STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews, the facility failed to notify the Responsible Party (RP) for 1 of 1 sampled	F 157	**"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 the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."** **F157 Deficiency corrected** Corrective action has been accomplished for the alleged deficient practice related to Resident #107. Resident #107's responsible party was notified on June 21, 2015 of seizure activity on June 17, 2015 by a licensed nurse. The resident's physician had been previously notified and additional orders were obtained and implemented. The residents care plan was reviewed and updated as necessary by the Interdisciplinary Team (IDT). The nurse involved no longer is employed at the facility. Facility residents with changes in condition have the potential to be affected by the alleged deficient practice. On or before August 1, 2015, the Interim Director of Nursing (IDON) Assistant Director of Nursing (ADON), or other assigned licensed nurse will review the 24 hour resident status report to identify changes in residents' condition and new physician's orders to ensure that the physician and/or family has been notified of the change and/ or new orders received. Any discrepancies identified regarding notification will be corrected immediately. Measures put into place to ensure that the alleged deficient practice does not recur includes: New or changed physician orders, change in condition documentation, 24 hour report, and other will be reviewed by the IDON, ADON, RN Supervisor or other assigned licensed nurse daily Monday thru Friday during the morning meeting. The weekend supervisor or other designated licensed nurse will monitor	8/7/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed Cindy Pittman — TITLE: administrator — (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 157 Continued From page 1

residents (Resident #107) after the resident experienced a seizure, necessitating lab work and an increased dose of an antiseizure medication.

The findings included:

Resident #107 was admitted to the facility on 3/26/13. The resident ' s cumulative diagnoses included a seizure disorder.

Resident #107 ' s most recent quarterly Minimum Data Set (MDS) dated 6/15/15 revealed the resident had moderately impaired cognitive skills. She was totally dependent on staff for her Activities of Daily Living (ADLs), with the exception of requiring extensive assistance with bed mobility and supervision with eating.

A review of the resident ' s medical record included the following Nursing Progress Notes:
6/17/2015 at 11:52 PM (Authored by Nurse #1)
" VS (Vital Signs)-124/68 (Blood Pressure), 72 (Heart Rate), 98.1 (Temperature), 18 (Respiration Rate). Resident displayed minimal generalized seizure activity as evidenced by a repetitive jerking movement of bilateral upper & lower extremities, the activity lasted about 1 minute, then resident regained consciousness, monitored for injury with no injury sustained, pupil size normal, pupil shape normal, and reactive to light, she was incontinent of bowel prior to seizure activity, patient left in bed asleep with eyes closed, safety precautions in place and call bell within reach. "

6/18/2015 at 1:24 AM (Authored by Nurse #1)

" The seizure happened around 2130 (9:30 PM),

F 157

weekend changes in condition and ensure timely notification of the residents' physician, resident/responsible party with documentation of the notification as well as any new orders/instructions. The facility has re-instituted the use of the InterAct SBAR (Subjective, Background, Assessment and Request) form for documentation of changes in the resident condition. SBAR forms are reviewed during morning meeting Monday through Friday by the IDON, ADON or other identified licensed nurse to ensure notification has occurred. Negative findings will be addressed and corrected upon discovery. Mandatory in-service will be conducted by the IDON, ADON, or RN Supervisor entitled "Notification of Change" for licensed nurses to include the importance notifying the resident's responsible party and physician of any changes which includes significant changes such as weight loss, acute illness, development of pressure ulcers, worsening pressure ulcers and other changes in condition that require notification. Training for newly hired licensed nurses regarding physician and resident/family notification will be incorporated in the facility's orientation program.

The IDON/ADON or other assigned administrative nurse will review data related to new orders, changes in condition and 24 hour report analyzing monthly for 3 months for patterns/trends and report in QAPI (Quality Assurance/ Performance Improvement) meeting monthly for 3 months thereafter. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 157	Continued From page 2	F 157		

MD (Medical Doctor) made aware via written communication located in nurses triage book, will pass on to oncoming nurse to contact RP (Responsible Party). "

Further review of Resident #107 ' s medical records revealed the resident was seen by her physician on 6/18/15. The MD Notes indicated the resident ' s Assessment/Plan included increasing the Dilantin (an antiseizure medication) currently prescribed, and obtaining laboratory results to check the level of Dilantin in her blood. A physician ' s order was written on 6/18/15 as follows: 1) Increase Dilantin to 200 milligrams (mg) by mouth every morning, 100 mg by mouth at 12:00 PM, and, 200 mg by mouth every night at bedtime; and, 2) Obtain a Comprehensive Metabolic Panel (a laboratory blood test used as a broad screening tool to review renal function, liver function, and electrolyte and fluid balance) and Dilantin level in one week.

