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 07/31/2013

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 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on review of records from the facility, hospital and emergency medical services and interviews with staff, physician and emergency medical technician, the facility failed to ensure residents were free of an excessive dosage of Fentanyl (a narcotic analgesic) for one of three residents (Resident #3) receiving Fentanyl transdermal patches.	F 329	**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.** ***483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS*** F329 **Deficiency corrected** ***Criteria #1 (How corrective action will be accomplished for the residents affected)*** Resident # 3 no longer resides in the facility. ***Criteria# 2 (How corrective action will be accomplished for those residents having the potential to be affected)*** Current residents receiving Fentanyl patches medication have the potential to be affected. On 7/31/13 a body audit was completed by the nursing supervisors for the 6 residents in-house with Fentanyl medication patches. All residents were assessed and in compliance with having only one (1) fentanyl patch on their body. The six (6) resident out of ninety (90) residents Electronic Medication Administration Records (EMAR) were audited by the Director of Nurses (DON), Minimum Data Set (MDS),nurses and Nursing supervisors to ensure residents with fentanyl patch orders were assessed and documented each shift for site placement and removal and disposal of fentyl patch was witnessed by second nurse. Four (4) out of six (6) residents with fentanyl patch orders were identified as not having the site assessed every shift. Six (6) out of six (6) residents were identified as not having a fentanyl patch disposal log.	8/19/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Kimberly L. Snyder — Administrator — 8/20/13

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 329	Continued From page 1 The findings included: Resident #3 was admitted to the facility on 5/31/13. Diagnoses included multiple compression fractures of the thoracic spine, chronic back pain, diabetes mellitus, chronic airway obstruction, atrial fibrillation, congestive heart failure, anxiety state, morbid obesity, insomnia and hypertension. Physician orders on admission included Demerol (a narcotic analgesic) 50 milligrams (mg) orally every 4 hours as needed for pain. For diabetes management, orders included Humulin N (an intermediate-acting insulin) 24 units with breakfast and 12 units with supper, and Humalog (a rapid acting insulin) 12 units daily with breakfast and sliding scale before meals and at bedtime. (Blood samples, obtained by fingerstick, must be checked for glucose levels so that the appropriate dose of insulin can be administered in accordance with the sliding scale.) On 6/3/13 the Demerol was changed to 50 mg every 3 hours as needed for severe pain. The History and Physical (H&P) dated 6/4/13 indicated the resident had chronic pain and was under consideration for surgery for the compression fractures. The H&P also indicated the resident complained of left shoulder pain which the physician suspected was from a history of shingles. Physician orders on 6/4/13 included Lidoderm patch (a local anesthetic used to treat pain after a shingles infection) under left shoulder for 12 hours daily. On 6/6/13 physician orders included to discontinue the sliding scale insulin and	F 329	1. A Fentanyl disposal log form was devised and attached to each resident's Fentanyl narcotic sign-out sheet for 2nd nurse verification of witnessed removal and disposal at the time of the patch change. 2. Validation of patch placement every shift by licensed nurse was added to the EMARS ***Criteria #3 (What measures will be put in place or systemic changes to ensure corrections)*** Licensed nurses attended an in-service between 7/31/13 – 8/5/13 by the Director of Nursing regarding fentanyl patch application, monitoring, and disposal. Twenty-three (23) out of Twenty - eight (28) licensed nurses attended the inservice. Those nurses that have not attended the educational sessions will not be scheduled to work until they have completed the education requirements. All residents with Fentanyl patch orders will be audited weekly by the nursing supervisors, MDS coordinators, and DON to 1. Ensure only one patch is on the resident's body to ensure compliance with administration . 2 Observation audits will be conducted to ensure that removal and disposal of fentanyl patches are witnessed by a 2nd nurse at the time of the patch change. 3. Site was verified every shift for placement. All audits will be conducted weekly for four (4) weeks, then monthly for three (3) months to include weekends and as needed. Identified concerns will be corrected as needed. Any variances found, nurses will be re-educated by the nursing supervisor or Director of Nursing to meet acceptable standards of performance or corrective disciplinary process will be initiated by the DON.	8/19/13

