STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 12/06/2011

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HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

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F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, physician interviews and record reviews, facility staff failed to assess the resident's lower extremities following reports of increased pain, coldness, bluish discoloration and lack of palpable pulses in one (1) of six (6) sampled residents. (Resident #1). The findings are: Resident #1 was admitted on 10/11/11 with diagnoses including a left (L) hip fracture with an open reduction, internal fixation on 10/07/11, degenerative joint disease and peripheral vascular disease. A review of a facility document titled "Comprehensive Pain Evaluation" dated 10/11/11 stated Resident #1 had pain in his left (L) hip and (L) leg. The pain was documented as seven (7) and described as "throbbing" based on a pain scale of one (1) "no pain" to ten" (10) "worst pain." A review of facility documents titled "Nursing	F 309	Disclaimer: Preparation and or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. executed solely because it is required by the provisions of Federal and State law. F309 1. Resident # 1 is no longer a resident of the facility. 2. Because all residents having pain have the potential to be affected by the cited deficiency, the medical records for residents in the facility have been reviewed to ensure that appropriate assessment, communication, documentation, and intervention and revision to the Plan of Care have occurred. 3. Licensed nursing staff have been re-educated regarding the Pain Management Program, with particular emphasis on the need for physical assessment of the pain site, communication of that assessment, documentation of that assessment, and intervention and comprehensive Care Plan revision as needed. This education has been incorporated into the facility orientation program for newly hired Licensed Nursing staff. 4. The Nurse Mentors/Nurse Leaders will, on a weekly basis, review a minimum of five medical records to ensure that appropriate assessment, communication, documentation, and intervention have occurred. New admissions will be reviewed at the weekly Acuity Intervention Team meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ty Lewis — TITLE: Exec. Director, NHA — (X6) DATE: 12/29/11

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.

DEC 30 2011
BY: MH

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F 309	Continued From page 1 Progress Summary" (weekly assessment) by Licensed Nursing (LN) staff indicated on 10/11/11 Resident #1's pain was "severe" and rated ten (10) on the pain scale. Handwritten notes indicated pain was located in his left hip. A review of Physicians Orders dated 10/11/11 stated Morphine Extended Release (ER)15 milligrams orally twice a day at scheduled times; Percocet 5/325 milligrams one (1) tablet orally every four (4) hours as needed for mild pain and Percocet 5/325 milligrams two (2) tablets orally every four (4) hours as needed for moderate to severe pain. On 10/12/11 a physician's order stated to discontinue Morphine ER 15 milligrams orally twice a day and give Morphine ER 30 milligrams orally twice a day. On 10/13/11 physician's orders stated no blood thinners due to gastrointestinal distress and physical therapy five (5) times per week for four (4) weeks. A review of therapy notes dated 10/12/11 indicated a physical therapy evaluation was completed and the plan of care was discussed with Resident #1 for therapy to occur twice daily. The admission Minimum Data Set (MDS) dated 10/18/11 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The resident required extensive assistance by staff for transfers and supervision during ambulation with one person physical assistance. A review of a Care Area Assessment Summary dated 10/18/11 was titled "Pain" and indicated the location as left lower extremity. The document stated medications "make it better, therapy	F 309	Results of this monitoring will be shared with the Director of Nursing weekly and with the facility Quality Assessment and Assurance Committee monthly. Monitoring will continue for a minimum of ninety days at which time the Quality Assessment and Assurance Committee will determine whether the deficiency has been resolved. If it is determined that the deficiency has been resolved, monitoring will continue on a quarterly basis.	1/3/2012

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F 309	Continued From page 2 makes it worse" and it occurs "frequently." A review of a Care plan dated 10/18/11 indicated Resident #1 was at risk for pain. The interventions included to assist with repositioning to promote comfort and to assess necessity for pain medication prior to therapies to allow improved mobility and therapy participation. On 10/19/11 the nursing progress summary indicated Resident #1's pain was "severe" and the pain was rated as nine (9). There was no documentation regarding the location of the pain. A review of a Physician's order dated 10/28/11stated to apply Voltaren one (1) percent topical gel (a topical nonsteroidal anti-inflammatory drug) to bilateral heels twice a day. A review of a physician's order dated 10/31/11 stated to decrease Morphine ER to 10 milligrams orally every twelve hours and use Percocet for break through pain as ordered. A review of a hand-written Podiatrist note dated 10/31/11 revealed Resident #1 was seen due to long toenails and bluish discoloration on left (L) foot. The Podiatrist's notes stated in part no palpable pulses and probably will consider non-invasive arterial study of bilateral lower extremities. A review of Physician's orders dated 11/01/11 stated to discontinue the order for Morphine ER 10 milligrams orally every twelve hours; Morphine ER 15 milligrams orally every 12 hours and Neurontin 100 milligrams orally at bedtime daily	F 309		