Telephone interviews were conducted on 7/7/15 at 11:02 AM and 7/8/15 at 3:32 PM with Resident #107 ' s RP. During the interview, the RP reported Resident #107 had a seizure approximately two weeks ago but was not informed of it. The RP stated that on 6/19/15 she was only told about the resident ' s antiseizure medication being increased and the facility doing blood work to check on her Dilantin level but was not told the resident had experienced a seizure on 6/17/15. The RP reported that when she was visiting the resident on 6/21/15, a nurse (not identified) came in to give Resident #107 her 12:00 PM dose of Dilantin. When the RP inquired as to whether this was the higher dose of medication recently prescribed, and the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 157	Continued From page 3	F 157		

indicated it was and stated the increased dose should prevent another seizure. The RP stated this was the first she had heard about the resident having this seizure. Upon questioning, the nurse reportedly told the RP, "Oh, I thought they told you." During the interview with the RP, she indicted she would have expected to be notified of the resident ' s seizure. When asked if she would have wanted to be called in the night to be informed of the seizure, the RP replied, "Sure."

A telephone interview was conducted on 7/09/2015 at 12:32 PM with Nurse #1. Nurse #1 was the 2nd shift nurse assigned to care for Resident #107 on the evening of 6/17/15 when she experienced the seizure. Upon inquiry of the 6/17/15 seizure, the nurse recalled that around 9:00 PM that evening, a nursing assistant came to get her to check on the resident. When she entered the room, she saw resident had seizure activity that lasted less than one minute. The nurse characterized the seizure as, " a generalized grand mal seizure " (a type of seizure characterized by a loss of consciousness and violent muscle contractions). Nurse #1 could not recall if she herself had contacted the RP or passed information along to the next shift in report. The Nursing Notes authored by Nurse #1 on 6/17/15 and 6/18/15 were verbally reviewed with her. Upon review of the note which indicated information about the seizure would be passed along to the next shift for contacting the RP, Nurse #1 stated, "Whatever I wrote, I did."

A telephone interview was conducted on 7/8/15 at 3:37 PM with Nurse #2. Nurse #2 was the 3rd shift nurse assigned to care for Resident #107 on the evening of 6/17/15 to the morning of 6/18/15. Inquiry was made as to whether the nurse

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 157	Continued From page 4 recalled being told Resident #107 had a seizure the evening of 6/17/15 and that the RP needed to be contacted in regards to this. Nurse #2 stated she did not recall being told that the resident had a seizure nor having any information about it passed on to her in report. An interview was conducted on 7/8/15 at 2:33 PM with the facility ' s interim Director of Nursing (DON). Upon inquiry, the DON indicated she would have expected Resident #107 ' s RP to have been notified of the seizure and for the notification to have been documented in her medical record. Upon review of the resident ' s progress notes, the DON acknowledged she did not see any documentation to indicate the resident ' s RP had been notified of the seizure experienced on 6/17/15.	F 157	F279 Deficiency Corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #16. A care plan was developed and implemented on July 8, 2015 related to the use of anti-anxiety and two anti-depressant medications for Resident #16. Residents receiving psychotropic medications have the potential to be affected by the same alleged deficient practice. The MDS (Minimum Data Set) staff and other members of the Interdisciplinary Team (IDT) including the Social Worker will conduct an audit to identify residents receiving psychotropic medications and will review care plans for identified residents by August 7, 2015. The IDT will review new physician's orders during morning meeting	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	Monday through Friday to identify residents with new orders for psychotropic medications. Resident Care Plans will be reviewed by the Interdisciplinary Team (IDT) and updated as needed. Measures put into place to ensure that the alleged deficient practice does not recur include: mandatory in-service for the IDT regarding ensuring comprehensive care plans are developed for residents that include measurable objectives and timetables to meet the residents' medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, including for use psychotropic medication. The MDS (Minimum Data Set) staff and other members of the Interdisciplinary Team (IDT) nursing staff including the Social Worker will conduct an audit to identify residents receiving psychotropic medications and will review care plans for identified residents by August 7, 2015. The IDT will review new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 279	Continued From page 5 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a care plan to address the use of an antianxiety and two antidepressant medications for 1 of 5 sample residents (Resident #16) reviewed for unnecessary medications. The findings included: Resident #16 was re-admitted to the facility on 1/16/15 from an acute care hospital. His cumulative diagnoses included anxiety and depression. A review of Resident #16 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 1/16/15 revealed the resident had moderately impaired cognitive skills for daily decision making. He was independent with eating and locomotion on/off the unit; required extensive assistance with bed mobility, transfers, dressing and toileting; and, was totally dependent on staff for personal hygiene and bathing. Section I of the MDS assessment revealed the resident had active diagnoses which included anxiety and depression. Section N of the MDS assessment indicated his medications included an antianxiety medication (on 7 out of 7 days) and antidepressant medication (on 7 out of 7 days). A review of Resident #16 ' s current care plan (last reviewed on 5/6/15) revealed the use of	F 279	physician's orders during morning meeting Monday through Friday to identify residents with new orders for psychotropic medications. Resident Care Plans will be reviewed by the Interdisciplinary Team (IDT) and updated as needed. Training for newly hired members of the IDT regarding care plan development and implementation will be incorporated in the facility's orientation program The IDON/ADON or other assigned administrative nurse will review data related to care plan development analyzing for patterns/trends and report in QAPI (Quality Assurance/ Performance Improvement) meeting monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 279	Continued From page 6	F 279		

psychotropic medications (including antianxiety and antidepressant medications) was not addressed.

