STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING ______ B. WING ______	C 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT REIDSVILLE	543 MAPLE AVENUE REIDSVILLE, NC 27320

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a care plan to address the use of CPAP (Continuous Positive Airway Pressure) for 2 of 3 sampled residents (Resident #1 and Resident #2) reviewed for respiratory care. The findings included: 1) Resident #1 was admitted to the facility on 7/2/15 from an acute care hospital. His cumulative diagnoses included sleep apnea and a history of acute respiratory failure.	F 279	Preparation and /or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared by the provisions of Health and Safety code section 1280 ad 42C.F.R 405.1907 Deficiency Corrected 1.) How corrective action will be accomplished for those found to have	8/4/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/04/2015

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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A review of Resident #1's medical record revealed his 7/2/15 admission orders included the following: Resident to have CPAP (Continuous Positive Airway Pressure) every night at bedtime with auto setting of 5-20 at bedtime; Remove CPAP every morning. CPAP is a treatment that uses mild air pressure to keep the airways open.

Resident #1's admission MDS (Minimum Data Set) assessment was dated 7/9/15. Section O of the MDS assessment revealed he received oxygen therapy and BiPAP (Bilevel Positive Airway Pressure) / CPAP while he was a resident in the facility.

A review of Resident #1's care plan (initiated on 7/3/15) revealed the use of CPAP was not addressed in his care plan.

An interview was conducted with Nurse #1 on 7/22/15 at 4:14 PM. Nurse #1 reported she assumed responsibility for completion of the MDS assessments and development of interdisciplinary care plans for each of the facility ' s residents. Upon review of Resident #1's care plan, the nurse acknowledged the CPAP was not part of the resident's care plan. When asked if she would have expected to address the use of CPAP in the care plan, the nurse stated, "yes."

An interview was conducted with the facility's Director of Nursing (DON) on 7/23/15 at 9:02 AM. Upon inquiry, the DON stated she would have expected the use of CPAP to be included on the resident's care plan. She reported Nurse #1 added the CPAP onto his care plan after its omission was brought to their attention.

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been effected.
Resident #1 and #2 care plans were reviewed and updated to reflect the use of a CPAP machine on 7/22/15.

2.) How corrective action will be accomplished for those having potential to be affected by the same practice.
For current residents that have orders for CPAP machines have the potential to be affected. Current residents that utilize a CPAP machine their care plans were reviewed and if needed were updated to reflect the use of the machine.

3.) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur.
MDS staff were re-educated by the Director of Nursing on care plans to ensure that when a resident has orders for a CPAP machine that it is included in the care plan. The Director of Nursing will audit the care plans weekly for 4 weeks and then monthly for 3 months of residents that have orders for CPAP to ensure the use of the machine is indicated on the care plan.

4.) How the facility plans to monitor its performance to make sure that solutions are sustained.
The Director of Nursing will present the results of the audits to the QA&A committee monthly for four months. The QA&A committee will determine if

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F 279	Continued From page 2	F 279	continued monitoring is necessary.	

2) Resident #2 was re-admitted to the facility on 6/11/15 from an acute care hospital. His cumulative diagnoses included obstructive sleep apnea and chronic respiratory failure.

A review of Resident #2 ' s medical record revealed his 6/11/15 admission orders included the following: CPAP (Continuous Positive Airway Pressure) every evening at bedtime. CPAP is a treatment that uses mild air pressure to keep the airways open.

Resident #2's annual MDS (Minimum Data Set) assessment was dated 6/18/15. Section O of the MDS assessment revealed he received oxygen therapy and BiPAP (Bilevel Positive Airway Pressure) / CPAP while he was a resident in the facility.

A review of Resident #2's care plan (reviewed on 6/30/15) revealed the use of CPAP was not addressed in his care plan.

An interview was conducted with Nurse #1 on 7/22/15 at 4:14 PM. Nurse #1 reported she assumed responsibility for completion of the MDS assessments and development of interdisciplinary care plans for each of the facility's residents. Upon review of Resident #1's care plan, the nurse acknowledged the CPAP was not part of the resident's care plan. When asked if she would have expected to address the use of CPAP in the care plan, the nurse stated, "yes."

An interview was conducted with the facility's Director of Nursing (DON) on 7/23/15 at 9:02 AM. Upon inquiry, the DON stated she would have expected the use of CPAP to be included on the resident's care plan. She reported Nurse #1

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F 279	Continued From page 3 added the CPAP onto his care plan after its omission was brought to their attention.	F 279		