STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN CARE OF SHALLOTTE	**237 MULBERRY STREET SHALLOTTE, NC 28459**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and physician and staff interviews, the facility failed to provide pain management for a resident presenting with signs and symptoms of pain such as crying out and stating I hurt (Resident #2) for 1 of 1 residents observed for pain management. Findings included: Resident #2 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. A review of the care plan for Resident #2 revealed an updated plan of care on 02/06/20 for at risk for pain related to comorbidities, general discomfort and history of spine point tenderness over [MEDICATION NAME] 11-12. Interventions included to assess for increased and decreased pain, assist with positioning for comfort, medications as ordered, notify physician as needed with any changes, and vital signs as ordered and as needed. Notify physician with any abnormalities. The Minimum Data Set ((MDS) dated [DATE] quarterly assessment revealed Resident #2 was moderately cognitively impaired, demonstrated rejection of care behavior, required extensive assistance with two persons physical assistance with bed mobility, transfers, and toileting, extensive assistance with one person physical assistance with personal hygiene and dressing and supervision with one staff physical assistance with eating. Resident #2 was always incontinent of bowel and bladder had two or more falls with no injury during this assessment. Resident #2 was not steady and only able to stabilize with staff assistance, had no impairments and used a wheelchair. Resident #2 was not noted to be on any scheduled pain medication regimen, did not receive any as needed pain medication and was coded as having non medication interventions for pain. Resident #2 was noted to have received 7 days of antianxiety, antidepressant, and anticoagulant medications during this assessment. The MDS quarterly assessment dated [DATE] revealed Resident #2 was cognitively impaired. Resident #2 required extensive assistance with two person physical staff assistance with bed mobility, transfers, dressing and toileting, extensive assistance with physical staff assistance of one with eating and personal hygiene. The resident had an impairment to one side to lower extremity and used a wheelchair. She was frequently incontinent of bowel and bladder. The resident was coded as not having any falls since her last assessment 05/20/20. Resident #2 was coded as having to be assessed for pain. She was on scheduled pain medications and as needed pain medications and did not receive any non-medication interventions for pain. A review of the physician orders [REDACTED]. A review of the July, 2020, Medication Administration Record (MAR) revealed there was an order written [REDACTED]. If pain was present, document in the progress note. Documentation on the MAR revealed the resident ' s pain was assessed at 10:00 PM by Nurse #1 with 0 for pain scale on 07/11/20, assessed by Nurse #1 at 6:00 AM on 07/12/20 with 0 for pain scale, and at 2:00 PM on 07/12/20 the pain assessment was scaled 5 out of 10 for pain by Nurse #2. A review of the staffing assignment sheet revealed the nurse who worked on 07/11/20 going into 07/12/20 from 7:00 PM - 7:00 AM was Nurse #1. The staffing assignment revealed Nurse #2 relieved Nurse #1 on the morning of 07/12/20 for the 7:00 AM - 7:00 PM shift. A nursing note written by Nurse #1 on 07/12/20 at 7:48 AM revealed a nursing assistant (NA) was going to get resident up this morning and the resident was complaining of pain to the right leg and hip when moved. There was no bruising or [MEDICAL CONDITION] noted. The note indicated the nurse called the provider on call at 7:00 AM and received an order for [REDACTED]. The note stated the nurse called the responsible party (RP) and left message to call the facility back. A nursing note written by Nurse #1 on 07/12/20 at 8:07 AM revealed a stat (urgent) x-ray was ordered with the x-ray company at 7:15 AM. A written statement by NA #2 who was a training NA revealed upon doing bed mobility on 07/12/20 with Resident #2 to change her brief and get her up for breakfast, Resident #2 was holding her stomach yelling I can ' t. Nurse #2 was aware and notified. A nursing note written by Nurse #2 on 07/12/20 at 9:42 AM revealed the resident continued to yell out. Nurse #2 spoke with the RP who was made aware of resident ' s behavior and the x-ray. The RP requested something be given to the resident for anxiety. The note indicated Nurse #2 called the provider on call and received a onetime dose of an antianxiety medication, [MEDICATION NAME], 0.25 milligram (mg) to be given now (9:42 AM). A review of the July MAR revealed the [MEDICATION NAME] 0.25 mg was administered at 12:02 PM by Nurse #2. The order was noted to be obtained at 9:45 AM on the MAR. A head to toe evaluation completed by Nurse #2 on 07/12/20 at 2:30 PM revealed, in part, resident was noted yelling out throughout the night, x-ray of right hip was obtained and resulted in fracture of right hip. The immediate intervention was to send the resident to the hospital. The assessment stated the resident was disoriented, responsive, and tearful and