A review of the resident ' s medical record on 7/8/15 included a summary of his current medication orders. The medications included: 1 milligram (mg) clonazepam (a medication used for the treatment of anxiety) given as one tablet by mouth four times daily for anxiety (initiated on 12/12/14); 100 mg trazodone (an antidepressant medication which may have a hypnotic or sleep-inducing effect) given as one tablet by mouth every night at bedtime for insomnia (initiated on 1/16/15); and, 20 mg citalopram (an antidepressant medication) given as one tablet by mouth every day for depression (initiated on 1/17/15).

An interview was conducted with Nurse #3 on 7/8/15 at 10:25 AM. Nurse #3 was one of two nurses who assumed responsibility for coordinating the development of interdisciplinary care plans for the facility ' s residents. When asked, Nurse #3 indicated the use of psychotropic medication needed to be addressed in a resident ' s care plan. Resident #16 and his current care plan were reviewed with Nurse #3 and Nurse #4 (the second nurse who assumed responsibility for MDS assessments and care plan development). Upon review, Nurse #3 and Nurse #4 acknowledged the use of psychotropic medications was not addressed in Resident #16 ' s care plan.

An interview was conducted on 7/8/15 at 2:15 PM with the facility ' s interim Director of Nursing (DON). During the interview, Resident #16 ' s care plan was reviewed. Upon inquiry, the DON

