### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Autumn Care of Biscoe

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>INITIAL COMMENTS</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>The allegations in the complaint investigation were not substantiated. However, deficient practice at tags F 157 and F 305 was identified while investigating the complaint. Event ID# CVKX711.</td>
<td>F 000</td>
<td>Preparation and submission of the plan of correction is in response to DHISR 2567 for the survey and does not constitute an agreement or admission by Autumn Care of Biscoe of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Autumn Care of Biscoe contends that it was in substantial compliance with the requirements 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, Autumn Care of Biscoe submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of 5/20/13.</td>
<td>5/20/13</td>
</tr>
<tr>
<td>F 157</td>
<td>463.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</td>
<td>F 157</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| SS=G   | A facility must immediately inform the resident; consult with the resident’s physician; and if known, notify the resident’s legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  
The facility must also promptly notify the resident and, if known, the resident’s legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident’s representative. |

**Laboratory Director or Provider/Supplier Representative's Signature:**

![Signature]

**Title:**

![Title]

**Date:** 7/21/13

---

**Notes:** 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 patient. (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.
<table>
<thead>
<tr>
<th>(X) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LICENSING IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by:</td>
<td>F 157</td>
<td>IF 157: This facility has and will continue to inform the resident; consult the resident's physician and notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form or treatment); or a decision to transfer or discharge the resident from the facility as specified in § 483.12(a). Steps taken in regards to Resident # 188 found to have been cited during the survey findings: Resident # 188 transferred to hospital on 4/24/13.</td>
<td>5/20/13</td>
</tr>
</tbody>
</table>
Continued From page 2

pain.

The PT (physical therapy) notes dated 4/8/13 were reviewed. The notes indicated that Resident #188 was evaluated and noted that the right leg was shorter than the left leg and the resident had some pain on the right hip with walking. On 5/9/13 at 1:12 PM, therapy staff #4 (PT) was interviewed. She acknowledged that she was the one who evaluated Resident #188 on admission. She indicated that the right leg was shorter about 2-3 inches than the left leg and thought it was not normal after surgery. She indicated that she did not inform nursing about it because the family indicated that the surgeon stated that it was expected after surgery. She also stated that pain was expected in the beginning of therapy and would decrease later on.

The nurse's notes and the medication administration record (MAR) for 4/8/13 indicated that the resident had received Percocet at 11:54 AM for pain rated at "4".

The occupational therapy (OT) notes dated 4/9/13 indicated that Resident #188 stated that she was in a lot of pain. The PT notes dated 4/9/13 indicated that the resident stated "my hip hurt pretty bad last night what are we going to do?" The notes further indicated that Resident #188 was in a lot of pain and it was reported to the nurse and a pain medication was administered prior to therapy.

The MAR for 4/9/13 revealed that the resident had received Percocet at 1:32 PM and at 7:52 PM.

Steps taken in regards to residents having the potential to be affected by the survey findings: A discussion was held with each therapist on 5/9/13 regarding residents currently receiving therapy for changes in condition (pain, decline, progress, concerns) by the D.O.N. and Administrator with corrective action taken immediately for any concern identified by D.O.N. and Administrator. An in-service was conducted by the Administrator and D.O.N. on 5/10/13 with therapy staff regarding Coordinating Resident Care with other disciplines. All nurses were re-instructed by the D.O.N. and SDC on 5/10/13 regarding Coordinating Resident Care and physician/family notification. A Pain Assessment & Reporting in-service was done on 5-16-13 by the SDC with nursing staff. Each licensed nurse and therapist completed an online class through AHEC on Pain and Aging beginning on 5/17/13 and completed on 5/20/13.
Systemic Changes: All new hires will be instructed during orientation regarding timely notification of physician and family of changes and Coordinating Resident Care by the Rehab Manager and SDC and annually thereafter. All newly hired nurses will be re-instructed regarding pain assessment during orientation by the SDC and annually thereafter. Therapy department will provide documentation daily for all patients receiving therapy to the charge nurse regarding resident performance during therapy to include progress, decline, participation, and pain by utilizing the Therapy Communication form which was started on 5/9/13. Family and Physician will be notified of changes as indicated. During morning meeting (Mon-Fri), therapy manager will communicate concerns and declines in resident's therapy performance to the D.O.N., Administrator and IDT.