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F 329	Continued From page 2 fingersticks. The physician was interviewed on 7/31/13 at 3:20 PM. He indicated that the resident demanded that the fingersticks get stopped, so he discontinued the sliding scale insulin and did not order periodic fingersticks. The physician stated he expected staff to check a blood glucose only if the resident was showing signs of hypoglycemia or hyperglycemia. The admission Minimum Data Set (MDS) dated 6/7/13 indicated Resident #3 was cognitively intact and had frequent pain. The Care Plan for pain, dated 6/10/13, revealed a problem of back pain, requiring pain meds daily. Interventions included administering medications as ordered and notifying the physician if ineffective. Physician progress notes dated 6/6/13 and 6/11/13 revealed continued pain. On 6/11/13 the Demerol was changed to 50 mg every 3 hours for back pain, hold if drowsy. On 6/27/13 Resident #3 presented to the pain clinic. The visit note indicated that surgery was the only option that would provide relief. Physician orders dated 7/2/13 included Fentanyl Patch 50 micrograms (mcg) per hour every 72 hours. The Medication Administration Record (MAR) indicated the first patch was applied to the resident's lower back on 7/2/13 at 1641 (4:41 PM) by Nurse #1. The MAR included a stop date of 7/3/13 at 0020 (12:20 AM). The MAR listed a Fentanyl Patch every 72 hours with a start date of 7/3/13 at 0400 (4:00 AM) and indicated it was applied to the left rear shoulder on 7/3/13 at 0648 (6:48 AM) by Nurse #2. There was no documentation that the previous patch	F 329	***Criteria # 4 (How the facility plans to monitor its performance to make sure that solutions are ensured)*** The Director of Nursing will report results of the audits to the Quality Assurance committee monthly. Continued compliance will be monitored 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.	8/19/13

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F 329	Continued From page 3 was removed. During an interview on 7/31/13 at 12:43 PM, Nurse #2 stated she had only taken care of Resident #3 one time and did not recall details. She said she would have administered the Fentanyl patch on 7/3/13 because it had come up on the electronic MAR as being due at that time. The nurse said her practice was to pull off the old patch if one was there. She did not recall if she actually removed a Fentanyl patch from Resident #3. Nurse #2 also indicated she could not recall if removal of the old patch was something she would document. Nurse's notes, written by Nurse #3, dated 7/4/13 at 2:21 PM read, "Resident at 11 AM requested a bacon sandwich which was not available and refused alternative that was offered. At 11:30 AM resident requested her scheduled pain med which was given. At 11:45 AM resident requested for iced [sic], Resident was observed by staff at 12:30 PM unresponsive, writer and other staff [responded] immediately, on assessment resident BS (blood sugar) 27, Glucagon (an injectable medication used to raise low blood sugar) 1 mg injection given, medic called and resident sent to the ED (Emergency Department)." Emergency Medical Services (EMS) record dated 7/4/13 indicated arrival time at the resident's bedside was 1:38 PM. The notes read in part, "Patient was found unresponsive lying in bed. Breathing normally. EMS was advised that staff had been administering insulin without first checking blood glucose. Patient had also been receiving narcotic pain medication every 3 hours and had 2 Fentanyl patches on her chest and back. Patient's blood glucose was checked at 27.	F 329		8/9/13

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F 329	Continued From page 4 An IV (intravenous access) was established and 25 grams of D50 (a 50% solution of dextrose and water to raise blood sugar) was administered. Blood glucose was rechecked at 327 however, patient was still unresponsive. Patients pupils were checked and were pinpoint. 1 mg of Narcan (a drug to counteract narcotics) was administered with improvement. Patient was still not completely alert and was very lethargic. Responsive to verbal and painful stimuli." Emergency Department records indicated Resident #3 was alert on arrival and pupils were equal and reactive to light. The resident scored 11 - 12 on the Glasgow Coma Scale (the range is 3 - 15, with 3 indicating deep coma and 15 is fully awake). The hospital discharge summary dated 7/11/13 revealed the resident was admitted due to altered mental status and significant back pain. While hospitalized, the resident had an aspiration event, subsequent respiratory failure and expired on 7/11/13. During an interview on 7/31/13 at 12:47 PM, Nurse #3 recalled sending Resident #3 to the ED. The nurse said the resident was demanding pain medication that morning, and settled for her scheduled dose of Demerol at 11:00 AM. The nurse recalled that the resident had requested a sandwich, but when the Nursing Assistant (NA) brought it in the resident refused it because it was not the kind of sandwich she ordered. Nurse #3 did not recall what was meant by "iced" in the note she wrote. The nurse said a little while after giving the Demerol, someone reported to her that the resident was unresponsive. She checked the BS and it was in the 20's. She gave Glucagon and called Emergency Medical Services (EMS). The nurse stated when the Emergency Medical	F 329		8/19/13

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F 329	Continued From page 5 Technicians (EMTs) arrived they administered glucose and her blood sugar came up to the 300's but the resident was not responding. The nurse recalled the EMT saying the resident's pupils were pinpoint and an antidote was given. Nurse #3 indicated that the resident did respond. The nurse remembered seeing a Fentanyl patch on the resident's left shoulder and also saw a Lidoderm patch on her. The NA assigned to Resident #3 on the 7-3 shift on 7/3/13 and 7/4/13 was unavailable for interview during the survey. During an interview on 7/31/13 at 3:53 PM, the EMT primary caregiver for Resident #3 recalled that the resident did not respond much after the glucose was administered but she did respond more after Narcan was administered. The EMT indicated he did not notice that the resident had a 2nd Fentanyl patch on her until she was in the ambulance. The EMT said he removed both Fentanyl patches plus a third patch that had no identification (Lidoderm patch is a plain white patch). During an interview on 7/31/13 at 2:45 PM, the Director of Nursing (DON) explained that the original entry on the MAR for the Fentanyl was discontinued because the resident had requested a change in the administration time. She said the nursing supervisor intended to update the order with the new administration time but the computer system discontinued the old order and entered a new order on the MAR. The computer automatically prompted the first dose to be given on the same day that the change was made. The DON said she had just become aware of this problem and will work with the corporate office for	F 329		8/19/13

