## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345227

### C. Wing _____________________________

**Date Survey Completed:** 07/23/2015

**Printed:** 09/02/2015

**Form Approved OMB NO. 0938-0391**

### Name of Provider or Supplier

**Avante at Reidsville**

**Street Address, City, State, Zip Code:** 543 Maple Avenue, Reidsville, NC 27320

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 279</td>
<td>SS=D</td>
<td>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
<td>F 279</td>
<td></td>
<td></td>
<td></td>
<td>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 CPAP (Continuous Positive Airway Pressure) for 2 of 3 sampled residents (Resident #1 and Resident #2) reviewed for respiratory care. The findings included: 1) Resident #1 was admitted to the facility on 7/2/15 from an acute care hospital. His cumulative diagnoses included sleep apnea and a history of acute respiratory failure.</td>
<td>8/4/15</td>
</tr>
</tbody>
</table>

Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared by the provisions of Health and Safety code section 1280 ad 42C.F.R 405.1907

**Deficiency Corrected**

1.) How corrective action will be accomplished for those found to have

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

Electronically Signed

Electronically Signed

08/04/2015

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.
A review of Resident #1's medical record revealed his 7/2/15 admission orders included the following: Resident to have CPAP (Continuous Positive Airway Pressure) every night at bedtime with auto setting of 5-20 at bedtime; Remove CPAP every morning. CPAP is a treatment that uses mild air pressure to keep the airways open.

Resident #1's admission MDS (Minimum Data Set) assessment was dated 7/9/15. Section O of the MDS assessment revealed he received oxygen therapy and BiPAP (Bilevel Positive Airway Pressure) / CPAP while he was a resident in the facility.

A review of Resident #1's care plan (initiated on 7/3/15) revealed the use of CPAP was not addressed in his care plan.

An interview was conducted with Nurse #1 on 7/22/15 at 4:14 PM. Nurse #1 reported she assumed responsibility for completion of the MDS assessments and development of interdisciplinary care plans for each of the facility's residents. Upon review of Resident #1's care plan, the nurse acknowledged the CPAP was not part of the resident's care plan. When asked if she would have expected to address the use of CPAP in the care plan, the nurse stated, "yes."

An interview was conducted with the facility's Director of Nursing (DON) on 7/23/15 at 9:02 AM. Upon inquiry, the DON stated she would have expected the use of CPAP to be included on the resident's care plan. She reported Nurse #1 added the CPAP onto his care plan after its omission was brought to their attention.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 279</td>
<td>Continued From page 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Resident #1 and #2 care plans were reviewed and updated to reflect the use of a CPAP machine on 7/22/15.

2.) How corrective action will be accomplished for those having potential to be affected by the same practice.

For current residents that have orders for CPAP machines have the potential to be affected. Current residents that utilize a CPAP machine their care plans were reviewed and if needed were updated to reflect the use of the machine.

3.) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.

MDS staff were re-educated by the Director of Nursing on care plans to ensure that when a resident has orders for a CPAP machine that it is included in the care plan. The Director of Nursing will audit the care plans weekly for 4 weeks and then monthly for 3 months of residents that have orders for CPAP to ensure the use of the machine is indicated on the care plan.

4.) How the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Nursing will present the results of the audits to the QA&A committee monthly for four months. The QA&A committee will determine if
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 279</td>
<td></td>
<td></td>
<td>Continued From page 2 2) Resident #2 was re-admitted to the facility on 6/11/15 from an acute care hospital. His cumulative diagnoses included obstructive sleep apnea and chronic respiratory failure. A review of Resident #2’s medical record revealed his 6/11/15 admission orders included the following: CPAP (Continuous Positive Airway Pressure) every evening at bedtime. CPAP is a treatment that uses mild air pressure to keep the airways open. Resident #2’s annual MDS (Minimum Data Set) assessment was dated 6/18/15. Section O of the MDS assessment revealed he received oxygen therapy and BiPAP (Bilevel Positive Airway Pressure) / CPAP while he was a resident in the facility. A review of Resident #2’s care plan (reviewed on 6/30/15) revealed the use of CPAP was not addressed in his care plan. An interview was conducted with Nurse #1 on 7/22/15 at 4:14 PM. Nurse #1 reported she assumed responsibility for completion of the MDS assessments and development of interdisciplinary care plans for each of the facility’s residents. Upon review of Resident #1’s care plan, the nurse acknowledged the CPAP was not part of the resident’s care plan. When asked if she would have expected to address the use of CPAP in the care plan, the nurse stated, “yes.” An interview was conducted with the facility’s Director of Nursing (DON) on 7/23/15 at 9:02 AM. Upon inquiry, the DON stated she would have expected the use of CPAP to be included on the resident’s care plan. She reported Nurse #1 continued monitoring is necessary.</td>
<td>F 279</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER:** AVANTE AT REIDSVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

543 MAPLE AVENUE
REIDSVILLE, NC 27320

**MULTIPLE CONSTRUCTION B. WING _____________________________**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 345227

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED:** 07/23/2015

**OMB NO.: 0938-0391**

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

**FORM APPROVED OMB NO.: 0938-0391**

**FORM CMS-2567(02-99) Previous Versions Obsolete**

**If continuation sheet Page 3 of 4**
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 279</td>
<td>Continued From page 3 added the CPAP onto his care plan after its omission was brought to their attention.</td>
<td>F 279</td>
<td></td>
</tr>
</tbody>
</table>