D.O.N., QA Nurse and SDC QA Monitoring to prevent reoccurrence: The D.O.N. and MDS Nurse will review the Therapy Communication form daily for 4 weeks then once weekly for 3 months for appropriate care interventions and timely notification of physician/family as
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 4 revealed that the resident continued to have much pain. The MAR for 4/17/13 indicated that the resident had received the Percocet at 12:45 PM and at 9:24 PM. The OT notes dated 4/18/13 revealed that the resident required frequent breaks due to increased pain. The PT notes indicated that the resident stated &quot;my hip is hurting but I will be alright.&quot; The PTA continued to express concern about the resident's pain. The therapy notes revealed that Resident #188 was seen by the physician on 4/18/13. The physician was informed of the pain during therapy and he ordered to give Percocet 2 tablets prior to therapy. The records did not indicate that the physician was informed of the swelling on the right leg and the leg length difference, right leg shorter than the left leg. The MAR for 4/18/13 revealed that the resident had received Percocet at 9:20 AM for hip pain rated at &quot;5&quot;. The OT notes dated 4/19/13 revealed that Resident #188 stated &quot;my leg hurts so bad, I can not move it.&quot; The notes further indicated that the resident had increased pain during movement which did not appear to be getting better. The PT notes revealed that the resident stated &quot;I'm trying but it just hurts so badly.&quot; The resident was in a lot of pain from hip to knee. On 5/8/13 at 3:05 PM, Nurse #1 was interviewed. She stated that she was aware that Resident #188 was in pain due to her surgery. The resident was indicated. During weekly Medicare meeting each resident on therapy case load will be discussed regarding progress, decline, pain and other concerns with documentation placed in the residents chart. Therapy documentation will be reviewed by the D.O.N. or MDS Nurse daily for changes in resident condition. Performance with the physician/family notified for any decline noted. All residents will be audited for acute changes 5 x weekly for timely notification of physician and family by the QA Nurse and D.O.N.. Residents with weight changes will be audited weekly for timely notification of physician and family by the D.O.N. and QA Nurse. Residents that have an incident will be audited 5 x weekly for timely notification of family and physician by the QA Nurse and D.O.N.. Residents with wounds will be audited weekly for timely notification of physician and family by the D.O.N. and QA Nurse. Any area of identified concern will be addressed in Quality Assurance meeting for further action plans as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 157 Continued From page 5

on pain medication which was effective. She further stated that the physician had ordered to give Percocet 2 tablets to be given prior to therapy and that seemed to be working. She was not informed that the resident was having a lot of pain during therapy with movement and gait. She indicated that if she had known, she would inform the physician about it.

The PT notes dated 4/21/13 indicated that Resident #188 stated "I would like my pain pill before we start." The nurse was notified and pain medication was administered. The notes further indicated that resident was in a lot of pain from hip to knee with gait. On 5/7/13 at 5:55 PM, Nurse #2 was interviewed. She stated that she was aware that Resident #188 was in pain and she was on pain medication which was effective. She stated that she was not informed that the resident was in much pain during therapy. She also stated that if the resident had complained of continued pain with movement and gait, she would assess the site for swelling and for any increased in pain and would inform the physician.

The nurse's notes revealed that the resident's pain was rated at "8" on 4/21/13 at 11:12 AM.

The PT notes dated 4/22/13 revealed that the resident had worked hard, still having much pain. She pointed the pain across the groin and she was unable to flex her hip and knee.

The MAR for 4/22/13 revealed that the resident had received 2 tablets of Percocet at 8:46 AM. The notes further indicated that the resident stated that her pain was never completely relieved. At 10:25 PM, 1 tablet of pain medication
Continued From page 6

was given due to complain of pain on the right hip rated at " 8 ". There was no indication in the
records that the physician was informed of the
pain not completely relieved after the pain
medication was administered and the increased
intensity of pain the resident was experiencing
with movement and gait.

The PT notes dated 4/23/13 revealed that the
resident was assisted on right hip mobility but she
could not tolerate it. She complained of pain in
thigh with movement. She continued to work
hard but continued to have difficulty with
movement of hip flex and with extreme pain. The
MAR revealed that 2 tablets of Percocet were
administered at 8:47 AM prior to therapy.

The OT notes date 4/24/13 revealed that
Resident #188 stated " my leg hurts so bad, I can
not move it."

The records from 4/18/13 to 4/24/13 did not
indicate that the physician was informed of the
increased intensity of pain during movement and
gait, that the resident could not move her leg
anymore and that the pain medication did not
completely relieve the pain..

