FEB 0 3 2012

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 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CONCORD	515 LAKE CONCORD RD 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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to follow-up on a concern voiced by a family member for one (1) of three (3) residents (Resident # 1). Resident #1 was admitted 9/15/2011 with diagnoses including Diabetes Type 2, Epilepsy, hypertendsion, peripheral vascular disease (PVD), chronic obstructuive pulmonary disease (COPD), congensive heart failure (CHF), atrial fibrilation and end stage renal disease (ESRD). Review of the Admission Minimum Data Set (MDS) dated 9/22/11 revealed Resident #1 was cognitively impaired. Review of the incident and grievance logs for October 2011 - December 2011 revealed there was a Geievance and Incident dated 10/21/11 on behalf of Resident #1. Review of the Incident/Accident Form for the 10/21/11 Grievance pertaining to Resident #1 read, in part. " Family complains of CNA (nursing assistant NA) unable to identify by name, man handled him on the morning he went to the hospital " (this was later determined to be Oct 19, 2011). " This (NA) did not clean his bottom,	F 166	Preparation and or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion 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 the federal and state law. Deficiency has been corrected **483.10 (f) (2) Right To Prompt Efforts To Resolve Grievances** **F 166** 1. On 1-5-12, the investigation was re-opened for the grievance filed on 10-21-11by Resident #1's family member. All CNAs and Nurses were interviewed and re-educated concerning handling geriatric residents gently. 2. An 100% audit of all current month grievances was completed to validate completion within five (5) working days. No other outstanding grievances were identified.	1/27/2012 1/27/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Billings LNHA	Administrator	1/30/2012

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

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F 166	Continued From page 1 when she changed him. Also, this (NA) almost dropped him when she put him in his wheelchair. " " Someone told (Name of resident) family this facility does not have a chair for him to be put in. " Under incident type it read " Grievance/Resolved. " Review of the investigation for the Grievance/Incident, noted above, that was reported on 10/21/11 revealed that in regards to the resident being " man handled " one staff member was interviewed. NA # 4 was interviewed by Nurse #1 during the facility investigation and indicated that he did not transfer the resident, as he had been on break, and he only adjusted Resident #1 ' s legs in the wheelchair after another staff member had transferred him. He did not understand what he had done incorrectly but was re-educated on using a gentle tehnique with elderly residents. Further review of the investigation revealed that no on the staff members were interviewed and it was not determined who transferred the resident. Further review of the investigation for the Grievance/Incident, noted above, that was reported on 10/21/11, revealed that there was no investigation of the concern that " This (NA) did not change his bottom " or that " Someone told (Name of resident) family this facility does not have a chair for him to be put in. " Interview with Nurse # 1 on 1/5/11 at 12:30 PM, who was responsible for nursing care grievance investigations, revealed that only NA #4 (a male NA) was interviewed regarding the 10/21/11 grievances regarding Resident #1. However, the concern referred to a female NA. No steps were	F 166	3. All grievances will be given to the Administrator or designee to be reviewed and distributed to the appropriate department managers for investigation. A thorough investigation will be conducted within three (3) working days. The grievance response will be available to the originator of the grievance within five (5) working days. Upon completion of the grievance, the grievance will be returned to the Administrator or designee. Within five (5) working days after the completed grievance is returned, the Administrator or designee will follow up with the grievance originator to make sure of their acceptance of the grievance investigation results. An audit will be conducted weekly of the grievance log by the Administrator or designee to ensure All grievances have been completed within five (5) working days.	

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F 166	Continued From page 2 taken to identify the NA who may have transferred Resident # 1 on that occasion. Nurse #1 also noted however, that she thought the grievance was specifically referring to a male NA as it said " man handled " and she inferred that this pertained to care provided by a man. Duiring the interview she acknowledged that the grievance referred to a female staff member " man handeling " the resident. Interview with the Administrator on 1/5/11 at 12:40 PM revealed that it was her expectation that there would have been further interviews for the grievance dated 10/21/11 for Resident #1, with other involved staff members and residents. She acknowledged that the concern was not thourally investigated and resolved as per facility policy. During interview with NA #4 on 1/5/11 at 3:15 he stated he did not transfer the resident on October 19, 2011. He stated that this was the only day he had ever worked with the resident and this was confirmed by the staffing assignment records provided by the facility. NA #1 further stated that another NA had transferred Resident #1 for him as he had been on break. Interview on 1/5/11 at 3:30 PM with NA # 5, who was identified as caring for the resident on 10/19/11 when he returned to the facility and his assigned NA was on break, revealed that she provided incontnent care for the resident on his return from an appointment that day. She stated that once she assisted the nurse to put the resident back in the bed she unfastened the briefs then determined she needed to get more wipes, so she left the room to get them and then	F 166	All department managers have been educated on the policy and procedure of investigating a grievance. 4. This process will be monitored at our QA&A meeting every week for two(2) months and every month thereafter for compliance.	1/27/2012

