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 07/15/2016

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

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F 000	INITIAL COMMENTS IDR 8/29/16 resulted in deletion of F 157 and F 309. The Facility withdrew the IDR request for F 514. F 323 was upheld.	F 000		
F 323 SS=G	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 record reviews, resident and staff interviews, the facility failed to provide assistance from two staff during a mechanical lift in the shower. The resident fell from the mechanical sit to stand lift and sustained a fractured femur for 1 of 3 residents sampled for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 02/03/11 with diagnoses that included cerebral palsy, weakness, abnormal posture, osteoarthritis (OA) of the knee, and congenital kyphosis. Review of the most recent quarterly minimum data set (MDS) dated 04/15/16 revealed that Resident #1 was cognitively intact and had no behaviors. The MDS further revealed that Resident #1 required total assistance of 2 staff members with transfers and had functional limitations on one upper and lower extremity. The MDS also stated that Resident #1 had no falls	F 323	F 323 1. Corrective action has been accomplished for the alleged deficient practice related to supervision to prevent accidents for Resident #1 who was lowered to the floor while in the sit-to-stand lift on June 23, 2016. Resident #1 was assessed by the licensed nurse. The resident□s responsible party and physician were notified on June 23, 2016 of the incident and the resident□s complaints of knee pain. Xrays were ordered by the physician. The resident was reassessed by the physician on June 29, 2016 and additional xrays ordered. As per the physcian□s order xrays were obtained on June 30, 2016. The nursing assistant involved received 1:1 education and counseling related to the full body	8/12/16

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

Electronically Signed | 08/08/2016

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F 323	Continued From page 1 during the look back period. Review of a facility policy titled "No lift Policy" revised 08/04/09 read in part "All transfers requiring the mechanical lift will be performed with 2 co-workers during the mechanical lift process." Review of a care plan initiated 03/01/11 read, in part, Resident #1 was at risk for falls secondary to cerebral palsy. The goal of the care plan was Resident #1 would not have a fall with injury through the next review date. The intervention of the care plan included: Educate staff on 2 person assistance during the use of the mechanical lift (initiated 05/05/15). Review of a Physical Therapy (PT) Evaluation and Plan of Care dated 02/19/16 indicated that Resident #1 required the use of a sit to stand lift and the short term goal was Resident #1 would transfer with the sit to stand lift with modified assistance of 2 staff members. Review of a facility document titled "Kardex" with no date noted read, in part, that Resident #1 required the mechanical stand up lift with assistance of 2 staff members. Review of a nurse's note dated 06/23/16 at 4:23 PM read resident was lowered to the floor in the shower room during care. Resident #1 complained of left knee pain. X-ray to left knee was ordered stat, no injury noted. Assisted back to chair then to bed by staff. Will continue to monitor. The note was signed by Nurse #1. The facility was unable to provide an incident report or investigation of the fall. Review of a physician order dated 06/23/16 read X-ray of left knee due to pain from fall "stat". Review of a Radiology Report dated 06/23/16 read in part: No fracture or dislocation is seen. Conclusion: Mild OA of the left knee. Review of a physician order dated 06/29/16 read	F 323	mechanical lift and the sit-to-stand lift policy. 2. Facility residents who use the full body mechanical lift or sit-to stand lift have the potential to be affected by the same alleged deficient practice. Residents currently residing in the facility who utilize a full body mechanical lift or a sit-to-stand lift have been identified utilizing a transfer assessment/ evaluation. The transfer assessment/evaluations were completed on or before August 1, 2016 by members of the therapy staff. A review of resident incidents over the previous 6 months was conducted by the Director of Nursing on July 19, 2016 to identify residents with similar incidents. None were noted. Kardexes (written communication of care needs for ancillary staff) were reviewed and updated as needed for use of a full body lift and the sit-to-stand lift on or before August 1, 2016. Care plans will be reviewed and updated as needed by members of the Interdisciplinary Team (IDT). Incidents/accidents will be reviewed in morning meeting daily Monday through Friday with the interdisciplinary team including a representative from the therapy department, the Administrator, Director of Nursing, Unit Managers, MDS staff and Social worker. Care plans will be updated following review of the incident and discussion of the team. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: Newly admitted residents will be assessed/evaluated for fall risk	