On 4/24/13, Resident #188 went to the orthopedic
surgeon for her follow up appointment. The
progress notes from the orthopedic surgeon
dated 4/24/13 was reviewed. The notes indicated
that an x-ray of the hip was taken and
demonstrated an oblique fracture of the proximal
femur. Resident #188 was transported to the
hospital from the clinic on 4/24/13 for surgery.

The hospital notes with the admission date of
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCD IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 7 4/24/13 indicated that Resident #188 had sustained a peri prosthetic fracture (fracture around joint replacement prosthetics/implants) of the right hip. The notes revealed that the resident had sustained the fracture while doing physical therapy. She was admitted from the office to the hospital for surgical repair of her peri prosthetic fracture. She underwent open reduction and internal fixation and implant revision of her right hip hemi arthroplasty. On 5/8/13 at 9:10 AM, therapy staff #1 (PTA) was interviewed. She acknowledged that she was assigned to work with Resident #188 during her stay at the facility. She admitted that the resident was having pain so bad during therapy. She revealed that the resident's right leg was swollen since she was admitted. She also stated that her right leg was shorter than the left leg. She indicated that she had informed the nurse about her pain and a pain medication was administered. She also stated that in 2 weeks, it was not unusual for a resident to be experiencing pain and swelling and she did not think that something was wrong because the resident did not have any incidents that happened. On 5/8/13 at 9:15 AM, therapy staff #2 (OTA) was interviewed. She stated that she had worked with Resident #188 during her stay at the facility. The resident was having hard time moving her right leg due to pain. She stated that nursing was aware of the resident's pain and pain medication was administered and was effective. She also stated that pain was not unusual for a resident with a fractured leg. On 5/8/13 at 9:35 AM, therapy staff #3 (OT) was</td>
<td>F 157</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
<td>------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 157</td>
<td>Continued From page 8</td>
<td>interviewed. She stated that pain was expected in about 2 weeks and the orthopedic appointment should be made within 2 weeks after surgery. She stated that she was aware that the resident was having pain but the pain was relieved with the pain medications. On 5/8/13 at 10:35 AM, administrative staff #1 was interviewed. She stated that she was aware that the resident was having pain and the pain medication was effective. She was not aware that the pain was on-going and was increasing during therapy. She also was not aware that the right leg was shorter than the left leg and was swollen. She expected that the therapy staff should communicate with nursing when the resident continuously experiencing pain during therapy and any abnormality so nursing could inform the physician. On 5/8/13 at 2:10 PM, the physician was interviewed. He stated that he had seen the resident once and that was on 4/18/13. The notes for that visit had been dictated and the dictated notes were not available for filing yet. He was informed of pain during therapy and he had ordered additional pain medication (Percocet 2 tablets) to be given prior to therapy. He stated that he was not informed of the swelling on the right leg, the difference of the leg length and the continued and increased pain especially during therapy. He added that if he had known it, he would reassess the resident, get an x-ray or get an orthopedic consult.</td>
<td>F 157</td>
<td></td>
</tr>
<tr>
<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>F 309</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 309: Continued From page 9

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 record review and physician and staff interview, the facility failed to assess the underlying cause of continued and increased intensity of pain for 1 (Resident #188) of 1 sampled resident. The findings included:

Resident #188 was admitted to the facility on 4/7/13 with multiple diagnoses including right hip fracture from a fall and status post hemi arthroplasty (surgical procedure in which half of the hip joint was replaced) of the right hip. The admission Minimum Data Set (MDS) assessment dated 4/12/13 indicated that Resident #188 had intact cognition, had a fall prior to admission and had received a PRN (as needed) medication for pain. The assessment also indicated that Resident #188 had pain present which made it hard for her to sleep at night, limited her daily to day activities and the pain intensity was "9". The analog pain scale of 0-10 indicated "0" as having no pain and "10" as agonizing pain.