had full range of motion to all extremities. Evidence of pain was noted in the right hip. Pain was throbbing with pain level 5 out of 10. The pain duration was unknown. Pain was persistent daily. A nursing note written by Nurse #2 on 07/12/20 at 3:29 PM revealed the night nurse reported to this nurse the resident had been yelling out all night complaining of right hip hurting and right leg. An order was received to get stat x-ray of right hip, right tibia/fibula and right knee. Results of the x-ray came back with right [MEDICAL CONDITION] with osteopenia (reduced bone mass). The RP was notified and made aware and requested to have the resident sent to the Emergency Department. Emergency Medical Services arrived at 2:40 PM and left with the resident at 3:00 PM to the hospital. A written statement by the Restorative Aide (RA) #1 revealed upon entering the 200 hall on 07/12/20, NA #1 informed her that something was wrong with Resident #2 because she was yelling out and stating her hip hurts. RA #1 was informed by Nurse #2 not to get her up, and when RA #1 went to assist NA #2 with changing the resident, she was yelling. RA #1 asked Resident #2 what was wrong and she said I ' m hurting. RA #1 said, Where? and she said My right hip. RA #1 stated she assisted the x-ray tech with the x-rays and the resident continued to yell but tolerated it. An interview was conducted with a supervisor at the x-ray company via phone on 08/14/20 at 12:46 PM. The supervisor confirmed they received a call from Nurse #1 on 07/12/20 for an x-ray order for Resident #2 at 7:14 AM. The supervisor stated once we received the order for the image, we put it in our system by 7:22 AM. The supervisor reported our technician arrived at the facility at 9:22 AM and they remained inside the facility until 11:17 AM. Once the technician exited the facility and sent the images to radiologist, it was finalized and sent back to her department at 1:16 PM and the report was faxed to the facility at 1:20 PM with the result. The supervisor stated if an order was for stat the technician had to be in the facility within 2 hours of the time of the call. An interview was conducted with NA #1 on 08/14/20 via phone at 1:15 PM. NA #1 reported she worked the night shift on 07/11/20 going into 07/12/20. NA #1 stated she checked on the resident through the night and she was sleeping. NA #1 stated she did not have to do personal care on Resident #2 during the night, but the morning of 07/12/20, she went to get her up and she was resistant when it came to her turning her and stated it hurt her. NA #1 stated she had seen her in pain and complain before, but this time it was more intense. NA #1 stated she did not get her up. NA #1 stated the resident told her the pain was from her hernia. NA #1 stated she had never complained of that before so she told Nurse #1 and the nurse said she had always had that (the hernia), she has had it for years. NA #1 stated she told the nurse she had never heard anything about a hernia and she was in pain like the NA had never seen before and that she was not going to get her up. NA #1 stated she could not recall if the nurse went to see the resident when she told her, but she added, she told on coming NA (NA#2) that she was having pain. NA #1 stated this was about 6:00 AM on 07/12/20. Nursing Assistant (NA) #2 was not available for an interview on 08/13/20 or 08/14/20. An interview was conducted with RA #1 on 08/14/20 via phone at 12:05 PM. RA #1 stated she worked on 07/12/20 and was assisting NA #2 with care. She stated Resident #2 was the type of resident that if she did not want to do something at that time, you would have to reproach after a few minutes. RA #1

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

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

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F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) stated she yelled out a lot and had behaviors and sometimes it was hard to pinpoint what was going on with her. RA #1 stated when she went in to do care on Resident #2 on 07/12/20, Resident #2 was yelling and said she was in pain. RA #1 stated when she told Nurse #2 she was in pain, the nurse was already aware because she told me to leave her in bed. RA #1 stated she assisted the x-ray technician when they arrived around 9:30 AM and the resident was moaning all the while they were doing the x-ray and repositioning her. RA #1 stated Resident #2 would complain of pain in different areas including her stomach, but on this day she was very specific that it was her right hip. An interview was conducted with Nurse #1 on 08/14/20 at 9:24 AM via phone. Nurse #1 stated if a NA reported to her that a resident was having pain, she would go in and assess the resident; find out where the pain was, what the scale of the pain was and if it was new pain. Nurse #1 stated she would then see if they had any pain medication ordered and if the resident did not have pain medication ordered she would call the doctor or give Tylenol (pain relieving medication) per the facilities ' standing orders. Nurse #1 stated she would add the new pain to the communication section on the computer so the pain could be assessed each shift. Nurse #1 added if the pain