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 279	Continued From page 7 stated, "I would expect these meds (referring to the antianxiety and antidepressant medications) to be care planned."	F 279	F 323 Deficiency corrected	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to maintain bedrails to prevent potential entrapment for 1 of 1 resident (Resident #127) whose bedrails were not securely tighten to the bed. The findings included: Resident #127 was admitted to the facility on 10/17/14 with a diagnosis that included muscle weakness, lack of coordination, senile dementia, dementia with behavioral disturbances, and depressive disorder. The most recent Minimum Data Set (MDS) Assessment dated 6/11/15 revealed Resident #127 was totally dependent on staff for activities of daily living. The MDS further indicated Resident #127 was severely cognitively impaired for decision making. Review of the facilities incident report dated 6/16/15 indicated Resident #127 had a fall in her room. The findings stated, " Resident have behaviors of consistently getting out of chair. No awareness. Resident has altered mental status.	F 323	Corrective action has been accomplished for the alleged deficient practice related to supervision to prevent accidents and a loose quarter bed rail for Resident #127. Resident # 127's bed was changed to a new bed with manufacturer installed enabler bars on July 8, 2015 by the Director of Facility Services. Resident # 127's care plan was reviewed by the Interdisciplinary Team (IDT) and updated as needed. Facility residents have the potential to be affected by the same alleged deficient practice. On July 8, 2015 and again on July 15, 2015 beds in the facility were inspected by the Director of Facility Services and/ or the Maintenance Assistant to ensure beds were in good working order including rails. No additional loose rails were identified. A review of incidents since June 1, 2015 was conducted by the Interim Director of Nursing (IDON) to identify potential incidents related to bed rails. None were identified. Incidents/ accidents will be reviewed in morning meeting daily Monday through Friday. Facility rounds will be conducted by department managers to include observation of bedrails/beds daily Monday through Friday beginning on or before August 1, 2015. Measures put into place to ensure that the alleged deficient practice does not recur include: Resident use equipment will be inspected for functionality and safe operation as a part of the facility's preventative maintenance program (PM), with equipment inspected prior to being placed in service and at regular intervals throughout its use in the facility based on recommendations of the PM program. Mandatory in-service will be conducted beginning on or before August 1, 2015 by the IDON, the Director of Facility Services or other designated administrative staff for facility staff regarding the facility's preventative maintenance program including reporting maintenance needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 323	Continued From page 8 Attempting to get out of chair or out of bed is a continuous behavior " . The corrective actions indicated Resident #127 would be brought out to nursing station so she can be watched by multiple staff. In a continuous observation of Resident #127 on 7/8/15 at 11:42am until 11:59am revealed Resident #127 to be lying in a lowered bed, bedrails up and fall mat to left side of bed. The resident is observed to be continuously moving laying on her on left side. While on her left side, Resident #127 ' s left elbow was in-between the bedrail and the mattress. Resident #127 right hand is observed to be on the bedrail pulling on it. The bedrail was observed to be lose and leaning on the residents left arm that is in-between the bedrail and the mattress. The resident was observed to attempt to reposition herself as evidenced by pulling her left elbow out from between the handrail and the mattress. The residents left elbow would come from be-tween the bedrail and the mattress and then slide back in-between the handrail and the mattress. During the observation the resident could be seen to lay her head on the bedrail. The bedrail moved freely. Interview with Nurse #1 on 7/8/15 at 12:22pm indicated she was not responsible for ensuring bedrails fit securely to the bed. The Nurse indicated it was the responsibility of the Maintenance Director to put bedrails on the bed. Nurse #1 further indicated she assumed the Maintenance Director periodically checked the bedrails for fit and safety for the resident. Resident #127 did not use her handrails. During an Interview and observation with the Maintenance Director on 7/8/15 at 12:30pm revealed he was unaware of Resident #127 ' s bedrail being lose. The Maintenance Director	F 323	In addition, staff will be in-serviced regarding the importance of ensuring adequate supervision and devices are provided to residents to minimize the risk of accidents/ incidents including but not limited to; the use of devices, types of devices, functionality of resident equipment, types of supervision for specific incidents/ accidents, reporting on TELS for maintenance needs. Training for newly hired staff regarding providing supervision and devices to prevent accidents will be incorporated in the facility's orientation program beginning on or before August 1, 2015. Incidents/accidents will be reviewed in morning meeting daily Monday through Friday. Equipment noted to be not functional and not repairable by the licensed nurse will be removed from service and replaced. Resident care rounds to include random observation at least daily of compliance with safety measures/devices will be conducted by administrative staff on an on- going basis and will included inspection of safety devices. The Interim Director of Nursing, ADON, Director of Facility Services or other assigned administrative staff will review data obtained during resident care rounds, incident /accident review in morning meeting, analyzing for patterns / trends and reporting in QAPI meeting monthly ongoing, adjusting the above plan as needed based on evaluation of the QAPI committee for effectiveness of the plan during aforementioned meetings. The QAPI Committee will develop additional interventions and ensure implementation of those interventions for negative trends identified to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ____ B. WING ____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 323	Continued From page 9 stated he put bedrails on resident beds and the expectation is for the bedrails to be fit appropriately to prevent resident from getting caught in-between the mattress and the bedrail. Maintenance revealed Resident #127 shakes the handrails continuously which could have resulting in the bedrails becoming lose. The Maintenance Director stated Resident #127 ' s bedrails were very lose and not firmly attached to the bed. Maintenance indicated he checked bedrails weekly for proper fit. During an interview and observation with the Director of Nursing (DON) on 7/8/15 at 12:30 pm revealed she was unaware of Resident #127 ' s bedrails being lose. The DON described Resident #127 ' s bedrails as very lose and not firmly attached to the bed. The DON stated the handrail needed to be tighten to prevent Resident #127 from getting an appendage entrapped in-between the handrail and the mattress. The DON stated it was her expectation bedrails be monitored for appropriate fit to ensure residents do not get entrapped between the bed and the mattress.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 431	Continued From page 10 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to consistently follow established procedures for the administration and reconciliation of controlled medications for 3 of 3 sampled residents (Resident #81, #14, and #45) receiving controlled substances prescribed on an as needed basis; and, the facility failed to record complete information, including the residents' name, on the Emergency Box Narcotic Log to enable a periodic reconciliation and accurate accounting of all controlled medications. The findings included:	F 431	F431 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to the administration and reconciliation of controlled medication for residents # 81, #14 and #45 as well as incomplete information on the Emergency Narcotic Log including the resident's name. Residents # 81, #14 and #45 prn (as needed) narcotic medication is documented per established procedures. A new procedure has been developed and implemented for recording the resident's name when the facility's Emergency Narcotic kit has been accessed. The nurse involved is no longer employed at the facility. Facility residents have the potential to be affected by the same alleged deficient practice. Administrative nursing staff and/ or pharmacy consultant will conduct on-going random medication pass observations to identify potential residents with at least one nurse observed weekly to ensure appropriate procedures are followed regarding controlled substances. Appropriate action will be completed when variances are identified. Measures put into place to ensure that the alleged deficient practice does not recur include: mandatory in-service for licensed nursing staff regarding the use of controlled substances including but not limited to ordering, receiving, administering, documentation, reconciliation and the nurses responsibility and obligations