The CAA (care area assessment) for pain dated 4/19/13 indicated "pain triggered related to pain during assessment period, she is at risk for discomfort from pain related to hip. Resident is assessed for pain by observing for facial
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 10</td>
<td>expression such as grimacing, flinching with treatment/touch, verbal complaint of pain, moaning, groaning, etc (et cetera). Measures to relieve pain with PRN medications and scheduled medications per doctor, orders will be adhered to. She will have pain relieved during next review. Will proceed to care plan and referral as needed.</td>
<td>F 309</td>
<td>regarding Coordinating Resident Care with other disciplines. All nurses were re-instructed by the D.O.N. and SDC on 5/10/13 regarding Coordinating Resident Care. A Pain Assessment &amp; Reporting in-service was done on 5-16-13 by the SDC with nursing staff. Each licensed nurse and therapist completed an online class through AHEC on Pain and Aging beginning on 5/17/13 and completed on 5/20/13. Systemic Changes: All new hires will be instructed during orientation regarding Coordinating Resident Care by the Rehab Manager and SDC and annually thereafter. All newly hired nurses will be re-instructed regarding pain assessment during orientation by the SDC and annually thereafter. Therapy department will provide documentation daily to the charge nurse regarding resident performance during therapy to include progress, decline, participation, and pain (Therapy Communication form). During morning meeting (Mon-Fri), therapy manager will communicate concerns and declines in resident's therapy performance to the D.O.N. and Administrator. QA Monitoring to prevent reoccurrence:</td>
<td>5/20/13</td>
<td></td>
</tr>
<tr>
<td>(X4) ID TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 309</td>
<td>Continued From page 11 indicated that she did not inform nursing about it because the family indicated that the surgeon stated that it was expected after surgery. She also stated that pain was expected in the beginning of therapy and would decrease later on.</td>
<td>F 309</td>
<td>The D.O.N. and MDS Nurse will review the Therapy Communication form daily for 4 weeks then once weekly for 3 months for appropriate care interventions. During weekly Medicare meeting each resident on therapy case load will be discussed regarding progress, decline, pain and other concerns with documentation placed in the residents chart. All residents will be audited for acute changes 5 x weekly for timely notification of physician and family by the QA Nurse and D.O.N.. Any area of identified concern will be addressed in Quality Assurance meeting for further action plans as indicated according to situation (i.e. disciplinary, in-servicing, return demonstration, etc.).</td>
<td>5/20/13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The occupational therapy (OT) notes dated 4/9/13 indicated that Resident #188 stated that she was in a lot of pain. The PT notes dated 4/9/13 indicated that the resident stated "my hip hurt pretty bad last night what are we going to do?" The notes further indicated that Resident #188 was in a lot of pain and it was reported to the nurse and pain medication was administered prior to therapy. The MAR revealed that the resident had received Percocet at 1:32 PM and 7:52 PM.

The PT notes dated 4/10/13 and 4/12/13 indicated that Resident #188 stated that her leg was very sore. The PT notes dated 4/12/13 revealed that Resident #188 was experiencing pain in the right hip with movement and gait. The MAR revealed that the resident had received Percocet on 4/10/13 at 9:39 AM for pain rated at "4", on 4/11/13 at 4:02 PM and on 4/12/13 at 9:34 AM and was effective.

The PT notes dated 4/15/13 indicated that the resident was experiencing pain in the right hip with movement and gait, the resident seemed to hold her breath due to pain. This was reported to the nurse that hip did not seem to be progressing well. The MAR indicated that the resident had received Percocet at 10:44 AM and at 9:33 PM. The nurse who was informed by the therapist was not available for interview.
F 309  Continued From page 12

The OT notes dated 4/16/13 revealed that Resident #188 stated "I am still hurting." The PT notes dated 4/16/13 indicated that the resident stated that my leg is hurting especially in the knee. The notes further indicated that the pain was with movement and gait. The MAR indicated that the resident had received Percocet at 8:20 AM for pain rated at "5" and at 9:46 PM and was effective.

The OT notes dated 4/17/13 revealed that Resident #188 stated "I am hurting so bad." Resident had increased pain during movement which did not appear to be getting better, discussed with PTA (physical therapy assistant). The PTA asked the resident as to when her follow up appointment with the surgeon would be. The notes further indicated that the plan was to make the appointment. The PT notes dated 4/17/13 indicated that Resident #188 stated "I'm hurting bad." The notes revealed that resident continued to have much pain, discussed with PT about starting e stim (electro stimulation) for pain. The MAR indicated that the resident had received Percocet at 12:45 PM and at 9:24 PM.