was an unusual pain (pain the resident may have already had, and now has new and increased pain), she would call the physician for a stronger pain medication and an x-ray. Nurse #1 stated the pain would be documented in the communication book to advise the physician of the pain and new medication. Nurse #1 stated NA #1 told Nurse #1 she had been complaining of pain for the last 2 to 3 days with her hernia. Nurse #1 stated she went in to assess Resident #2 and she reported her right leg and left leg hurt. Nurse #1 stated there was no swelling or bruising on her legs. She stated she turned the resident onto her left side and the resident complained of pain to her right side. Nurse #1 stated, again, the resident had been in pain for the last couple of days but it was due to her hernia. Nurse #1 stated she was told the resident had a hernia and had it for years. Nurse #1 stated she called the on-call physician to notify that the resident was having pain in her right leg and she obtained an order to get a stat x-ray of the right hip, femur, knee and ankle. Nurse #1 stated she did not document the resident was having pain and should have using the face scale because she did not think the resident would have been able to rate the pain on a scale of 1 - 10. Nurse #1 stated there was no actual form to document the pain. Nurse #1 then confirmed there was an assessment on the MAR that pain could be recorded. Nurse #1 stated she did not give the resident anything for pain and she probably should have gotten an order for [REDACTED].#1 stated when she called the on call provider she was just focused on getting the x-ray and did not think to ask for an order for [REDACTED]. Nurse #1 was not aware of any treatment for [REDACTED]. Nurse #1 stated she notified the family of the Resident complaining of pain and that an x-ray was ordered. An interview was conducted with Nurse #2 on 08/13/20 at 2:35 PM. Nurse #2 stated if a NA came to her and reported a resident was having pain she would go and assess the resident ' s pain. Nurse #2 stated she would check with resident to see where the pain was, if they could move the extremity or area the pain was located at, check the area for bruising, swelling, or redness. Nurse #2 stated if the resident confirmed the pain, she would have asked the resident to rate the pain and give pain medicine. Nurse #2 stated if it was new pain she would notify the doctor. Nurse #2 stated when she was made aware of Resident #2 ' s pain, she assessed the resident and repositioned her and called the doctor. Nurse #2 reviewed the MAR and confirmed the resident had no pain medications ordered. Nurse #2 reviewed her assessment and confirmed the resident had a pain level of 5, but no pain medication was given. Nurse #2 stated if the resident was yelling out, she could have had pain, but the resident yelled out a lot and we gave [MEDICATION NAME] in the past and that worked so that was why she called to get an [MEDICATION NAME] order. Nurse #2 stated she could not remember why it was documented as given at 12:02 PM instead of around 9:45 AM when it was ordered. Nurse #2 stated with as needed medications, that were not scheduled, the computer system would time stamp when the medication was given. Nurse #2 reported she did not think to get an order for [REDACTED].#2 stated she recalled calling the doctor to get an order for [REDACTED]. Nurse #2 stated the doctor did not give me an order for [REDACTED].#2 stated as a nurse, I should have asked the doctor to give me something for pain for her. She stated she should have obtained an order for [REDACTED]. The MD stated she was not aware of Resident #2 having a [DIAGNOSES REDACTED]. The MD stated if a resident was having new pain, she would get a notification via a printed note on her desk or the nurse would come to her face to face. The MD believed an on call team was notified regarding Resident #2 on 07/12/20 and there was an order for [REDACTED].#2 ' s RP was not fond of giving any pain medications to Resident #2, but that we (medical staff) have to advocate for pain for the residents. The MD stated usually Resident #2 ' s point of distress was anxiety and that was why the [MEDICATION NAME] was requested and given. The MD stated the [MEDICATION NAME] on 07/12/20 was requested by the family. The MD stated if the nurses documented pain and there was a positive pain scale, she would expect the nurse would ask for pain medication and advocate for the residents ' pain. The MD stated she did not feel the family would have objected to given the resident Tylenol for her pain. The MD stated she believed the [MEDICATION NAME] was good for the anticipatory pain because the resident would get really anxious and the [MEDICATION NAME] would help her to be calm, but pain medication (Tylenol) would help with the process. The MD stated the [MEDICATION NAME] should have been given at the time it was ordered around 9:45 AM and not at 12:02 PM. The MD stated, that although the family was reluctant to give the resident pain medication, she believed it would have been very reasonable for the nurses to obtain an order to start with Tylenol to treat Resident #2 ' s pain, and if the resident continued to complain of pain, then to consider something else.