans to ensure timely physician notification and follow-up of any change in condition. Measures and Systemic Changes put into place to assure deficient practices do not recur are as follows: All nursing Staff were educated at mandatory in-service on 8-29 and 8-30-23 regarding the resident assessment policy and change of condition policy, as well as education on proper documentation of notification of appropriate personnel and proper documentation of change of condition. Corrective Actions will be Monitored to Ensure Compliance by: The Director of Nursing, or her	08/30/2023

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	Review of text message, dated 7/31/23 at 3:28 a.m., RN 3 sent a text message to the night shift nurse and indicated she forgot to mention to her about Resident B's right lower extremity was turned outward and should probably have an x-ray. The nurse receiving the text message responded she had noticed it as well and would notify the Unit Manager. The electronic medical record lacked any notification or documentation of the nurses' findings. During a phone interview, on 8/18/23 at 11:45 a.m., the Medical Director indicated he was notified on 8/1/23 of an external rotation to Resident B's right leg while he was making rounds at the facility. A portable x-ray was completed on 8/1/23 and the Medical Director was notified of the results on 8/4/23. He consulted an orthopedic doctor regarding the x-ray results. The orthopedic doctor was unable to determine the age of the fracture due to the x-ray images were not clear due to them being from a portable machine. The orthopedic doctor advised the medical director to obtain another x-ray in one week. The orthopedic doctor advised keeping her leg as stable as possible during turning and repositioning and no mechanical lift transfers. The Medical Director indicated the resident's increased pain could be masked by her opioid medications that she already took routinely for pain. During an interview, on 8/18/23 at 12:32 p.m., Unit Manager 5 indicated she was told about Resident's B external rotation on Monday, 7/31/23 by RN 3. The Unit Manager spoke with the Medical Director on Tuesday 8/1/23 when he was at the facility making his rounds. She indicated the Medical Director placed an order for the resident to have a portable x-ray done on the right femur. The Medical Director was not notified of the		designee, will be conducting audits 5x per week times 4 weeks, then 3 x per week x 4 weeks, then 2 x per week x 4 weeks, then 1 x per week x 3 months. The outcome of the audit will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

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	external rotation the day that staff notified the Unit Manager. She indicated the x-ray was obtained on 8/1/23 as ordered but she did not get the results out of the computer system until 8/4/23. She indicated she had missed a day of work that week and she obtained the results when she was back to work on 8/4/23. The Unit Manager indicated not all nursing staff had access to pull the report from the system. Resident B's record was reviewed on 8/17/23 at 10:50 a.m. The profile indicated the resident's diagnoses included, but were not limited to, quadriplegia (paralysis of all four limbs), respiratory failure unspecified with hypoxia (happens when you don't have enough oxygen in your blood, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures). The resident required a mechanical ventilator (type of breathing apparatus that provides mechanical ventilation by moving breathable air into and out of the lungs). Review of Medication Administration Record (MAR), indicated in the month of August 2023, Resident B had complained of pain at a scale of 5 or higher 9 out of 17 days reviewed and required as needed pain medication to be administered in addition to the resident's routine pain medication. Review of shower sheet, dated 7/28/23, indicated Resident B was given a bed bath and external rotation was not noted by staff. Review of shower sheet, dated 7/31/23, indicated Resident B was given a shower at 11:53 a.m. The shower sheet lacked any documentation of the external rotation being noted by staff. Resident B was transferred per mechanical lift for her shower on this day per the Director of Nursing (DON).			

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	A health status note, dated 8/1/23 at 1:40 p.m., indicated Resident B's right lower extremity was rotated outward, Medical Director notified, and new order received for x-ray. Review of x-ray report, completed on 8/1/23 at 3:40 p.m. The report indicated Resident B had an "old or healing" intertrochanteric (fractures of the proximal femur that occur between the greater and lesser trochanter) right femoral fracture. The record lacked a care plan for a fractured femur of unknown origin after diagnosis of x-ray. The record lacked any assessment documentation of the right leg in the electronic medical record from 7/30/23 to 8/18/23. The record lacked documentation physical therapy and or occupational therapy were requested to assess for positioning or transferring the resident related to fracture. A health status note, created on 8/7/23 at 10:57 a.m., with an effective date of 8/4/23, indicated Unit Manager 5 spoke with resident about her results of the x-ray. Resident B was unaware of how the fracture could have happened. The resident denied any falls or rough turning and/or pulling by staff. A health status note, created on 8/7/23 at 11:50 a.m., with an effective date of 8/4/23, indicated Unit Manager 5 paged the orthopedic doctor regarding Resident B's x-ray of her right femur. The orthopedic doctor indicated the resident did not require surgery and did not need to be sent to the emergency room.			

