

1/31/14

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

PRINTED: 01/16/2014
FORM APPROVED
OMB NO. 0938-0391

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| 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 01/02/2014 |
| NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 000 | INITIAL COMMENTS The Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted a complaint investigation survey from December 30-31, 2013 and conducted a partial extended survey January 2, 2014. The survey team identified Immediate Jeopardy at 483.25 for Resident #4 on December 31, 2013. The Immediate Jeopardy began on December 9, 2013. The Immediate Jeopardy was removed on January 2, 2014 and the facility was left out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy). | F 000 | This plan of correction is the facility's credible allegation of compliance. It is the practice of this facility to provide nursing services relevant to maintaining a safe environment for all residents. It is the practice of this facility to assess all residents to determine what safety interventions are necessary to minimize the risk for elopement. Those residents who have been identified as an elopement risk by the facility interdisciplinary team inclusive of the physician, nursing staff, and social worker will have appropriate interventions care planned and implemented with the goal of maintaining safety and minimizing the risk for elopement. | |
| F 323 SS=J | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to prevent one (1) of seven (7) cognitively impaired residents (Resident #4) who exhibited wandering behaviors from eloping from the facility. On December 9, 2013, December 22, 2013 and December 25, 2013, Resident #4 exited the building unsupervised by staff. | F 323 | Corrective action has been achieved for Resident #4 due to being in hospital. Resident #4 was discharged to hospital on December 30 th 2013. Resident #4 was readmitted to the facility on January 21, 2014. Facility nurse has assessed resident #4 for elopement risk and is following facility policy and procedure. Resident number #4 has been placed on 15 minute checks for observation to monitor elopement risk until facility secures placement in a locked facility. Facility will seek placement appropriate for resident #4 needs and will implement resident specific interventions with the goal of maintaining safety and minimizing the risk for elopement <small>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</small> | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Handwritten Signature]

Administrator

1/28/14

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.

N.C.

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| F 323 | <p>Continued From page 1</p> <p>Immediate Jeopardy began on 12/09/13 and was identified on 12/31/13 at 5:33PM. Immediate Jeopardy was removed on 1/2/14 at 6:30 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and 100% of employee training. Findings included:</p> <p>The manufacturer's instruction on wanderguards was reviewed. The instruction indicated under warning "Do not place the signaling device on or next to metal such as wheelchair frames, jewelry, watches, etc (etcetera) or allow it to come in contact with a door or associated hardware, such as crash bar, push bar, etc. Metal could interfere with the signal sent to the door module."</p> <p>Resident #4 was originally admitted to the facility 7/1/09 with last readmission dated 10/5/13. Cumulative diagnoses included: encephalopathy (brain damage), cirrhosis of the liver (scarring of the liver and poor liver function) and hepatic (liver) encephalopathy with a mildly elevated ammonia level (worsening of brain function when the liver is no longer able to remove toxic substances in the blood. Ammonia is a toxic substance normally made harmless by the liver. In liver disease, ammonia builds up in the body and elevated ammonia levels can cause, in part, poor judgment, disorientation, confusion and changes in thinking).</p> <p>An elopement risk assessment dated 10/3/13 indicated Resident #4 propelled herself and had some assistance with propelling. Resident #4 was content with placement; no attempt at</p> | F 323 | <p>All facility residents were assessed for Wandering and Elopement behaviors on December 31, 2013 by members of Nursing Administration inclusive of the Director of Nursing, Assistant Director of Nursing, and Licensed Practical and Registered Nurses. The assessment tool is inclusive of evaluation of behavior, cognition, physical functioning, history of wandering, and diagnoses.</p> <p>A resident identified as an Elopement/Wandering risk has had a care plan created or reviewed to determine appropriate interventions necessary to meet the intended goal of providing safety through minimizing the risk of elopement.</p> <p>Inservice Education provided to all facility personnel on the current policy for Wandering and Elopement beginning on December 31, 2013 and completed on January 1, 2014. Inservice education completed by the facility educator and was inclusive of:</p> <p>Inclusive list of all residents identified as being at risk for Wandering and Elopement will continue to be maintained at each nurses station. The Administrator and members of Administrative Nursing including the Director of Nursing, Assistant Director of Nursing, Resident Care Management Director, and other members of the Inter Disciplinary Team will continue to utilize the formalized morning Operations and Clinical morning meeting, as a part of the facility Quality Assurance Committee, to discuss any reported elopement risk behaviors that warrant follow up; Members of the Inter Disciplinary Team will</p> <p><small>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</small></p> | | |