related to safe-guarding controlled substances; consequences and expectations regarding handling controlled substances. Training for newly hired staff regarding providing supervision and devices to prevent accidents will be incorporated in the facility's orientation program beginning on or before August 1, 2015. Administrative nursing staff and/ or pharmacy consultant will conduct on-going random medication pass observations to identify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 431	Continued From page 11 1a) Resident #81 was re-admitted to the facility on 2/2/15 with a cumulative diagnoses which included anxiety and mononeuritis (a form of damage to one or more peripheral nerves which can result in severe pain). A review of Resident #81 ' s current medication orders included the following: 0.5 milligrams (mg) lorazepam (an antianxiety medication) given as one tablet by mouth every 8 hours as needed for anxiety; 50 mg tramadol (an opioid analgesic) given as one tablet by mouth every 8 hours as needed for pain. Lorazepam and tramadol are controlled substance medications. A review of the resident ' s Controlled Drug Receipt/Record/Disposition form (a declining inventory record which is also known as a Narcotic Log) for tramadol revealed 50 mg tramadol was given to Resident #81 on 5/20/15 at 4:00 PM, 5/21/15 at 4:00 PM, and 6/30/15 at 8:00 PM. A review of the May 2015 and June 2015 Medication Administration Record (MAR) did not indicate this medication was administered to Resident #81 on these dates/times. The May 2015 and June 2015 MARs noted the resident ' s level of pain was rated as " 0 " on 5/20/15 2nd shift (3:00 PM-11:00PM), 5/21/15 2nd shift (3:00 PM-11:00PM), and 6/30/15 2nd shift (3:00 PM-11:00PM). A review of the resident ' s Nursing Progress Notes from 2nd shift on 5/20/15, 5/21/15, and 6/30/15 did not indicate there were any concerns of the resident experiencing pain. A review of the resident ' s Controlled Drug Receipt/Record/Disposition form for lorazepam revealed 0.5 mg lorazepam was given to Resident #81 on 7/6/15 at 7:30 PM. A review of	F 431	potential residents with at least one nurse observed weekly to ensure appropriate procedures are followed regarding controlled substances. Appropriate action will be taken including additional education and discipline when discrepancies are identified to ensure continued compliance. The Director of Nursing, consultant pharmacist or designee will review data obtained during weekly and random observations, analyzing for patterns / trends and reporting in QAPI meeting monthly ongoing, adjusting the above plan as needed based on evaluation of the QAPI committee for effectiveness of the plan during aforementioned meetings. The QAPI Committee will develop additional interventions and ensure implementation of those interventions for negative trends identified to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 431	Continued From page 12 the July 2015 Medication Administration Record (MAR) did not indicate this medication was administered to Resident #81 on 7/6/15. The July 2015 MAR indicated the resident did not exhibit any behaviors on 7/6/15. A review of the resident ' s Nursing Progress Notes from 7/6/15 did not indicate there were any concerns regarding the resident ' s behaviors, mood, or level of anxiety. An interview was conducted with the facility ' s Administrator and interim Director of Nursing (DON) on 7/8/15 at 9:10 AM in regards to the facility ' s procedures for the administration and reconciliation of controlled medications administered to residents. The DON outlined the facility ' s procedures, indicating a nurse needed to sign off on the Controlled Drug Receipt/Record/Disposition form as soon as the medication was pulled for administration to the resident. The medication also needed to be recorded on the MAR once it was administered to the resident. An interview was conducted on 7/8/15 at 12:00 PM with the DON. Upon review of Resident #81's Controlled Drug Receipt/Record/Disposition form and MARs, the DON acknowledged there were inconsistencies between the two records. The nurse who signed the Controlled Drug Receipt/Record/Disposition form in 3 of the 4 instances was identified as Nurse #1. A telephone interview was conducted on 7/9/2015 at 12:32 PM with Nurse #1. Nurse #1 was the hall nurse who had signed off on the Controlled Drug Receipt/Record/Disposition form as pulling a controlled substance for Resident #81 on 5/20/15, 5/21/15, and 7/6/15 without documenting administration of the medication on the resident '	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 431	Continued From page 13 s MAR. Inquiry was made as to the process/ documentation of " as needed " narcotics to residents. Upon inquiry, Nurse #1 reported she typically gave the medication to a resident, then signed off on both the Narcotic Log and the resident ' s MAR at the same time after the medication was administered. When asked about the most recent discrepancy of the documentation with Resident #81 on 7/6/15, the nurse stated, " That probably was an accident." A follow-up interview was conducted on 7/9/15 AT 9:40 AM with the DON regarding what her expectation was regarding the established procedures for controlled substance administration and reconciliation. The DON indicated that when a controlled substance was pulled for administration to a resident, it was expected for a nurse to, " Sign that you took it and sign that you gave it. " 1b) Resident #14 was re-admitted to the facility on 7/20/12 with a cumulative diagnoses which included anxiety. A review of Resident #14 ' s current medication orders included the following: 0.5 milligrams (mg) lorazepam (an antianxiety medication) given as one tablet by mouth every 4 hours as needed for anxiety. Lorazepam is a controlled substance medication. A review of the resident ' s Controlled Drug Receipt/Record/Disposition form for lorazepam revealed 0.5 mg lorazepam was given to Resident #14 on 6/20/15 at 8:00 PM and 6/22/15 at 6:00 PM. A review of the June 2015 Medication Administration Record (MAR) did not indicate this medication was administered to	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 431	Continued From page 14 Resident #14 on either 6/20/15 or 6/22/15. The June 2015 MAR indicated the resident did not exhibit any behaviors on 6/20/15 or 6/22/15. A review of the resident ' s Nursing Progress Notes from 6/20/15 and 6/22/15 did not indicate there were any concerns regarding the resident ' s behaviors, mood, or level of anxiety. An interview was conducted with the facility ' s Administrator and interim Director of Nursing (DON) on 7/8/15 at 9:10 AM in regards to the facility ' s procedures for the administration and reconciliation of controlled medications administered to residents. The DON outlined the facility ' s procedures, indicating a nurse needed to sign off on the Controlled Drug Receipt/Record/Disposition form as soon as the medication was pulled for administration to the resident. The medication needed to be recorded on the MAR once it was administered to the resident. An interview was conducted on 7/8/15 at 12:00 PM with the DON. Upon review of Resident #14 ' s Controlled Drug Receipt/Record/Disposition form and MARs, the DON acknowledged there were inconsistencies between the two records. The nurse who signed the Controlled Drug Receipt/Record/Disposition form in both of the 2 instances was identified as Nurse #1. A telephone interview was conducted on 7/9/2015 at 12:32 PM with Nurse #1. Nurse #1 was the hall nurse who had signed off on the Controlled Drug Receipt/Record/Disposition form as pulling a controlled substance for Resident #14 on 6/20/15 and 6/22/15 without documenting administration of the medication on the resident ' s MAR. Inquiry was made as to the process/	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 431	Continued From page 15 documentation of " as needed " narcotics to residents. Upon inquiry, Nurse #1 reported she typically gave the medication to a resident, then signed off on both the Narcotic Log and the resident ' s MAR at the same time after the medication was administered. When asked about the most recent discrepancy noted for another sample resident (Resident #81) on 7/6/15, the nurse stated, " That probably was an accident." A follow-up interview was conducted on 7/9/15 AT 9:40 AM with the DON regarding what her expectation was regarding the established procedures for controlled substance administration and reconciliation. The DON indicated that when a controlled substance was pulled for administration to a resident, it was expected for a nurse to, " Sign that you took it and sign that you gave it. " 1c) Resident #45 was re-admitted to the facility on 5/21/15 with a cumulative diagnoses which included generalized anxiety disorder. A review of Resident #45 ' s current medication orders included the following: 1 milligram (mg) lorazepam (an antianxiety medication) given as one tablet by mouth every 6 hours as needed for anxiety. Lorazepam is a controlled substance medication. A review of the resident ' s Controlled Drug Receipt/Record/Disposition form for lorazepam revealed 1 mg lorazepam was given to Resident #45 on 6/4/15 at 9:00 PM. A review of the June 2015 Medication Administration Record (MAR) did not indicate this medication was administered to Resident #45 on 6/4/15. The June 2015 MAR	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 431	Continued From page 16	F 431		

