

12/21/12

PRINTED: 12/19/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/04/2012
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NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD RD CONCORD, NC 28025
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(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
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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to develop a care plan for the open wound on 1 (Resident #8) of 3 sampled residents with wounds. The finding includes: Resident #8 was admitted to the facility on 11/22/11 with multiple diagnoses including cellulitis and abscess of the trunk. The quarterly Minimum Data Set (MDS) assessment dated 9/21/12 indicated that Resident #8 had memory and decision making problems.</p>	F 279	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>F279 Comprehensive Care plans</p> <p>The facility will continue to 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. Deficiency corrected</p> <p><u>Criteria #1</u> Resident #8's care plan has been updated to reflect the current wound.</p>	12/13/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kimberly L. Snyder</i>	TITLE <i>Administrative</i>	(X6) DATE
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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 279	Continued From page 1 The hospital discharge summary indicated that Resident #8 was admitted to the hospital on 10/17/11 due to abscess on his left flank. The notes revealed that incision and drainage (I & D) was performed at the hospital. The " Resident assessment data collection form " dated 11/22/11 indicated that Resident #8 was admitted to the facility with open abscess on his left flank. Review of the resident's care plan revealed that there was no care plan developed for the open wound/abscess on the left flank. On 12/3/12 at 2:45 PM, Resident #8 was observed during the dressing change. The open wound had a red wound bed and was bleeding when cleaned with normal saline. The wound was covered with Mepilex border dressing. On 12/3/12 at 4:55 PM, the MDS Nurse was interviewed. She stated that she normally did not develop a care plan for open wounds. She only develops care plan for pressure ulcers, stage III and IV. On 12/4/12 at 10:40 AM, the administrative staff was interviewed. She stated that a care plan should have been developed for Resident #8 for his open wound/abscess on the left flank.	F 279	<u>Criteria# 2</u> The Minimum Data Set (MDS) nurse was in-serviced on 12/4/12 by the Director of Nursing. An audit was conducted and completed on 12/13/12 for all residents with wounds to ensure a care plan is in place to reflect the current wound and treatment in place with no issues identified. <u>Criteria #3</u> All new admissions care plans will be reviewed by the Director of Nursing and/or nursing supervisors to ensure all appropriate plan of care is in place to address current status of the resident. Scheduled quarterly care plans of residents with wounds will be reviewed by the MDS nurse and interdisciplinary team. Any new wounds identified will be care planned when identified and monitored in weekly Interdisciplinary Team meeting. <u>Criteria # 4</u> The Director of Nursing and/or nursing supervisor will report results monthly in the QA&A committee for three months and as needed. The committee will make recommendations as needed. The Administrator is responsible for overall compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		12/13/12

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F 309	<p>Continued From page 2</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to assess and to treat the open wound as ordered on 1 (Resident #8) of 3 sampled residents with wounds. The finding includes:</p> <p>The hospital discharge summary indicated that Resident #8 was admitted to the hospital on 10/17/11 due to abscess on his left flank. The notes revealed that incision and drainage (I & D) was performed at the hospital.</p> <p>Resident #8 was admitted to the facility on 11/22/11 with multiple diagnoses including cellulitis and abscess of the trunk. The quarterly Minimum Data Set (MDS) assessment dated 9/21/12 indicated that Resident #8 had memory and decision making problems.</p> <p>The " Resident assessment data collection form " dated 11/22/11 indicated that Resident #8 was admitted to the facility with open abscess on his left flank.</p> <p>Review of the resident's care plan revealed that there was no care plan developed for the open wound/abscess on the left flank.</p> <p>On 7/12/12, there was a doctor's order to clean the area with normal saline and apply dressing</p>	F 309	<p>F309 Provide Care to Maintain Highest Well Being</p> <p>The facility will continue to ensure that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental & psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Deficiency corrected</p> <p><u>Criteria # 1</u> Resident # 8's dressing has been changed and reviewed to reflect the physician's order. The nurse assigned to this resident was in-serviced and counseled on 12/5/12 by the Director of Nursing on following standards of practice with emphasis on administering treatments per physician's order.</p> <p><u>Criteria #2</u> An audit has been conducted and completed on 12/13/12 for all residents with wound treatment orders to ensure physician's orders are followed. The Director of Nursing completed on 12/12/12 an in-service for all nurses on following the standard of practice and administering wound treatments per physician's order. Nurses not available for scheduled in-service will not be scheduled to work until in-service is completed.</p>	12/13/12

