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

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 06/05/2013

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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that medication error rate was less than 5% as evidenced by 3 errors (Residents # 4, 5, & 6) of 34 opportunities for error, resulting in an error rate of 8.8%. Findings included: 1. Resident #4 was admitted to the facility on 11/22/11 with multiple diagnoses including Gastro esophageal reflux disease (GERD). Review of the electronic physician's orders for June, 2013 revealed that Resident #4 was on Omeprazole (a proton pump inhibitor) delayed release 20 mgs (milligram) 1 capsule once a day since 5/2/13 for GERD. On 6/4/13, there was a doctor's order to discontinue the Omeprazole. On 6/5/13 at 6:25 AM, Nurse #1 was observed during medication pass. Nurse #1 was observed to prepare and to administer Omeprazole 20 mgs 1 capsule to Resident #4. The electronic Medication Administration Record (EMAR) for June, 2013 was reviewed. The Omeprazole was still an active order and was not discontinued.	F 332	**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.** ***F332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE*** The facility must ensure that it is free of medication error rates of five percent or greater **Deficiency corrected** ***Criteria #1 (How corrective action will be accomplished for the residents affected)*** **Resident # 4** physician was contacted on 6/5/13 informing him resident #4 received Omeprazole 20mgs 1 capsule at 6:25AM and should have been discontinued per his orders on 6/5/13, this medication was resumed per MD for GERD on 6/6/13. **Resident #5** physician was contacted on 6/5/13 informing him TUMS (calcium carbonate) 1 tablet had been given at 11:30 AM to Resident #5 instead of Calcium Carbonate with D as ordered, the medication was stocked in the medication cart and the nurse re-educated on the correct medication to be administered. **Resident #6** physician was contacted on 6/5/13 informing him of omission of Dexilant. The medication order was clarified and was obtained from the pharmacy. The medication arrived and was administered to Resident #6 on 6/6/13. Nurse #1, #2, #3, #4, and #5 were all re-educated on 6/5/13 -6/6/13 on correct medication administration. Residents who were affected by this are receiving their medications as ordered and have had no negative outcome.	6-6-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly L. Snyder — TITLE: Administrator — (X6) DATE: 6/21/13

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 332	Continued From page 1 On 6/5/13 at t 10:50 AM, Nurse supervisor #1 was interviewed. She acknowledged that the order to discontinue the Omeprazole was not transcribed to the EMAR. She (Nurse supervisor) indicated that Nurse #2 had signed off the order and expected her (Nurse #2) to transcribe the order to the EMAR but she did not. She (Nurse supervisor) stated that she was not aware about the new order for Omeprazole. She added that the computer was down on 6/4/13 and that might be the reason why it was not transcribed to the EMAR. Nurse #2 was not available for interview. On 6/5/13, administrative staff #1 was interviewed. She stated that the computer was down for an hour on 6/4/13 and the order should have been transcribed when the computer came back up. 2. Resident # 5 was admitted to the facility on 5/31/13 with multiple diagnoses including thoracic compression fracture. Review of the electronic physician's orders for June, 2013 revealed that Resident #5 was on Calcium Carbonate 500 mgs with D 1 tablet three times a day with meals. On 6/5/13 at 8:35 AM, Nurse #3 was observed during medication pass. Nurse #3 was observed to prepare and to administer TUMS (calcium carbonate) 1 tablet to Resident #5. At 11:30 AM, Nurse #3 was interviewed. She acknowledged that she administered Calcium carbonate instead of Calcium Carbonate with D as ordered. 3. Resident #6 was admitted to the facility	F 332	***Criteria# 2 (How corrective action will be accomplished for those residents having the potential to be affected)*** Current residents receiving medication have the potential to be affected. An audit of all current residents receiving medications was initiated on 6/5/13. The Electronic Medication Records (EMARS) were reviewed by the Director of Nursing(DON), Nursing Supervisors and MDS coordinators for order accuracy and completeness. Seven (7) residents out of ninety-five (95) resident orders were clarified for accuracy and corrected. All current EMARS of residents have been audited and in compliance as of 6/14/13. ***Criteria #3 (What measures will be put in place or systemic changes to ensure corrections)*** All licensed nurses attended a live in-service between 6/5/13 – 6/26/13 by Tracey Yap, PHD, Registered Nurse from Duke University School of Nursing, regarding medication administration, including the "5R"'s of medication administration and physician notification when a medication is not available. Pharmacy representative was present on 6/10/13 and conducted a "med pass" observation with Nurse #3 and other random nurses on 6/10/13 to ensure compliance with medication administration. Those nurses that have not attended the educational sessions will not be scheduled to work until they have completed the education.	6/26/13