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| F 323 | <p>Continued From page 2</p> <p>elopement. No behaviors noted. Safety measures being implemented--wander bracelet/ roam alert. Score 6.0 (score of 10 or greater puts resident at risk).</p> <p>A Quarterly Minimum Data Set (MDS) dated 11/2/13 indicated Resident #4 had short term and long term memory impairment and modified independence with cognitive skills. She required limited assistance with transfers. No ambulation occurred during the assessment period. Resident #4 was independent with locomotion on and off the unit. There was no limitation in range of motion for the upper/ lower extremities. Mobility device used was checked as wheelchair.</p> <p>A care plan last reviewed in November 2013 revealed Resident #4 was at risk for elopement from facility related to confusion as evidenced by episode of elopement from facility. Interventions included: approach in a quiet, calm manner using a soft voice. Ensure a wanderguard (security alarm bracelet) was in place at all times and working properly. Notify physician, responsible party, Administrator and DON (Director of Nursing) of any elopement attempts; observe whereabouts at all times in the facility. Provide assistance with ambulation.</p> <p>A nursing note dated 11/10/13 at 3:10 PM stated Resident #4 attempted to leave through the front door. Supervisor aware of need for wanderguard bracelet.</p> <p>A nursing note dated 11/10/13 at 6:12 PM stated wanderguard applied to left wrist at 4:30 PM. No further attempts to go out of a door thus far this PM.</p> | F 323 | <p>review the cumulative list weekly as part of Quality Assurance Committee activities to determine if those identified residents are still exhibiting behaviors indicative of a risk for wandering and elopement. Residents that continue to exit seek will be reviewed for discharge planning as part of the weekly QOL meeting. All staff who see any resident having exit seeking behaviors will immediately report the behaviors to residents nurse, and redirect the resident consistent with Facility policy and procedure. Nurse will evaluate resident for elopement risk and follow facility policy and procedure for elopement risk.</p> <p>Residents deemed at risk will have wanderguard bracelet placed for safety and monitoring.</p> <p>Facility will keep extra bracelet on med carts at all times. In the absence of bracelet facility will provide one on one monitoring until available. Extra bracelets were ordered on 12/30/13. Bracelets were received on 1/7/2014.</p> <p>Facility Maintenance Supervisor will test doors daily Monday through Friday to ensure they are working properly for four weeks then weekly thereafter. Maintenance Director will log functionality of doors to ensure they are working properly. Weekend maintenance assist/floor tech will check doors on weekends effective 1/2/2014 and log the functionality of the doors to ensure they are functioning properly.</p> <p>All residents with wanderguard will be checked for function and placement Qshift by nurse and</p> <p><small>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</small></p> | | |

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| F 323 | <p>Continued From page 3</p> <p>A nursing note dated 11/13/13 at 10:56 AM stated Resident #4 at around 7:30 PM was seen between the two front doors at the front of the building. She had gotten out of the first door. Her wanderguard bracelet was intact and on her left wrist. She was brought back inside by the supervisor on 3-11 shift.</p> <p>A care plan dated 11/14/13 was reviewed. One of the care problems indicated Resident #4 was an elopement risk/ wanderer AEB (as evidenced by) history of attempts to leave facility unattended. Interventions included: Distract Resident #4 from wandering by offering pleasant diversions, structured activities, food, conversation, television and book. Wander device to remain on resident.</p> <p>A care plan dated November 2013 was reviewed. One of the care plan problems indicated Resident #4 at times had delirium or an acute confusional episode related to an association with increased ammonia levels. Interventions included: monitor and report to physician new onset signs/ symptoms of delirium-changes in behavior, altered mental status, wide variation in cognitive function throughout the day, disorientation, communication decline, lethargy, restlessness and agitation.</p> <p>A nursing note dated 12/1/13 at 5:49AM stated Resident #4 was alert and responsive with periods of confusion noted.</p> <p>A nursing note dated 12/2/13 at 2:49AM stated Resident #4 was alert and verbal with confusion.</p> <p>A nursing note dated 12/9/13 stated Resident #4, at around 9:30 PM was noted by another resident (Resident #1) leaving the facility. Resident #4</p> | F 323 | <p>recorded in MAR. Any removal of bracelet discovered by staff will be reported to nurse immediately for further intervention and replacement. All reported elopements or elopement attempts will continue to be reviewed by the IDT team Monday through Friday during the Operations and Clinical morning meeting. Facility will continue to lock front door nightly upon receptionist leaving for the day. Receptionist will report to A hall nurse that she is leaving and door needs to be locked for the night by A Hall nurse effective 1/2/2014.</p> <p>Newly admitted residents will be assessed by a member of the Nursing Department using the facility assessment tool to determine if he or she is at risk for wandering and elopement. If the resident is identified as being at risk a care plan will be developed by members of the Interdisciplinary Team with appropriate interventions implemented with the goal of minimizing the risk of wandering and elopement. This is not new policy, but rather reinforcement of existing policy.</p> <p>Facility resident will be assessed every 90 days or sooner, during the completion of the quarterly Minimum Data Set or upon identification of a Significant Change in Status. The facility tool for assessment of Wandering and Elopement Risk will be completed by the Resident Care Management Director. If the assessment tool indicates the resident is at risk for wandering and elopement then a resident specific care plan will be developed and implemented with interventions for minimizing</p> <p><small>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</small></p> | | |