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F 323	Continued From page 2 X-ray to the left hip, pelvis, and femur in the morning 06/30/16 for left leg pain (2 views) one time only. Review of Radiology Report of left hip dated 06/30/16 read Conclusion: Acute, displaced left femoral neck fracture as noted. Interview with Nursing Assistant (NA) #2 on 07/14/16 at 9:18 AM revealed that she was walking a patient right past the shower room 06/23/16 and she heard Resident #1 hollering for help so she went to the shower room. NA #2 stated when she opened the door she saw Resident #1 hanging from the sit to stand lift with her bottom pooched out and NA #1 was the only other staff member in there at that time. Before NA #2 could get to Resident #1 she was on the floor. NA #2 stated "it looked like the chair slid out from under her." NA #2 stated that when Resident #1 landed on the floor her feet were still in the base of the sit to stand lift. NA #2 further stated that Resident #1 kept saying "my leg hurts", another staff member had went and got the nurse and then they transferred Resident #1 off the floor and put her in her wheelchair. NA #2 stated that after Resident #1 was back in her wheelchair I left the shower room and did not assist in getting Resident #1 back to her bed. Interview with Resident #1 on 07/14/16 at 9:56 AM revealed that on 06/23/16 between 11:00 AM and 12:00 PM NA #1 and #2 got her out of bed with the sit to stand lift, and then NA #1 proceed to push me to the shower room. Resident #1 stated that NA #1 proceed to hook up the sit to stand lift by herself and while being lowered to the shower chair heard NA #1 say "the chair is tipping forward" and Resident #1 stated the next thing I knew I was on the floor and I started hollering "help." Resident #1 stated that NA #2 heard her hollering "help" and came in to the shower room	F 323	potential on admission, quarterly and with a significant change thereafter. Transfer assessments / evaluations will be completed on admission, quarterly, and with significant change to determine transfer assistance needs. Resident sustaining a fall will be evaluated by the IDT following the fall and interventions currently in place reviewed and updated as needed. An investigation into the etiology of an incident will be conducted as deemed necessary. Fall risk assessments will be completed on admission, quarterly, with significant change and following a fall. Equipment utilized for residents will be inspected for functionality 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 inservice training has been initiated by the DON, UM, RN Supervisor and/or other designated staff member for nursing staff regarding the facility□s incident management system which includes: the importance of ensuring adequate supervision and devices for residents to minimize the risk of accidents/ incidents including the use of lifts, types of lifts, expectation of the participation of two (2) staff members during the use of mechanical lifts for transfers; types of supervision for specific incidents/ accidents, incident documentation, reporting and investigation. Education regarding the proper use of the lifts, lift anatomy, sizes	

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F 323	Continued From page 3 and I was laying on the floor with my feet still in the base of the stand-up lift. Resident #1 stated that when Nurse #1 came into the shower room she asked me if I was hurting and I stated while rubbing my left knee "yes my knee is hurting bad", I told them that my knee did not bend because of my cerebral palsy and it was bent so I knew something was wrong. Resident #1 stated 3 NAs rolled me from side to side to get me on the total lift pad and lifted me off the floor and put me back in my wheelchair and took me to my room and laid me on my bed. Resident #1 stated she was informed that the X-ray of her knee was negative for a fracture. Resident #1 stated that a week later her MD came to see her and ordered additional X-rays and that is when they discovered the fractured femur. Resident #1 stated that the whole thing could have been avoided if NA #1 would have had someone in the shower room to help her. Interview with the MD on 07/14/16 at 10:36 AM revealed that initially the staff reported to him on 06/23/16 that Resident #1 was lowered to the floor and was complaining of left knee pain so he ordered an X-ray of that area and those were negative. The MD stated that he did not hear anything from the staff until he returned a week later for his regularly scheduled visit to the facility and the staff then reported that Resident #1 was still complaining of pain so he went and examined Resident #1. The MD noted that her pain was a little higher than the knee so he ordered an X-ray of her hip and that is when the fracture was detected After noting the fractured femur they made her non weight bearing and scheduled an appointment with an orthopedic doctor the next day. The goal was to keep Resident #1 on bed rest to allow the fracture to approximate and heal. Interview with Nurse #1 on 07/14/16 at 12:14 PM	F 323	and types of slings to be used based on resident needs and proper body mechanics while using the lifts will continue to be included in the facility□s orientation program for new nursing staff. Newly hired certified nursing assistants will have skills validation for the use of mechanical lifts conducted during their orientation by the designated staff and annually thereafter. The Director of Nursing or Interdisciplinary Team members will conduct announced and unannounced observation to observe the use of mechanical lifts by one (1) C.N.A. per day for 2 weeks, then at least five (5) per week for 2 weeks, then 3 per staff members monthly thereafter to ensure that 2 staff members are participating during resident transfers while utilizing a mechanical lift. Non-compliance by nursing staff will be addressed immediately. 4. The Director of Nursing, UM, or other assigned licensed nurse will review data obtained during random observations , incident /accident review in morning meeting, analyzing for patterns / trends and reporting in QAPI meeting weekly for 4 weeks then monthly thereafter, 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.	

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F 323	Continued From page 4	F 323		