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	A health status note, created on 8/16/23 at 11:31 a.m., with an effective date of 8/11/23, indicated Unit Manager 5 called the orthopedic doctor's office to clarify if Resident B needed to be seen in his office. The orthopedic doctor denied the resident being seen in his office but would like a repeat x-ray in one week. A health status note, dated 8/17/23 at 3:02 p.m., indicated a registered nurse called the orthopedic doctor's office to see if he had received the follow up x-ray performed on 8/15/23 for Resident B. The nurse at the doctor's office confirmed that they had received but the doctor had not yet reviewed the x-ray. A health status note, dated 8/17/23 at 3:20 p.m., indicated RN 3 spoke with Resident B in her room. Resident B requested to go to the hospital for a second opinion of her right femur fracture because she was in a "lot of pain" and wanted to go. RN 3 medicated the resident with Ibuprofen (anti-inflammatory medication) 600 mg (milligram) by mouth and Xanax (anti-anxiety medication) 0.5mg by mouth for comfort. A health status note, dated 8/17/23 at 4:00 p.m., indicated Resident B was transported to the hospital via ambulance for evaluation per family request. During an interview, on 8/18/23 at 12:58 p.m., the Administrator indicated Resident B had been interviewed by staff to determine a cause for her fracture. Resident B was unable to recall anything out of the ordinary happening. The Administrator denied interviewing any staff regarding the root cause to the fracture. It was the nurse's judgement on when they should notify the doctor. The external rotation on Resident B's leg was not			

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	considered emergent by the staff. During a phone interview, on 8/18/23 at 1:15 p.m., the Wound doctor indicated he was last at the facility on 7/27/23 and had not noticed an external rotation to the right lower extremity. Review of an orthopedic note, dated 8/18/23 at 2:54 p.m., the Orthopedic doctor indicated he had reviewed an x-ray that was completed on 8/1/23. The x-ray indicated Resident B had a non-displaced, subacute (a condition between acute and chronic) to chronic (long term) appearing intertrochanteric hip fracture with evidence of healing. The orthopedic doctor recommended continued non-operative treatment as long as the resident was not having significant pain and was tolerating transfers and positioning. He was aware the resident had transferred to a local hospital per patient request. Computerized Tomography (CT) of the low right extremity, dated 8/17/23, indicated Resident B had a subacute to chronic non healed comminuted (a bone that is broken in at least 2 places) right femur intertrochanteric fracture. Review of a consultation note, dated 8/18/23, Orthopedic physician was consulted due to Resident B's fracture. The orthopedic doctor at the hospital indicated the resident had a subacute fracture to the right proximal (situated nearer the center of the body or the point of attachment) femur, likely 2 to 6 weeks old. The physician planned to take Resident B to the operating room on 8/19/23 for a gamma nail (used to treat proximal femoral fractures) and fracture fixation (stabilize extremely misaligned broken bones by re-setting). Review of Operative note, dated 8/19/23, indicated			

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	Resident B had a preoperative diagnosis of an unstable fracture of the right proximal femur. The operation was an open reduction and internal fixation (put pieces of a broken bone into place using surgery) of the right proximal femur with 120-degree Stryker gamma nail with proximal distal interlocking (metallic implants used for the repair of traumatic long bone fractures) and a long leg splint. On 8/18/23 at 9:52 a.m., the Administrator provided an undated document, titled, "Guidelines for Physician Notification for Change in Condition Overview," and indicated it was the policy currently being used by the facility. The policy indicated, "1. All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and are to be documented int eh medication record ...2. Medical care problems are communicated to the attending physician in a timely manner, concise, and thorough manner ...." On 8/18/23 at 9:52 a.m., the Administrator provided a document dated 2/23/22, titled, "Notification of Resident Change in Condition," and indicated it was the policy currently being used by the facility. The policy indicated. " ...1. A licensed nurse shall immediately inform the resident, consult with the resident's physician, and the resident's representative when: ...b. A significant change in the resident's physical, mental, or psychosocial status ...." On 8/18/23 at 1:15 p.m., the Administrator provided an undated document, titled, "Resident Assessment," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Purpose: To gather comprehensive information as a basis for the identifying resident			

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	problems/needs and developing or revising an individual plan of care ... 3. Other assessment monitoring shall be initiated and recorded on facility approved forms or in conjunction with the resident's clinical condition, assessed need and planned interventions ...4. Other clinical assessments will be performed in conjunction with body systems, with specific problems/complaints ...." This Federal tag relates to Complaints IN00415330 and IN00415942. 3.1-37			