indicated the resident did not exhibit any behaviors on 6/4/15. A review of the resident ' s Nursing Progress Notes from 6/4/15 did not indicate there were any concerns regarding the resident ' s behaviors, mood, or level of anxiety.

An interview was conducted with the facility ' s Administrator and interim Director of Nursing (DON) on 7/8/15 at 9:10 AM in regards to the facility ' s procedures for the administration and reconciliation of controlled medications administered to residents. The DON outlined the facility ' s procedures, indicating a nurse needed to sign off on the Controlled Drug Receipt/Record/Disposition form as soon as the medication was pulled for administration to the resident. The medication needed to be recorded on the MAR once it was administered to the resident.

An interview was conducted on 7/8/15 at 12:00 PM with the DON. Upon review of Resident #45 ' s Controlled Drug Receipt/Record/Disposition form and MARs, the DON acknowledged there were inconsistencies between the two records. The nurse who signed the Controlled Drug Receipt/Record/Disposition form on 6/4/15 was identified as Nurse #1.

A telephone interview was conducted on 7/9/2015 at 12:32 PM with Nurse #1. Nurse #1 was the hall nurse who had signed off on the Controlled Drug Receipt/Record/Disposition form as pulling a controlled substance for Resident #45 on 6/4/15 without documenting administration of the medication on the resident ' s MAR. Inquiry was made as to the process/ documentation of " as needed " narcotics to residents. Upon inquiry, Nurse #1 reported she typically gave the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 431	Continued From page 17	F 431		

medication to a resident, then signed off on both the Narcotic Log and the resident ' s MAR at the same time after the medication was administered. When asked about the most recent discrepancy noted for another sample resident (Resident #81) on 7/6/15, the nurse stated, " That probably was an accident."

A follow-up interview was conducted on 7/9/15 AT 9:40 AM with the DON regarding what her expectation was regarding the established procedures for controlled substance administration and reconciliation. The DON indicated that when a controlled substance was pulled for administration to a resident, it was expected for a nurse to, " Sign that you took it and sign that you gave it. "

2) An observation of the narcotic Emergency Kit (E-Kit) and review of the E-Kit Narcotic Log was completed with the interim Director of Nursing (DON) on 7/8/15 at 9:45 AM. A review of the Narcotic Log (dated from 3/4/15 to 7/8/15) revealed there was no documentation of which resident each controlled substance medication had been used. An interview was conducted with the interim DON at the time of the observation. The DON reported she had recently identified the issue of the E-Kit Narcotic Log not being resident-specific and had a plan in place (not yet fully implemented) to request an alternative record from the pharmacy to allow for the appropriate and complete documentation of this information. The DON indicated she expected the Narcotic Log to include resident-specific information.