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F 309	<p>Continued From page 3</p> <p>with 4 x 4 gauze, change every Monday, Wednesday and Friday and as needed and every shift.</p> <p>On 10/26/12, there was a doctor's order to clean the left flank with normal saline, to apply 4 x 4 Mepilex pad (antimicrobial foam dressing that absorbs exudates and maintain a moist wound environment), and to change every other day and as needed.</p> <p>The treatment administration record (TAR) for November 1-12, 2012 was reviewed. The records indicated that the open wound was cleaned with normal saline and covered with 4 x 4 gauze dressing, instead of mepilex border dressing as ordered (10/26/12). On 12/3/12 at 3:45 PM, the treatment nurse was interviewed. He stated that he was not responsible for transcribing the doctor's order to the TAR. He further stated that the facility had started using the computer for their medical records on 11/13/12 and that might be the reason that the treatment that was ordered on 10/26/12 was not started until 11/13/12.</p> <p>The TAR from November 13- November 30, 2012 was reviewed. On November 17 (Saturday), November 23 (Friday), November 25 (Sunday), November 27 (Tuesday) and November 29 (Thursday), the TAR was not initialed by the nurses to indicate that the treatment was provided. On 12/3/12 at 3:45 PM, the treatment nurse was interviewed. He stated that he worked Monday through Friday as a treatment nurse. He stated that he was either pulled to work on the floor or was not working on the days that the treatment was not provided. At 4:05 PM on 12/3/12, Nurse #1 was interviewed. She</p>	F 309	<p><u>Criteria #3</u> The Director of Nursing and/or nursing supervisors will monitor all residents that have a physician's order for wound treatments to ensure orders are followed. This will be done daily for one week, then weekly for one month, then monthly for three months and as needed.</p> <p><u>Criteria #4</u> The Director of Nursing and/or Nursing Supervisors will report results monthly in the QA&A committee for three months and as needed. The committee will make recommendations as needed. The Administrator is responsible for overall compliance.</p>	12/13/12	

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F 309	<p>Continued From page 4</p> <p>acknowledged that she was assigned to Resident #8 and on some days the treatment was not initialed as provided. She stated that the reason the treatment was not provided because most of the time it was so hectic on the floor especially when the doctors made their rounds. On 12/4/12 at 8:36 AM, Nurse #2 was interviewed. Nurse #2 was the weekend nurse supervisor. She stated that she was responsible to do the treatments during the weekends. She stated that the treatment nurse had provided her a list of residents who needed treatments and Resident #8 was not on the list. She acknowledged that she had not been providing wound treatment to Resident #8 on weekends.</p> <p>The TAR for December 1, 2012 was reviewed. On 12/1/12 (Sunday), the TAR was initialed to indicate the wound treatment was provided to Resident #8 by Nurse #1. On 12/3/12 at 4:05 PM, Nurse #1 was interviewed. She stated that she had put her initial on the TAR for 12/1/12 but did not do the treatment. She further stated that she thought that Nurse #2 had already provided the wound treatment. On 12/4/12 at 8:36 AM, Nurse #2 was interviewed who stated that she did not provide the wound treatment for Resident #8 on 12/1/12. She assumed that Nurse #1 had already provided the treatment.</p> <p>On 12/3/12 at 2:45 PM, Resident #8 was observed during the dressing change. The treatment nurse was observed to remove the old dressing which was dated 11/30/12 (Friday). The open wound had a red wound bed and was bleeding when cleaned with normal saline. The wound was covered with Mepilex border dressing. On 12/3/12 at 3:45 PM, the treatment nurse was</p>	F 309		12/13/12	