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F 309	Continued From page 3 for peripheral nerve pain. A review of a Licensed Physical Therapy Assistant (LPTA) note dated 11/01/11 for Resident #1 stated in part "second scheduled treatment session, left (L) foot/ankle cold to touch and with blue discolored spots." The documentation stated she reported it to the nurse who took care of the resident on 11/01/11 and documented the nurse stated the physician was already aware. Resident # 1's (L) foot pain was documented as eight (8). A review of the nurse's notes dated 11/01/11 stated "resident did complain of pain. Pain medication was given with relief." There were no nurses notes regarding an assessment of Resident #1's left (L) foot. On 11/02/11 the nursing progress summary indicated Resident #1's pain was "severe" and was rated nine (9). The hand-written notes stated "continues on pain management" but there was no documentation regarding the location of the pain. A review of the nurse's notes dated 11/07/11 at 10:45 AM revealed LN #1 documented "(L) foot cold to touch. No palpable pedal pulse and blue spots top (L) foot and bottom. (L) foot with cyanosis tip great toe." The Physician Assistant (PA) was informed and used a Doppler to check for pulses and said there was no pedal pulse. At 11:30 AM LN #1 called the resident's daughter to inform her he was being transported to the emergency room (ER) and at 11:45 AM LN #1 documented Emergency Medical Services (EMS) was transporting resident out of facility to the ER.	F 309		

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F 309	Continued From page 4 During an interview on 12/05/11 at 2:08 PM Licensed Nurse (LN) #1 stated Resident # 1 complained to her about leg pain bilaterally. She stated the resident told her frequently that his legs just "ached and described it like restless leg syndrome." She explained on the morning of 11/07/11 she put the Voltaren gel on his left (L) foot and his (L) foot was cool to touch and the left (L) big toe was slightly blue. She stated she notified the Physician's Assistant (PA) who was in the facility. LN #1 stated she had never noticed his (L) foot was discolored until the morning he went to the hospital. During an interview on 12/05/11 at 3:00 PM the Nurse Manager explained on 10/28/11 Resident #1 had bilateral heel pain, had an x-ray in the facility to rule out heel spurs and the X-rays were negative. She further stated he went to see a Podiatrist on 10/31/11 for long toenails. She explained the Podiatrist sent a hand-written note regarding his evaluation back to the facility and the document was initialed on 11/01/11 as reviewed by the Family Nurse Practitioner (FNP). The Nurse Manager verified there were no nursing assessment notes in the medical record on 11/01/11 when therapy staff reported Resident #1's left (L) foot was cold and had a bluish discoloration. She further stated on 11/02/11 there was a weekly assessment in Resident #1's medical record which indicated he was having severe pain and the pain limited his day to day activities and made it hard for him to sleep. During an interview on 12/05/11 at 3:33 PM LN #2 stated Resident #1 complained of bilateral pain in his lower extremities on 10/28/11. She	F 309		

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F 309	Continued From page 5 further stated she left a note for the physician to evaluate him and they prescribed pain cream for his heels on 10/28/11. She explained she usually applied the pain cream on her shift around eight (8) PM. She stated she checked for any swelling, discoloration or pedal pulses but did not document any assessment information in the nurses notes when she took care of the resident on November 1st, 3rd,4th, 5th, & 6th. She further stated Resident #1 complained of leg pain on November 5th and 6th and she did not document any assessment information on these dates. During a phone interview on 12/05/11 at 3:53 PM LN #3 stated she was Resident #1's nurse on the day shift on 11/01/11 and remembered he had foot problems and pain was an ongoing issue with him. She explained he had a topical ointment for pain in his feet that she put on him but later in her shift he said his feet were hurting again so she filled out a change of condition form for the Family Nurse Practitioner (FNP) but did not call the FNP to come and see the resident. She stated therapy staff talked with her on 11/01/11 and asked her to take Resident #1's Ted Hose off but she did not remember therapy staff reporting to her the resident's left (L) foot was cold or discolored. LN #3 further stated she did not document any assessment notes on 11/01/11 but gave report to the next shift about Resident #1's complaints of pain. During an interview on 12/05/11 at 4:22 PM the Nurse Manager stated she had reviewed LN #3's documentation in the medical record and verified there was no nursing assessment documented on 11/01/11.	F 309		