A telephone interview was conducted on 7/8/15 at 5:07 PM with the facility ' s consultant pharmacist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 431 Continued From page 18

Upon inquiry, the consultant pharmacist acknowledged there was a potential concern of accountability for the controlled substances when the E-Kit Narcotic Log failed to include the names of residents who received these medications.

F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview, the facility failed to follow established procedures for the consistent and accurate documentation of the administration of controlled medications on the Medication Administration Records and Narcotic Logs for 3 of 3 sampled residents (Resident #81, #14, and #45) receiving controlled substances prescribed on an as needed basis.

The findings included:

1) A review of Resident #81 ' s Controlled Drug

F 431 F514 Deficiency Corrected

F 514 Corrective action has been accomplished for the alleged deficient practice in regards to the documentation of the administration of prn (as needed) controlled medication for residents # 81, #14 and #45. Residents # 81, #14 and #45 as needed narcotic medication is documented per established procedures. The nurse involved is no longer employed at the facility.

Facility residents have the potential to be affected by the same alleged deficient practice. Administrative nursing staff, pharmacy consultant and/ or other designated licensed nurse will conduct on-going random audits of electronic medical records comparing those to the descending narcotic record to identify potential residents with at least 5 records reviewed daily, Monday through Friday, for 1 week, 3 records daily, Monday through Friday, for 1 week and then 5 records audited weekly for one month. Appropriate action will be completed when variances are identified.