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| F 323 | <p>Continued From page 4</p> <p>was found outside on the side of the building. Resident #4 did not have on a wanderguard bracelet.</p> <p>An incident report dated 12/9/13 at 9:30 PM was reviewed and revealed the location of occurrence was outdoors. Resident #4 was observed leaving the building by another resident (Resident #1). Nursing assistants went to get her and she was outside in the parking lot. She was in her wheelchair. Follow-up investigation noted that Resident #4 removed her wanderguard bracelet before she tried to elope. The wanderguard bracelet was replaced on Resident #4. Hourly rounds on Resident #4 were put into place. The report did not document how many days they planned to do the hourly rounds.</p> <p>A witness statement regarding the elopement on 12/9/13 by NA #1 stated she was at the A hall nursing station around 9:30PM when Resident #1 came up to her and stated that Resident #4 was seen outside of the building. NA#1 stated she and NA #2 ran out the front door and to the parking lot of the right side of the building and found Resident #4 almost to the sidewalk. They returned Resident #4 inside the building and immediately reported the incident to the supervisor.</p> <p>A witness statement regarding the elopement on 12/9/13 by NA #2 stated she was at A hall nursing station doing flow books around 9:30PM. Resident #1 came up in his wheelchair saying resident #4 had gone out the front door in the front lobby. She and NA #1 went down to the lobby and outside. Resident #4 was in her wheelchair on the left side of the building near the curb of the parking lot.</p> | F 323 | <p>the risk of wandering and elopement. This is not new policy, but rather reinforcement of existing policy.</p> <p>Acute changes in resident condition will be reviewed by members of the Interdisciplinary Team daily in the Operations and Clinical IDT Meeting. Residents exhibiting significant changes in behavior or clinical condition that may be contributory to the risk of wandering and elopement, will have a Wandering and Elopement Assessment tool completed and appropriate interventions implemented as necessary.</p> <p>Facility will maintain a comprehensive log of the date for each completed Wandering and Elopement Assessment tool and the resident specific determination. Newly identified residents at risk for Wandering and Elopement will be reviewed weekly for four weeks by the Interdisciplinary team, and then quarterly in congruence with Minimum Data Set assessment. Additional assessments may be completed sooner if a significant change in behaviors or clinical functioning is identified.</p> <p>Director of Nursing will report to Quality Assurance and Performance Improvement with identified trends or patterns. The identified trends or patterns will be reported to the Quality Assurance and Performance Improvement weekly for four weeks and then monthly for three months. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the plan based on trends identified, and adjust</p> <p><small>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</small></p> | | |