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F 309	Continued From page 6 During an interview on 12/05/11 @ 4:32 PM Nursing Assistant (NA) #1 revealed she was responsible for taking off Resident #1's TED Hose at night and gave him his shower. She stated she didn't remember any discoloration on his feet but he would tell her to tell the nurse that he needed a pain pill because his legs always hurt. During an interview on 12/05/11 at 4:36 PM the Physician's Assistant (PA) stated she examined Resident #1 on 11/07/11 and sent him to the emergency room (ER) because a nurse reported Resident #1 was complaining of foot pain and his foot was discolored. She explained she went immediately to assess him and his left (L) foot was cold and blue. She further stated there was swelling in his (L) foot and she couldn't feel any pulses. She explained she used a hand held doppler to check for pulses and there were no pulses. The PA stated nursing staff did not talk to her about leg pain until the day she sent him to the hospital and the only pain he complained about to her was arthritic type hand pain. She verified a podiatrist saw Resident #1 and his hand-written notes dated 10/31/11 indicated there were no pulses in his lower extremities and he would consider further studies. She explained when they sent a resident out of the facility to see a specialist, they expected them to take care of any concerns or issues and to let them know what they recommended. She further stated if something was urgent or needed to be done immediately the consulting physician would deal with the problem themselves or ask them for a referral right away. The PA further stated nursing staff was supposed to do an assessment and complete a change of condition form when a	F 309		

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F 309	Continued From page 7 resident had a change in condition and leave the documentation for the Physician's Assistant, Family Nurse Practitioner or Physician in a designated location at the nurses station. During an interview on 12/06/11 at 8:48 AM a Licensed Physical Therapy Assistant (LPTA) stated she provided therapy to Resident #1 in the morning on 11/01/11 and did not see anything unusal about his left (L) foot but Resident #1 stated his pain on the pain scale was a ten (10) and described the pain as sharp in his (L) foot. She stated during the afternoon therapy session his (L) foot was cold to touch as compared to the right (R) foot. She stated she went and got an Occupational Therapist to look at it and she said Resident #1's (L) foot felt cold. The LPTA stated she then went to get Resident #1's nurse (LN # 3) and reported to her that Resident #1's foot was cold. She explained the nurse stated the physician was already aware of the new complaint. During an interview on 12/6/11 at 10:33 AM a Family Nurse Practitioner (FNP) stated she remembered evaluating Resident #1 for heel pain. She explained he was having pain in both legs especially at night. She stated on 10/27/11 she ordered for him to see the Podiatrist because his toenails were long. She explained he went to the Podiatrist on10/31/11 and the Podiatrist cut the nails and documented to consider non arterial invasive studies, stockings for both extremities and there were nonpalpable pulses in his feet. She explained usually when a resident came back from a specialist visit, the specialist would write out a prescription for any additional studies or new orders. She verified there were no	F 309		

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F 309	Continued From page 8 additional orders or prescriptions from the Podiatrist office when Resident #1 returned to the facility. The FNP stated she had not been told anything about the therapy notes that described Resident #1's foot as cold and discolored on 11/01/11. She stated nursing staff should have called her or the Physician's Assistant (PA) to evaluate the resident. During a phone interview on 12/06/11 at 11:57 AM with a Vascular Surgeon who evaluated Resident #1 in the emergency room and performed surgery stated Resident #1 had a lot of chronic disease and he attempted to open up some small arteries in the left (L) foot but there was a lack of circulation for "a significant period of time." He stated he did another surgical intervention on 11/14/11 for a below the knee amputation of the (L) leg. During a follow up interview on 12/06/11 at 3:10 PM the Nurse Manager explained when a resident had pain the Licensed Nurses (LNs) should medicate the resident for pain and reassess for the effectiveness of the medication and should communicate with the physician regarding any medication concerns. She stated LNs should document the as needed (PRN) pain medications on the back of the Medication Administration record (MAR) and in the nurses notes. She further stated medications documented on the MAR should also match medications documented on the pain flow sheet. She stated she expected LNs to document on the back of the MAR the name of the medication, date given, the time given, reason, results/response to the pain medication and nurse's ititials and signature. She stated LNs	F 309		

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F 309	Continued From page 9 should document location and intensity of pain and verified that LNs did not always document pain according to the pain scale from one (1) to ten (10). The Nurse Manager verified PRN pain medications were listed on the back of Resident #1's MAR and some of the entries only stated the resident complained of pain but the location of pain was not documented on the MAR or in nurses notes or on the pain flow sheet. During an interview on 12/06/11 at 4:05 PM the Director of Nurses (DON) stated she expected licensed nursing (LN) staff to notify the physician when a resident had a change in condition.	F 309		