The OT notes dated 4/18/13 revealed that the resident required frequent breaks due to increased pain. The PT notes indicated that the resident stated "my hip is hurting but I will be alright." The PTA continued to express concern about the resident's pain. The MAR revealed that the resident had received Percocet at 9:20 AM for hip pain rated at "5". The notes further indicated that the resident was seen by the physician and he was informed of the pain during therapy. The physician had ordered additional Percocet 2.
NAME OF PROVIDER OR SUPPLIER: AUTUMN CARE OF BISCOE

STREET ADDRESS, CITY, STATE, ZIP CODE: 491 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 13 tablets to be given prior to therapy. The physician was not informed of the swelling on the right leg and the leg length discrepancy, the right leg shorter than the left. The OT notes dated 4/19/13 revealed that Resident #198 stated &quot;my leg hurts so bad, I can not move it.&quot; The notes further indicated that the resident had increased pain during movement which did not appear to be getting better. The PT notes revealed that the resident stated &quot;I'm trying but it just hurts so bad.&quot; The resident was in a lot of pain from hip to knee. Attempted supine there ox (therapeutic exercises) for hip mobility but resident could not tolerate. Resident even experienced discomfort when head of bed was lowered. Resident had been limited due to pain in hip and knee and she was unable to complete due to excruciating pain she was in and that we were concerned with the amount of pain limiting her movement and gait. On 5/8/13 at 3:05 PM, Nurse #1 was interviewed. She stated that she was aware that Resident #188 was in pain due to her surgery. The resident was on pain medication which was effective. She further stated that the physician had ordered to give Percocet 2 tablets to be given prior to therapy and that seemed to be working. She was not informed that the resident was having a lot of pain during therapy especially during movement and gait. She indicated that if she had known, she would inform the physician about it. The MAR revealed that the resident had received Percocet (2 tablets) at 9:09 AM and 1 tablet at 9:35 PM. The PT notes dated 4/21/13 indicated that Resident #188 stated &quot;I would like my pain pill before we start.&quot; The nurse was notified and</td>
<td>F 309</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FORM CMS-2587(09-06) Previous Versions Obsolete Event ID: CVKT11 Facility ID: 022649 If continuation sheet Page 14 of 19
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:** 346000

**Multiple Construction**

A. Building __________________

B. Wing __________________

**Date Survey Completed:** 05/08/2013

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Precise By Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced To The Appropriate Deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 14 pain medication was administered. The notes further indicated that resident was in a lot of pain from hip to knee with gait. Supine there ex (therapeutic exercise) for the right hip was attempted but resident could not tolerate. The resident had worked hard, still having much pain when returned to room and bed. The resident had made a comment that &quot;maybe the pain medication would start working in a little meaning that she was in a lot of pain.&quot; On 5/7/13 at 5:55 PM, Nurse #2 was interviewed. She stated that she was aware that Resident #188 was in pain and she was on pain medication which was effective. She stated that she was not informed that the resident was in much pain during therapy especially with movement and gait. She also stated that if she should have known it, she would assess the site for swelling and for any abnormalities that could possibly cause the pain and would inform the physician. The MAR indicated that the resident had received Percocet at 11:12 AM for pain rated at &quot;8&quot;. The PT notes dated 4/22/13 revealed that the resident had worked hard, still having much pain. She pointed the pain across the groin and she was unable to flex her hip and knee. The MAR revealed that the resident had received 2 tablets of Percocet at 8:46 AM. The notes further indicated that the resident stated that her pain was never completely relieved. At 10:25 PM, 1 tablet of Percocet was given due to complain of pain on the right hip rated at &quot;8&quot;. The PT notes dated 4/23/13 revealed that the resident was assisted on right hip mobility but she could not tolerate it. She complained of pain in groin with movement. She continued to work.</td>
<td>F 309</td>
<td></td>
</tr>
</tbody>
</table>
Continued from page 15

hard but continued to have difficulty with
movement of the hip joint on about 25/30 degrees hip
flexion and with extreme pain. The MAR revealed
that 2 tablets of Percocet were administered at
8:47 AM and 1 tablet at 7:52 PM.

The OT notes date 4/24/13 revealed that
Resident #188 stated "my leg hurts so bad, I can
not move it." The MAR revealed that the
resident was given 1 tablet of Percocet at 8:07
AM for pain rated at "8".

The records from 4/18/13 - 4/24/13 did not
indicate that the physician was informed of the
continued and increased intensity of pain
especially during movement and gait, the
resident's complaint that she could not move her
leg and that the pain medication was not
completely relieving the resident’s pain.

