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

PRINTED: 08/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to clarify an order for a medication prescribed by a Physician and accurately record medication administration for one (1) of three (3) residents. (Resident #1) The findings are: Resident #1 was admitted to the facility with diagnoses including atrioventricular block with symptomatic bradycardia, hypertension, back pain and blindness. The closed medical record revealed Resident # 1 had a Physician order dated 07/13/12 for Norco (a narcotic pain medication) five (5) milligrams (mg), three (3) times daily as necessary (PRN) for pain. A review of Resident #1's Medication Administration Record (MAR) for the month of July 2012 revealed Resident #1was given, oral doses of Norco by Licensed Nurses on: 07/14/12 at 10:45 AM 07/14/12 at 5:30 PM 07/14/12 at 10:00 PM and 07/15/12 at 12:30 PM	F 281	1. Medication Error Report was completed for discharged resident affected. 2. Nursing administration completed a full-house audit of all PRN orders for clarity and appropriate documentation on the MAR. All nurses were in-serviced on clarifying orders and accurately documenting medication administration. 3. Nursing administration will complete chart audits for new admissions within 24 hours. Any areas of concern will be addressed and corrections implemented as appropriate to ensure compliance is achieved. 4. The results from the audits will be reviewed at the monthly Quality Assurance Committee Meeting to maintain compliance and evaluate effectiveness for at least a three month period of time until the requirements of #3 are met.	8/20/12
	The facility narcotic medication utilization record (a shift-to-shift medication inventory) for Resident			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stefanie J Gerlott, [illegible] TITLE: Administrator (X6) DATE: 8/20/12

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 281	Continued From page 1 #1 revealed the following doses were removed from the packaging and given to Resident #1: 07/13/12 at 11:15 PM 07/14/12 at 6:30 AM 07/14/12 at 10:45 AM 07/14/12 at 5:30 PM 07/14/12 at 10:00 PM and 07/15/12 at 12:30 PM An interview was conducted with Licensed Nurse (LN) #1 at 6:26 PM on 08/07/12. LN #1 indicated when PRN pain medications had a three times daily frequency it should be given as the resident requested it, in eight-hour intervals. LN #1 further stated that she would have called the physician to clarify the order further. LN #1 stated the procedure for administration of narcotic pain medications was once the resident requested the medicine the LN was to check the MAR and see when the last dose had been administered. Then check the MAR to see when the next dose was due to be administered. LN #1 indicated the MAR had to be checked to assure the medication was not given too frequently or in excess doses. An interview with LN #2 was conducted on 08/07/12 at 6:33 PM. LN #2 stated with a medication order for three (3) times daily it was expected the medicine would be administered in eight (8) hour intervals as needed. LN #2 confirmed the narcotic pain medication she gave on 07/14/12 at 10:45 AM was not eight hours from the previous dose, due to that dose having not being recorded on the MAR. LN #2 stated further she should have compared the MAR with the narcotic medication utilization record. LN #2 confirmed she had given Resident #1 two (2)	F 281		

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F 281	Continued From page 2 doses of the narcotic pain medication. An interview was conducted with LN #3 on 08/08/12 at 4:22 PM. LN #3 stated she did remember giving Resident #1 two (2) doses of Norco pain medication. LN #3 further explained she remembered writing a nursing note regarding administering the pain medication at 11:15 PM and 6:30 AM. LN #3 stated she should have recorded the medication administration on the facility MAR as she did on the narcotic medication utilization record. The LN stated she must have just forgotten to complete the MAR she added that was the way Nurses were to tell if a medication had been given. LN #3 further revealed when an order was given for a medication to be administered three (3) times daily, she should have clarified the time intended with the medical provider. LN #3 also stated three (3) times a day should have been about every eight (8) hours. LN #3 confirmed Resident #1 did receive one extra dose of Norco pain medication due to the 6:30 AM dose not being recorded on the MAR. An interview with the Director of Nursing (DON) was conducted on 08/07/12 at 6:46 PM. The DON stated she expected Licensed Nurses to compare the MAR to the narcotic medication utilization record prior to administering a PRN medication. The DON further stated she expected the LN who administered the medication to record their signature and initial on both the MAR and the narcotic medication utilization record. The DON further added the LN who received the Physician order should have clarified the time frame with the Primary Care Provider (PCP) for Resident #1. She stated a	F 281		

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F 281	Continued From page 3 medication ordered three (3) times daily should be in eight (8) hour intervals. The DON further stated since one of the doses on 07/14/12 was not recorded on the MAR, that caused Resident #1 to get four doses on that day. The DON stated she expected the MAR and the narcotic medication utilization record be completed after each medication administration. An interview with the Nurse Practitioner (NP) for Resident #1 was conducted on 08/07/12 at 6:56 PM. The NP indicated any medication ordered three times daily should be administered at eight-hour intervals. The NP further stated frequently residents are ordered the same medication on an every four-hour schedule for severe pain without problem, but that is not the way it was ordered for Resident #1.	F 281		