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F 329	Continued From page 6 resolution.	F 329	***483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERROR*** **F333** The facility must ensure that it is free of significant medication error. **Deficiency corrected** ***Criteria #1 (How corrective action will be accomplished for the residents affected)*** Resident # 3 no longer resides at this facility. ***Criteria# 2 (How corrective action will be accomplished for those residents having the potential to be affected)*** All residents receiving Insulin medication have the potential to be affected. An audit of all current residents receiving Insulin medication and all residents with a "Therapeutic Interchange Request/Physician Order was conducted and completed on 8/1/13. All orders for Insulin and "Therapeutic Interchange Orders" were reviewed by the DON, Nursing Supervisors and MDS nurses for order accuracy to ensure orders were transcribed correctly into the EMAR Eight (8) of twenty nine (29) residents with Insulin orders were clarified for sliding scale usage or blood sugar monitoring. One (1) of nine (9) "Therapeutic Interchange Orders/Requests" was clarified for medication discontinuance. ***Criteria #3 (What measures will be put in place or systemic changes to ensure corrections)*** Licensed nurses attended an inservice between 7/31/2013 and 8/5/2013. Twenty-three (23) out of Twenty-Eight (28) licensed nurses completed the educational inservice sessions. The five (5) licensed nurses not able to attend will not be allowed to work until they have completed the educational session conducted by the Director of Nursing. The educational sessions included system change requiring 1) Second nurse to verify all new orders including therapeutic interchange requests approved by the Medical Director. 2) All new orders will be transcribed onto the physician paper order form. 3). The order will be entered into the EMAR .	8/19/13
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, physician interview and record review, the facility failed to administer insulin as ordered for 1 of 3 (Resident #3) sampled residents. The findings included: Resident #3 was admitted to the facility on 5/31/13. Diagnoses included diabetes mellitus. Physician orders dated 5/31/13 included Humulin Insulin 24 units daily with breakfast and 12 units daily with supper. A "Therapeutic Interchange Request/Physician Order" dated 6/20/13 to discontinue the Humulin Insulin and replace with Novolin Insulin 24 units daily before breakfast and 12 units daily with supper was approved by the physician on 6/25/13. The June Medication Administration Record (MAR) indicated Humulin 24 units with breakfast and Humulin 12 units with supper were discontinued on 6/25/13. Novolin 24 units daily before breakfast was started on 6/26/13. There was no entry on the June or July MARs for Novolin 12 units daily with supper. During an interview on 7/31/13 at 2:45 PM, the	F 333		

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F 333	Continued From page 7 Director of Nursing (DON) acknowledged the 5:00 PM dosage of Novolin was missing from the MAR. The DON added that the computer system for the MARs seemed to discontinue orders that were intended to be updated. She said she had just become aware of this problem and will work with the corporate office for resolution. During an interview on 7/31/13 at 3:20 PM, the physician indicated that Resident #3 should have received the Novolin Insulin with breakfast and supper as ordered.	F 333	4) The second nurse will verify the order entered into EMAR against the physician order form. 5) Both nurses will initial off on the physician order form the order was transcribed correctly into the EMAR. 6) The night nurse will complete a 24 hour chart check on all new orders for that day to ensure the order was transcribed into the EMAR as ordered. Any variances will be clarified and/or corrected at that time. New orders will be reviewed by the DON and Nursing Supervisors daily during clinical meeting for order and transcription accuracy, any variances will be corrected at that time. Any variances found, nurses will be either re-educated by the nursing supervisor or Director of Nursing to meet acceptable standards of performance or corrective disciplinary process will be initiated by the Director of Nursing. Five (5) random charts with "Therapeutic Interchanges Request/Physician Order" and new physician orders will be reviewed weekly for order accuracy, transcription, 2nd nurse verification and 24hr chart check completion by the DON weekly for four (4) weeks, then monthly for 3 months. Omissions or corrections will be corrected at the time of the audit. Any variances found, nurses will be either re-educated to meet acceptable standards of performance or corrective disciplinary process will be initiated by the Director of Nurses. Weekend supervisors will continue to review new orders on the weekend for accuracy. Any variances will be corrected at that time and nurses will be either re-educated by the nurse supervisor to meet acceptable standards of performance or corrective disciplinary process will be initiated by the Director of Nurses. *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 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.	8/19/13