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F 332	Continued From page 2 3/11/2013. Cumulative diagnoses included: H. Pylori (a bacteria that can make the stomach susceptible to infection) and GERD (gastro esophageal reflux disease). A review of Resident #6's physician's orders revealed an order dated 5/15/13 for Dexilant capsule delayed release (a medication used in treatment of GERD) Give one (1) capsule by mouth one time a day for GERD at 06:00 AM. The medication Administration Record (MAR) revealed the Dexilant was scheduled to be given at 6:00 AM. On 6/5/13 at 6:35 AM., Nurse #4 was observed administering scheduled medications to Resident #6. Oral medications were given but did not include the Dexilant. During an interview on 6/5/13 at 6:35 AM., Nurse #4 stated she would have to reorder the medication from the pharmacy. On 6/5/13 at 1:55 PM., Nurse #5 stated she did not see on the computer where the Dexilant had been reordered from the pharmacy. A check of the medication cart revealed Resident #6 did not have Dexilant in her medications. On 6/5/13 at 4:20 PM., Administrative staff #1 stated she had called the pharmacy and the pharmacy had never sent Dexilant for Resident #6 because there was not a strength noted on the 5/15/13 physician's order. Administrative staff #1 stated she expected the nursing staff to obtain the medication when ordered by the physician and the medication should have been administered as ordered.	F 332	Ten (10) Random Medication Administration Observations with several nurses over different shifts and units and multiple routes of administration observations will be conducted by the Nurse Supervisors and DON weekly for four (4) weeks, then ten (10) every month for three (3) months to include weekends. Variances will be corrected at the time of observation. Pharmacy representative will observe quarterly med-pass observations with variances corrected at the time of observation and results of "med pass" observations will be reviewed with Director of Nursing and Administrator. ***Criteria # 4 (How the facility plans to monitor its performance to make sure that solutions are ensured)*** The Director of Nursing or Nursing Supervisors will report results of the audits and any concerns to the Quality Assurance committee monthly. Continued compliance will be monitored through routine random medication administration observations and through the facility's Quality Assurance program. The committee will make recommendations as needed. Additional education and monitoring will be initiated for any identified concerns. The Administrator is responsible for overall compliance.	6-17-13

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician and pharmacy interview, the facility failed to acquire, receive, dispense and administer Dexilant (a medication used for gastroesophageal reflux disease) for one (Resident #6) of three (3) sampled residents. The findings included: Resident #6 was admitted to the facility 3/11/2013. Cumulative diagnoses included: H. Pylori (a bacteria that can make the stomach susceptible to infection) and GERD (gastroesophageal reflux disease).	F 425	*F425 PHARMACEUTICAL SVC-ACCURATE PROCEUDRES RPH.* The facility must provide pharmaceuticals services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. **Deficiency corrected** *Criteria # 1 (How corrective Action will be accomplished for the resident affected)* Resident #6 order for Dexilant was clarified by the MD and obtained from the Pharmacy. Dexilant was administered on 6/6/13 at 6:30 AM and resident is receiving 1 capsule by mouth daily as ordered. *Criteria #2 (How corrective action will be accomplished for those residents having the potential to be affected)* An audit of all residents receiving Dexilant has been conducted by the DON on 6/6/13 to ensure that Dexilant is available. Two (2) residents were identified as receiving Dexilant by mouth daily, both medications were available and administered as ordered. No corrective actions were needed.	6-6-13