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F 166	Continued From page 3 returned. She stated that when she returned a family member was present and seemed upset about something, and because of that she just wanted to provide the incontinent care, ensure Resident #1 was comfortable and remove herself from the room. NA # 5 indicaed that she informed the family member why she had been out of the room. She denied that she transferred the resident to the wheelchair and stated she did not think he had been up that day after that and, if he was, she did not know who had gotten the resident up. Interview with NA # 3 on 1/6/11 at 2:50 PM revealed that on 10/19/11 she transferred Resident to a wheelchair as he needed to go out to an appointment. She stated that she borrowed a wheelchair from aother resident as Resident #1 did not have a wheelchair. Her recollection was that Resident #1 may have been slipping down in his previous wheelchair and had not yet been assessed for a new one so did not have one of his own to get up in at the time. There was no indication from the Greivance or Incident reports that this had been communiated to the family and resolved to their satisfaction.	F 166		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the	F 226		

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F 226	Continued From page 4 facility failed to investigate or report an allegation of a resident being man handled for one (1) of three (3) residents (Resident #1) and failed to investigate or report misappropriation of a resident property for one (1) of three (3) residents (Resident #6). Review of the facility policy titled " Abuse and Neglect " dated effective 1/5/10 read, in part, " Misappropriation of Resident Property is defined as the patterned or deliberated misplacement, exploitation or wrongful, temporary or permanent use of a resident ' s belongings or money, without the resident ' s consent. " " ALL alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to: " " The Director of Nursing. " " The Administrator or the designated representative. " " Police, if appropriate. " " Follow Federal Guidelines for Reporting and always report to State survey and certification agency. " " Report immediately via fax, to the appropriate agency a) Immediately means as soon as possible but ought not exceed 24 hours after discovery of the incident. " " The results of all investigations must be reported within 5 working days to: " , " Other officials in accordance with local, state and federal law (including the state survey and certification agency. " 1. Resident #1 was admitted 9/15/2011 with diagnoses including Diabetes Type 2, Epilepsy, hypertendsion, peripheral vascular disease	F 226	Deficiency has been corrected **483.13(c) Develop/Implement Abuse/Neglect, Etc Policies** **F226** 1. A 24 hour report was sent to the appropriate authorities on 1-5-2012 related to the grievance filed for Resident #1 with an accusation of "man handling" and a 5 day follow-up report was sent in to the appropriate authorities on 1-9-2012. A 24 hour report was sent to the appropriate authorities on 1-5-2012 in reference to grievance filed for Resident #6 of misappropriation of property and a 5 day report was filed with the authorities on 1-9-2012. The property was replaced by the facility prior to reporting. 2. An audit of all the grievances received within the last three (3) months was conducted to ensure compliance with rules and regulations of abuse, neglect and misappropriation of property. No other incidences were identified.	1/27/2012

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F 226	Continued From page 5 (PVD), chronic obstructuive pulmonary disease (COPD), congensive heart failure (CHF), atrial fibrilation and end stage renal disease (ESRD). Review of the Admission Minimum Data Set (MDS) dated 9/22/11 revealed Resident #1 was cognitively impaired. Resident #1 was totally depentent for all activities of daily living with a one person physical assist. Review of the Incident/Accident Form for a 10/21/11 Grievance pertaining to Resident #1 read, in part. " Family complains of CNA (nursing assistant NA) unable to identify by name, man handled him on the morning he went to the hospital " (this was later determined to be Oct 19, 2011). Interview with Nurse # 1 on 1/5/11 at 12:30 PM, who was responsible for nursing care grievance investigations, revealed that only NA #4 (a male NA) was interviewed regarding the 10/21/11 grievances regarding Resident #1. However, the concern referred to a female NA. No steps were taken to identify the NA who may have transferred Resident # 1 on that occasion. Nurse #1 also noted however, that she thought the grievance was specifically referring to a male NA as it said " man handled " and she inferred that this pertained to care provided by a man. Duiring the interview she acknowledged that the grievance referred to a female staff member " man handeling " the resident. She also stated that she had not yet been able to contact the family member discuss the allegation. During interview with the Administrator on 1/5/11 at 12:40 PM she stated that an abuse	F 226	3. All future grievances will be investigated thoroughly and if indicated, reported to the proper authorities within twenty four (24) hours of notification by the Administrator or designee, with a follow up report within five (5) days. All staff have been educated on reporting of abuse, neglect and misappropriation of property. All staff are educated on reporting of abuse, neglect and misappropriation of property annually and new employees are trained during orientation. A weekly audit of the grievance log will be completed by the Administrator or designee to ensure occurrences of possible abuse, neglect and misappropriation of property are investigated and reported.	