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F 309	Continued From page 5 interviewed. He stated that the old dressing dated 11/30/12 was his initial and he did not know why the treatment was not provided on the weekend. Review of the nurse's notes and the weekly skin assessment records for the last 3 months (September through November, 2012), revealed there was no assessment for the open wound/abscess on the left flank to evaluate the appearance/size, progress or response to the treatment. On 12/3/12 at 3:45 PM, the treatment nurse was interviewed. He stated that he normally did not assess open wound, he only assessed pressure ulcers on a weekly basis. On 12/4/12 at 10:40 AM, the administrative staff was interviewed. She stated that open wounds should be assessed on a weekly basis to evaluate the response to treatment and the assessment should be documented in the progress notes.	F 309			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	<u>F 356 Posted Nurse Staffing Information</u> The facility will post the following information on a daily basis: <ul style="list-style-type: none">• Facility name• The current date• Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: -Registered nurses. -Licensed practical nurses. -Certified nurse aides. <ul style="list-style-type: none">• Resident census Deficiency corrected .	12/13/12	

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F 356	<p>Continued From page 6</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to record accurate information on the Daily Nurse Staff Posting Form. The findings included:</p> <p>On 12/4/12 at 9:00 AM., a review of the Daily Nurse Staff Posting Form for 11/26/12 was completed. The Daily Nurse Staff Posting Form information was compared with the actual staff assignment sheets for day/ evening/ night shifts. The assignment sheets for day shift (7:00AM-3:00PM) revealed that twelve (12) nursing assistants worked during the day shift and five (5) nursing assistants worked during the night (11:00PM-7:00AM) shift. The Daily Nurse Staff Posting Form indicated that fourteen (14) nursing assistants worked during the day shift and six (6) nursing assistants worked during the</p>	F 356	<p><u>Criteria # 1</u> The Director of Nursing, Nursing Supervisors, and the Staffing Coordinator were in-serviced and counseled by the Administrator on the correct procedure for posting the daily staffing and completed by 12/13/12.</p> <p><u>Criteria # 2</u> At the beginning of first shift, the Director of Nursing or nursing supervisor will review the above data for accuracy and make any adjustments as a result of any staff call-outs. The staffing co-ordinator , Director of Nursing or nursing supervisor will review the data for second and third shifts and make any adjustments as a result of any staff call-outs. The nursing supervisor on weekends or Director of Nursing will review the data for all three shifts and make adjustments as needed.</p>	12/13/12	

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F 356	<p>Continued From page 7 night shift.</p> <p>On 12/4/12 at 8:20AM., Administrative staff #4 stated she completed the Daily Nurse Staff Posting Form when she was given the schedules by the nursing supervisors. On Friday, she completed the form for Saturday, Sunday and Monday and placed them in the front lobby. She said the weekend nurse supervisor completed the census information and made any changes regarding staffing information. During the week, the changes for staffing would be done by the Director of Nursing or the nursing supervisors.</p> <p>On 12/4/12 at 8:37 AM., Nurse #3 stated she gave a weeks worth of the nursing assignments to the executive assistant. The executive assistant completed the posting information. If there were corrections to be completed for the Daily Nurse Staff Posting form, she sent that information to the executive assistant and the executive assistant made the appropriate corrections on the form. Nurse #3 said she never made any corrections on the Daily Nurse Staff Posting Form.</p> <p>On 12/4/12 at 10:16 AM., Administrative staff #1 stated the weekend nursing supervisor should make the changes on the Daily Nurse Staff Posting Form on the weekend. During the week, she did not think anyone had been instructed to make the changes. The DON said she was not aware that the changes had to be made on the Daily Nurse Staff Posting Form.</p>	F 356	<p><u>Criteria #3</u> The Director of Nursing, Nursing Supervisor and/or Administrator will monitor this process through observation and record for completion daily for one month, weekly for one month and monthly for three months and as needed.</p> <p><u>Criteria #4</u> The Director of Nursing or Administrator will report results monthly in the QA&A committee for three months and as needed. The committee will make recommendations as needed. The Administrator is responsible for overall compliance.</p>	12/13/12	