revealed that on 06/23/16 she was passing her morning medications and one of the NAs called her to the shower room and what she was told was that Resident #1 was lowered to the floor. The NAs explained that while lowering Resident #1 to the shower chair it had moved and Resident #1 was lowered to floor. Nurse #1 stated that she did move Resident #1's left leg and Resident #1 complained of pain in the left ankle. Resident #1 reported to her that while the staff was trying to lower her they had twisted her leg and she was hurting from her knee to her ankle. Nurse #1 stated that Resident #1 had no other injury and no obvious deformity but was complaining of pain. Nurse #1 stated that they used the total lift to get Resident #1 off the floor and into her wheelchair and took her back to her room and put her back to bed. Nurse #1 stated that luckily the doctor was in the building and I was able to obtain an order for an X-ray of her left knee.
Interview with NA #2 on 07/14/16 at 12:28 PM revealed that on 06/23/16 she had transferred Resident #1 by herself to the shower chair and Resident #1 had leaned forward and the chair started to tilt forward. NA #1 stated that I jumped in front of her and yelled for help and NA #2 came into the shower room and they grabbed Resident #1 but were unable to get her back into the chair so they lowered her to the floor. NA #1 stated that Resident #1 was hollering "get my foot" and one of the NAs grabbed her feet off the sit to stand lift. NA #1 stated that 3 NAs assisted in rolling Resident #1 from side to side to get her on the total lift pad and they lifted her off the floor and back to her wheelchair and took her back to her room and put her back in the bed. NA #1 stated that Nurse #1 had come in and assessed Resident #1 before they lifted her off the floor. NA #1 also stated that she was aware that all

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F 323	Continued From page 5 mechanical lifts required 2 staff members but stated Resident #1 gets upset if she has to wait for help, so on this day "I just went ahead and lifted her by myself." Interview with the Director of Nursing (DON) on 07/15/16 at 12:18 PM revealed that she would have expected NA #1 to have another staff member with her while lifting Resident #1 on 06/23/16 "because we can't take chances with these residents." After the incident we did some re-education with the staff on the importance of following the facility policy and for safety reason all lifts requiring the mechanical lift require 2 staff member to be present. Interview with the Administrator on 07/15/16 at 1:14 PM revealed that she would expect the staff to follow the facility policy that all lifts requiring the use of a mechanical lift must have 2 staff members present, at that same time honoring the request of the resident.	F 323		
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.	F 514		8/12/16

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F 514	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to document in the medical record administration of a pain medication to a resident with a fractured femur for a 1 of 3 residents sampled for supervision to prevent accidents (Resident #1). The Findings included: Resident #1 was admitted to the facility on 02/03/11 with diagnoses that included cerebral palsy, weakness, abnormal posture, osteoarthritis (OA) of the knee, and congenital kyphosis. Review of the most recent quarterly minimum data set (MDS) dated 04/15/16 revealed that Resident #1 was cognitively intact and had no behaviors. The MDS further revealed that Resident #1 required total assistance of 2 staff members with transfers and had functional limitations on one upper and lower extremity. The MDS also stated that Resident #1 had no falls during the look back period. Review of a nurse's note dated 06/25/16 at 1:29 PM read, in part, Resident #1 was still complaining of pain in her upper left leg from her knee to her groin. Resident #1 rated the pain a 7 on a pain scale from 1-10. Contacted the on-call physician to request an increase in the frequency of muscle relaxer and/or a stronger pain medication because Resident #1's pain was not relieved. Signed by Nurse #2. Review of Medication Administration Record (MAR) dated 06/01/16 through 06/30/16 revealed that Tylenol ordered for pain was not given on 06/25/16 when Resident complained of pain of a 7 on a pain scale of 1-10 to Nurse #2. Interview with Nurse #2 on 07/15/16 at 2:08 PM revealed that on 06/25/16 when Resident #1 complained of pain of a 7 on a pain scale of 1-10	F 514	F514 1. Corrective action has been accomplished for the alleged deficient practice in regards to the documentation of the administration of a prn (as needed) pain medication (Tylenol) for resident # 1. Resident #1 received Tylenol on June 25, 2016 for leg pain. The licensed nurse was provided 1:1 education and coaching related to ensuring documentation in the electronic medical record reflects medications administered to residents, including scheduled, prn and one time medications. 2. Facility residents have the potential to be affected by the same alleged deficient practice. The DON, UM, RN Supervisor and/ or other designated licensed nurse will conduct on-going random audits of electronic medical records reconciling the 24 hour report/progress notes with the Electronic Medication Administration Record (EMAR) to identify potential residents with at least 4 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. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: mandatory in-service training for licensed nursing staff regarding the importance of complete,	

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F 514	Continued From page 7 she only had Tylenol to give to her. Nurse #2 stated that it was sometime in the morning but could not recall the time, but remembered she had taken Resident #1 her morning medications and when she went into her room Resident #1 asked for something for pain. Nurse #2 stated she went back to the cart and got 2 Tylenol and had forgotten to go back and document the administration of the Tylenol. Interview with Nurse Supervisor on 07/15/16 at 2:59 PM revealed that all nurses were expected to electronically document on the MAR the administration of all medications that were given. Interview with the Unit Manger and Administrator on 07/15/16 at 3:21 PM revealed that all nurses were expected to electronically document on the MAR the administration of all medications that were given.	F 514	accurate and timely documentation in resident□s electronic medical record, including but not limited to documentation of medications, both scheduled and medication given on an as needed basis or one time basis. Training for newly hired staff regarding electronic medical records will be incorporated in the facility□s orientation program. The DON, UM, RN Supervisor and/ or other designated licensed nurse will conduct on-going random audits of electronic medical records with at least 4 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 taken including additional education and discipline when discrepancies are identified to ensure continued compliance. 4. 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.	