Measures put into place to ensure that the alleged deficient practice does not recur include: mandatory in-service for licensed nursing staff regarding the importance of complete, accurate and timely documentation in resident's medical record, both electronic and paper records including but not limited to documentation of medications, both scheduled and medication given on an as needed basis including controlled substances. Training for newly hired staff regarding providing supervision and devices to prevent accidents will be incorporated in the facility's orientation program beginning on or before August 1, 2015. Administrative nursing staff, pharmacy consultant and/ or other designated licensed nurse will conduct on-going random audits of electronic medical records comparing those to the descending narcotic record to identify potential residents with at least 5 records reviewed daily, Monday through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 514	Continued From page 19 Receipt/Record/Disposition form (a declining inventory record which is also known as a Narcotic Log) for tramadol revealed 50 mg tramadol was given to Resident #81 on 5/20/15 at 4:00 PM, 5/21/15 at 4:00 PM, and 6/30/15 at 8:00 PM. A review of the May 2015 and June 2015 Medication Administration Record (MAR) did not indicate this medication was administered to Resident #81 on these dates/times. A review of the resident ' s Controlled Drug Receipt/Record/Disposition form for lorazepam revealed 0.5 mg lorazepam was given to Resident #81 on 7/6/15 at 7:30 PM. A review of the July 2015 Medication Administration Record (MAR) did not indicate this medication was administered to Resident #81 on 7/6/15. An interview was conducted with the facility ' s Administrator and interim Director of Nursing (DON) on 7/8/15 at 9:10 AM in regards to the facility ' s procedures for the documentation of controlled medications administered to residents. The DON outlined the facility ' s procedures, indicating a nurse needed to sign off on the Controlled Drug Receipt/Record/Disposition form as soon as the medication was pulled for administration to the resident. The medication also needed to be recorded on the MAR once it was administered to the resident. An interview was conducted on 7/8/15 at 12:00 PM with the DON. Upon review of Resident #81 ' s Controlled Drug Receipt/Record/Disposition form and MARs, the DON acknowledged there were inconsistencies between the two records. The nurse who signed the Controlled Drug Receipt/Record/Disposition form in 3 of the 4 instances was identified as Nurse #1.	F 514	Friday, for 1 week, 3 records daily, Monday through Friday, for 1 week and then 5 records audited weekly for one month. Appropriate action will be taken including additional education and discipline when discrepancies are identified to ensure continued compliance. The Director of Nursing, consultant pharmacist or designee will review data obtained during weekly and random observations, analyzing for patterns / trends and reporting in QAPI meeting monthly ongoing, adjusting the above plan as needed based on evaluation of the QAPI committee for effectiveness of the plan during aforementioned meetings. The QAPI Committee will develop additional interventions and ensure implementation of those interventions for negative trends identified to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 514	Continued From page 20 A telephone interview was conducted on 7/9/2015 at 12:32 PM with Nurse #1. Nurse #1 was the hall nurse who had signed off on the Controlled Drug Receipt/Record/Disposition form as pulling a controlled substance for Resident #81 on 5/20/15, 5/21/15, and 7/6/15 without documenting administration of the medication on the resident ' s MAR. Inquiry was made as to the process/ documentation of " as needed " narcotics to residents. Upon inquiry, Nurse #1 reported she typically gave the medication to a resident, then signed off on both the Narcotic Log and the resident ' s MAR at the same time after the medication was administered. When asked about the most recent discrepancy of the documentation with Resident #81 on 7/6/15, the nurse stated, " That probably was an accident." A follow-up interview was conducted on 7/9/15 AT 9:40 AM with the DON regarding what her expectation was regarding the documentation for administration of controlled substances. The DON indicated that when a controlled substance was pulled for administration to a resident, it was expected for a nurse to, " Sign that you took it and sign that you gave it. " She indicated both the resident ' s Narcotic Log and MAR should be consistent and accurate. 2) A review of Resident #14 ' s Controlled Drug Receipt/Record/Disposition form for lorazepam revealed 0.5 mg lorazepam was given to the resident on 6/20/15 at 8:00 PM and 6/22/15 at 6:00 PM. A review of the June 2015 Medication Administration Record (MAR) did not indicate this medication was administered to Resident #14 on either 6/20/15 or 6/22/15.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 514	Continued From page 21 An interview was conducted with the facility ' s Administrator and interim Director of Nursing (DON) on 7/8/15 at 9:10 AM in regards to the facility ' s procedures for the documentation of controlled medications administered to residents. The DON outlined the facility ' s procedures, indicating a nurse needed to sign off on the Controlled Drug Receipt/Record/Disposition form as soon as the medication was pulled for administration to the resident. The medication also needed to be recorded on the MAR once it was administered to the resident. An interview was conducted on 7/8/15 at 12:00 PM with the DON. Upon review of Resident #14 ' s Controlled Drug Receipt/Record/Disposition form and MARs, the DON acknowledged there were inconsistencies between the two records. The nurse who signed the Controlled Drug Receipt/Record/Disposition form in both of the 2 instances was identified as Nurse #1. A telephone interview was conducted on 7/9/2015 at 12:32 PM with Nurse #1. Nurse #1 was the hall nurse who had signed off on the Controlled Drug Receipt/Record/Disposition form as pulling a controlled substance for Resident #14 on 6/20/15 and 6/22/15 without documenting administration of the medication on the resident ' s MAR. Inquiry was made as to the process/ documentation of " as needed " narcotics to residents. Upon inquiry, Nurse #1 reported she typically gave the medication to a resident, then signed off on both the Narcotic Log and the resident ' s MAR at the same time after the medication was administered. When asked about the most recent discrepancy noted for another sample resident (Resident #81) on 7/6/15, the nurse stated, " That probably was an	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 514	Continued From page 22 accident." A follow-up interview was conducted on 7/9/15 AT 9:40 AM with the DON regarding what her expectation was regarding the documentation for administration of controlled substances. The DON indicated that when a controlled substance was pulled for administration to a resident, it was expected for a nurse to, " Sign that you took it and sign that you gave it. " She indicated both the resident ' s Narcotic Log and MAR should be consistent and accurate. 3) A review of Resident #45 ' s Controlled Drug Receipt/Record/Disposition form for lorazepam revealed 1 mg lorazepam was given to Resident #45 on 6/4/15 at 9:00 PM. A review of the June 2015 Medication Administration Record (MAR) did not indicate this medication was administered to Resident #45 on 6/4/15. An interview was conducted with the facility ' s Administrator and interim Director of Nursing (DON) on 7/8/15 at 9:10 AM in regards to the facility ' s procedures for the documentation of controlled medications administered to residents. The DON outlined the facility ' s procedures, indicating a nurse needed to sign off on the Controlled Drug Receipt/Record/Disposition form as soon as the medication was pulled for administration to the resident. The medication also needed to be recorded on the MAR once it was administered to the resident. An interview was conducted on 7/8/15 at 12:00 PM with the DON. Upon review of Resident #45 ' s Controlled Drug Receipt/Record/Disposition form and MARs, the DON acknowledged there were inconsistencies between the two records.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING ______ B. WING ______	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD ROAD CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 514	Continued From page 23	F 514		

The nurse who signed the Controlled Drug Receipt/Record/Disposition form on 6/4/15 was identified as Nurse #1.

A telephone interview was conducted on 7/9/2015 at 12:32 PM with Nurse #1. Nurse #1 was the hall nurse who had signed off on the Controlled Drug Receipt/Record/Disposition form as pulling a controlled substance for Resident #45 on 6/4/15 without documenting administration of the medication on the resident ' s MAR. Inquiry was made as to the process/ documentation of " as needed " narcotics to residents. Upon inquiry, Nurse #1 reported she typically gave the medication to a resident, then signed off on both the Narcotic Log and the resident ' s MAR at the same time after the medication was administered. When asked about the most recent discrepancy noted for another sample resident (Resident #81) on 7/6/15, the nurse stated, " That probably was an accident."

A follow-up interview was conducted on 7/9/15 AT 9:40 AM with the DON regarding what her expectation was regarding the documentation for administration of controlled substances. The DON indicated that when a controlled substance was pulled for administration to a resident, it was expected for a nurse to, " Sign that you took it and sign that you gave it. " She indicated both the resident ' s Narcotic Log and MAR should be consistent and accurate.