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F 425	Continued From page 4 A review of Resident #6's physician's orders revealed an order dated 3/11/13 for Protonix tablet delayed release 40 milligrams (mg.)--give one tablet by mouth two times a day for GERD. Protonix was discontinued on 5/14/13. A physician's order dated 5/15/13 prescribed Dexilant capsule delayed release-- Give one (1) capsule by mouth one time a day for GERD at 06:00 AM. The Medication Administration Record (MAR) revealed the Dexilant was scheduled to be given at 6:00 AM. A review of the May MAR revealed Dexilant was documented as not given on the following days: 5/18/13, 5/19/13, 5/24/13, 5/25/13 and 5/26/13. Nursing staff documented "waiting on pharmacy to deliver" on those days. Dexilant was also noted as not given on 5/27/13 and 5/28/13 with no notation as to the reason the medication was not administered. On 6/5/13 at 6:35 AM., Nurse #4 was observed administering medications. Dexilant was not administered. Nurse #4 documented that the "pharmacy to supply". On 6/5/13 at 4:10 PM., Pharmacy staff stated the pharmacy had called the facility on 5/14/13 at 5:56 PM. and spoke to Nurse #8 regarding the electronic order for Dexilant. Pharmacy staff stated there was no strength ordered for the Dexilant and they informed the facility a strength was required before it would be delivered. Pharmacy staff stated it was their responsibility to notify the facility when clarification of a physician's order is needed and they expected the facility to respond to their request. Pharmacy staff stated	F 425	*Criteria #3 (What measures will be put in place or systemic changes made to ensure correction)* A live in-service education program for all nurses was provided by the Director of Nursing and Pharmacy Consultant on 6/5/13 – 6/17/13, regarding the acquiring, receiving, dispensing and administering of medications. No nurse will work until they have completed this education program. The DON and nursing supervisors will validate the receiving of medications ordered from pharmacy each day by auditing the pharmacy orders submitted by nurses against the medication delivery requisitions. Any medication ordered and not received, will be called in to pharmacy by the supervisor daily. New orders will be reviewed daily by the Supervisors and DON as well as review of the EMARS to insure new medications are administered as prescribed by the physician. *Criteria # 4 (How the facility plans to monitor its performance to make sure that solutions are ensured)* The Director of Nursing or Nursing Supervisors will report results of the audit monthly for three months and then quarterly in the Quality Assurance meeting. The committee will make recommendations as needed. Additional education and monitoring will be initiated for any identified concerns. The Administrator is responsible for overall compliance.	6-17-13 6-17-13

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F 425	Continued From page 5 there was no reply from the facility until today (6/5/13); therefore Dexilant had never been delivered to the facility. Nurse #8 was unable to be interviewed due to being on family medical leave. On 6/5/13, a physician's order was written for Dexilant capsule delayed release 60 milligrams daily at 6:30AM. On 6/5/13 at 4:20 PM., Nurse #6 stated she administered Protonix (a medication for treatment of GERD) on the days that she had documented as having administered Dexilant (5/15/13, 5/16/13, 5/22/13, 5/23/13, 6/3/13 and 6/4/13). Nurse #6 said she had called the pharmacy and was told to administer the Protonix until the medication was finished due to insurance not going to pay for Dexilant. She did not remember when she called the pharmacy. On 6/5/13 at 4:20 PM., Administrative staff #1 stated she expected the Dexilant to have been obtained from the pharmacy when it was ordered on 5/15/13 and administered as ordered by the physician. She was not aware that Resident #6 had not received Dexilant since 5/15/13. Also, prior to 6/5/13, Administrative staff #1 was not aware that the pharmacy had called and requested a clarification for the strength of the Dexilant. On 6/5/13 at 5:00 PM., Nurse #7 stated she had called the 800 number provided for pharmacy services on 5/19/13, 5/25/13, 5/26/13 and 5/27/13 and, as far as she could remember, was told it was going to be delivered. She did not recall	F 425		

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F 425	Continued From page 6 when they said it would be delivered. On 6/5/13 at 5:10 PM., Administrative staff #3 stated the physician's order was sent to the pharmacy and needed clarification. The pharmacy did their part and called the facility and spoke to a nurse and she was going to clarify the strength of the medication. That was not done. On 6/5/13 at 5:30 PM., Resident #6's physician stated Dexilant was especially designed for prolonged release and was equivalent to the Protonix 40 milligrams twice daily that had been ordered on admission 3/11/13. He said the medication was changed to Dexilant on 5/15/13 due to a pharmacy consult regarding no insurance coverage of Protonix. When informed of the dates noted as "pharmacy to deliver/ supply", he stated expected Resident #6 to receive Dexilant daily as ordered.	F 425		