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F 226	Continued From page 6 investigation was not initiated and 24 hour and 5 day reports were not done but should have been due to the allegation that that Resident #1 was " man handled. " She stated that she had not been aware of the allegation although she did sign the Grievance form as she had not read all the details and had not been informed. She further indicated she would initate an investigation at this time. 2. Resident # 6 was admitted on 8/28/09 and readmitted on 11/19/11 with diagnoses including Diabetes and renal disease. The Quarterly Minimum Data Set (MDS) dated 12/1/11 revealed Resident # 6 was cognitively intact. Review of the " Resident Grievance Form " dated 12/5/11 for Resident #6 read, in part, " (Name of Resident) states that when she left to go to Dialysis that her DVD player and DVD ' s were there but when she got back the DVD player and about 5 - 7 DVD ' s were mising. " Further review revealed that the DVD player and DVD ' s were searched for and could not be located, so they were replaced by the facility. Interview with the Administrator on 1/5/11 at 4 PM revealed that Resident # 6 ' s missing personal property was not investigated for misappropriation of personal property or reported via a 24 hour or 5 day report. She stated that because the facility replaced it she had not thought of the incident in that context. The Administrator also said that Resident #6 did have a DVD player and DVD ' s that went missing but precisely when was unknown. The Administrator	F 226	4. Results of audits will be reviewed in QA&A for further recommendations and follow-up for three (3) months.	

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F 226	Continued From page 7 did acknowledge that although she did not know how it went missing it was likely misappropriated and should have been investigated and reported. She stated she would initiate an investigation at this time.	F 226	Deficiency has been corrected **483.25(h) Free of Accident Hazards/Supervision/Devices** **F323**	
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 staff interview and record review the facility failed to safely transfer (1) of three (3) residents by physically lifting a resident (Resident # 1). Review of the facility policy titled " No Lift Policy " revised 8/4/09 read, in part, "This policy is designed to improve working conditions by reducing the incidence of back fatigue and back injuries, maintain a high level of quality care and standardize all lifting procedures and provide tools to lift safely while protecting staff and residents from injury." " Lifts and transfers without using a mechanical lifting device are limited to: 1) Assisting residents who are ambulatory and stable into and out of bed, chairs and commodes. 2) Assisting with residents needs in bed where the resident is able to assist, or repositioning a resident by sliding the bed	F 323	1. Resident #1 no longer resides at this facility. 2. All residents have the potential to be affected. A 100% audit of all care plans and kardexes was completed to ensure that appropriate transfer modalities are indicated for each resident. 3. All staff will be educated on the No Lift Policy annually and new employees with be trained during orientation. Director of Nursing or designee will monitor this process of proper lifting by conducting ten(10) random observations per week for three (3) months to monitor compliance. 4. Results of observations will be reviewed in the QA&A meeting for further recommendations and follow up for three (3) months or until 100% compliance is achieved.	1/27/2012 1/27/2012

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F 323	Continued From page 8	F 323		

sheet/pad. 3) Other lifts and transfers where the back and knees remain vertical and the lift does not exceed 30 pounds. All other situations require the use of a mechanical lifting device. "

Resident #1 was admitted 9/15/2011 with diagnoses including Diabetes Type 2, Epilepsy, hypertendsion, peripheral vascular disease (PVD), chronic obstructuive pulmonary disease (COPD), congensive heart failure (CHF), atrial fibrilation and end stage renal disease (ESRD).

Review of the Admission Minimum Data Set (MDS) dated 9/22/11 revealed Resident #1 was cognitively impaired. Resident #1 was totally depentent for all activities of daily living with a one person physical assist. The MDS also indicated that the resident did not walk during the assessment reference period and used a wheelchair when up.

Review of the Kardex (undated) revealed Resident #1 required a mechanical lift.

Review of the Grievance logs from October 2011 - Decmeber 2011 revealed a Grievance dated 10/21/11 that stated " Also, this CNA (Nursing Assistant NA) almost dropped him when she put him in his chair. "

Interview with NA #5 on 1/6/12 at 2:50 PM revealed that she was aware that the resident was to be transferred via a hoyer lift. She also stated that if Resident #1 was to be physically lifted, it would require two peopl,e as he was heavy and " dead weight ", and could not be lifted physiclly with just one person. NA #5 added that on October 19, 2011 she and another NA

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F 323	Continued From page 9 (NA # 6 - a Restorative Aide) physically lifted resident # 1 into a wheelchair, borrowed from another resident. NA #5 said that on this morning a family member was present and had said that Resident #1 had a doctors appointment, which no one at the facility was aware of. She indicated that it appeared the family member was anxious to make sure Resident #1 did not miss the appointment. NA #5 further stated that because a hoyer lift pad was not readily available she (NA #5) thought it would be quicker to have someone help her physically lift the resident into a wheelchair. NA #5 stated that NA # 6 helped her lift the resident from a sitting position on the bed into the wheelchair, which was close to the bed at an angle, She stated that the transfer occurred without incident. NA #5 added that physically lifting residents was fairly common in the facility and had happened before. She also indicated that she was aware and had been educated that the facility had a no lift (no physical lift) policy. However, she noted that in repositioning residents some lifting is required so she felt that no lift was not quite accurate. Interview with the Administrator on 1/6/12 at 4 PM revealed that she expects staff to follow the " No (Physical) Lift policy of the facility. She acknow;edged that by physically lifting a resident the resident and/or staff member could be injured. "	F 323		