On 4/24/13, Resident #188 went to the orthopedic
surgeon for her follow up appointment. The
progress notes from the orthopedic surgeon
dated 4/24/13 was reviewed. The notes revealed
that on examination, the resident had pain on
palpation of the thigh and also had increased
discomfort with internal or external rotation of the
hip. Weight bearing was not attempted. An x-ray
of the hip was taken and demonstrated an
oblique fracture of the proximal femur at the mid
portion of the femoral component. Resident #188
was transported to the hospital from the clinic on
4/24/13 for surgery.

The hospital notes with the admission date of
4/24/13 indicated that Resident #188 had
sustained a peri prosthetic fracture (fracture
around joint replacement prosthetics/implants) of
F 309 Continued From page 16

the right hip after hemi arthroplasty. The notes revealed that the resident had sustained the fracture while doing physical therapy. She was admitted from the office to the hospital for surgical repair of her periprosthetic fracture. She underwent open reduction and internal fixation and implant revision of her right hip hemi arthroplasty.

On 5/8/13 at 9:10 AM, therapy staff #1 (PTA) was interviewed. She acknowledged that she was assigned to work with Resident #188 during her stay at the facility. She admitted that the resident was having pain so bad during therapy but the resident would not admit having severe pain. She indicated that she could tell that the resident was hurting by not breathing well during therapy and she would say "I can't do it anymore." She revealed that the resident's right leg was swollen since she was admitted. She also stated that the resident had an order for weight bearing as tolerated and that her right leg was shorter than the left leg. She indicated that she had informed the nurse about her pain and a pain medication was administered. She also stated that in 2 weeks, it was not unusual for a resident to be experiencing pain and swelling and she did not think that something was wrong because the resident did not have any incidents that happened. She also stated that she was working with the resident on gait training and she knew that the resident was hurting by her breathing but the resident would say that "I have to do this so I can go back home."

On 5/8/13 at 9:15 AM, therapy staff #2 (OTA) was interviewed. She stated that she had worked with Resident #188 during her stay at the facility. She
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 17 was working with the resident on transfers in and out of bed and dressing. She was aware that the resident's pain was worse than what she normally described. She was having hard time moving her right leg due to pain. She indicated that the PTA (physical therapist assistant) had started questioning about her pain and the orthopedic follow up appointment with the nurse. She also stated that the PT had called the family who indicated that the surgeon wanted to see her in 2 weeks but there was no appointment made yet. On 5/8/13 at 9:35 AM, therapy staff #3 (OT) was interviewed. She stated that pain was expected in about 2 weeks and the orthopedic appointment should be made with in 2 weeks after surgery. She stated that she was aware that the resident was having pain but the pain was relieved with the pain medications. She also added that the orthopedic follow up appointment was made on 4/19/13 and the earliest date the office had available was 4/24/13. On 5/8/13 at 10:35 AM, administrative staff #1 was interviewed. She stated that she was aware that the resident was having pain and the pain medication was effective. She was not aware that the pain was on going and was increasing during therapy. She expected that the therapy staff should inform nursing when the resident continuously experiencing pain during therapy. She also expected nursing to assess the resident for the underlying cause of pain and to inform the physician. On 5/8/13 at 1:12 PM, therapy staff #4 (PT) was interviewed. She indicated that she had asked for a meeting with the family due to resident had</td>
<td>F 309</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Continued From page 18

plateau (long period of stability/progress ceases) due to a lot of pain, whether to push her or not. Review of the therapy staff #3 notes revealed that the meeting with the family occurred on 4/18/13. The notes indicated that the family was informed that the resident had decreased in mobility related to pain. The notes further indicated that the PTA had expressed concern over increased in right LE (lower extremity) pain and decreased tolerance for mobility with the use of the rolling walker. The family stated that she was aware of the increased in pain and was unsure of whether to push the resident or to let the resident listened to her body. The therapist discussed waiting for orthopedic appointment before pushing resident to participate at increased level. The notes indicated that the physician had ordered additional pain medication to possibly improve tolerance for treatment on 4/18/13. The notes further revealed that the orthopedic appointment was made for 4/24/13.

On 5/8/13 at 2:10 PM, the physician was interviewed. He stated that he had seen the resident on 4/18/13. He was informed of pain during therapy and he had ordered additional pain medication to be given prior to therapy. He was not informed of the swelling on the right leg, the difference of the leg length and the continued and increased pain especially during therapy. He added that if he had known it, he would reassess the resident, get an x-ray or get an orthopedic consult.