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| F 323 | <p>Continued From page 5</p> <p>Resident #1 who saw Resident #4 exit the building was no longer in the facility and unable to be interviewed.</p> <p>A review of laboratory results revealed an ammonia level on 12/10/13 was 136 (normal is 11-35).</p> <p>On 12/30/13 at 4:56 PM, Nurse #1 stated it was a resident who actually saw Resident #4 go out of the building. Nurse #1 stated Resident #4 had been without a wanderguard bracelet for awhile and did not have a wanderguard bracelet in place on 12/9/13. Nurse #1 stated she did not have a wanderguard bracelet available to put on Resident #4 and Resident #4 was put on every fifteen (15) minute checks (documentation stating where Resident #4 was located and what she was doing every fifteen minutes) after she came back in the building. She stated Resident #4 stayed pretty much in her room the remainder of the evening shift.</p> <p>On 12/30/13 at 5:18 PM, Nurse #2 stated she was the evening supervisor on 12/9/13. She said the nursing assistants came to her and told her that Resident #4 had been spotted outside and they had brought her back in. She stated they notified the Administrator, Director of Nursing, physician and resident ' s RP (responsible party) at the time of the incident and locked the front door. Nurse #2 said the front door was typically locked around 8:00 PM by the A hall nurse when the receptionist left for the evening. Once the front doors were locked, an alarm would sound if someone went out of the door. Nurse #2 stated Resident #4 did not have a wanderguard bracelet on until sometime last week. She stated</p> | F 323 | <p>the plan if negative trends are identified. If negative trends are identified, additional months of close observation will occur with additional staff education.</p> <p>Date of Completion: January 26, 2014</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.</p> | | |

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| F 323 | <p>Continued From page 6</p> <p>Resident #4 had a wanderguard bracelet on at one point but she did not know when it had been removed. Nurse #2 said she did not know anything until Resident #4 went out the door.</p> <p>On 12/31/13 at 9:31 AM, NA#1 stated Resident #4 was found in the front parking lot on the left side of the building close to the building. NA #1 said she did not know how long resident #4 was outside. She stated she did not think Resident #4 had a wanderguard bracelet on. NA #1 did not remember if any alarms went off during the time Resident #4 went out of the building.</p> <p>On 12/31/13 at 10:54 AM, NA #3 stated she was assigned to care for Resident #4 on the evening of 12/9/13. She said that was the first time she had provided care for Resident #4 and she was not made aware that Resident #4 was a wanderer until after she had already gone out of the building.</p> <p>On 12/31/13 at 11:22 AM, NA #2 stated Resident #1 came up to her and NA #1 and told then that Resident #4 got out the front door through the lobby. She stated Resident #4 was on the far right side of the building in the parking lot facing the rehabilitation building. Resident #4 told them she was trying to go to the store. NA #2 stated the time was around 10:00 PM. She said when they went out the front door in the lobby, no alarms went off when they exited the building and they did not have to unlock the front door when they went out to get Resident #4.</p> <p>On 12/31/13 at 11:30AM, an observation of the parking lot where resident was found on 12/9/13 was completed with NA #2. She pointed to the end of the building that would have been the right</p> | F 323 | | |

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| F 323 | <p>Continued From page 7</p> <p>side of the building when going out the door and stated Resident #4 was in the parking lot area at the end of the building 12/9/13. It was observed that one of the main entrances was directly across from the end of the building and that entrance leads to a very busy 4 lane street with an additional lane in the center for turning.</p> <p>On 12/31/13 at 4:27 PM, Nurse #2 stated, from her understanding, Resident #4 was down at the end of the building near the sidewalk on 12/9/13. She said the nurse and nursing assistant responsible for Resident #4 said they had just seen her five (5) to ten (10) minutes prior to Resident #4 exiting the building. Nurse #2 said it was cold that evening and she thought Resident #4 had on a lightweight jacket and her regular clothes. Nurse #2 said Resident #4 did not have a wanderguard bracelet on and nursing staff did not have access to any of the wanderguard bracelets. She said the wanderguard bracelets were kept in the DON 's (Director of Nursing) office and she was not aware that there were any kept on the med carts. Nurse #2 stated she worked on 12/10/13 and Resident #4 did not have a wanderguard bracelet on 12/10/13 and did not have one placed until the end of last week when Nurse #2 put one on Resident #4 ' s wheelchair. She said she did not think hourly rounds were actually initiated at all even after the 12/9/13 incident.</p> <p>On 12/16/13, laboratory results revealed Resident #4 ' s ammonia level was recorded at 69.</p> <p>A nursing note dated 12/19/13 at 11:32 PM stated Resident #4 still had no wander guard bracelet in place.</p> | F 323 | | | |

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| F 323 | <p>Continued From page 8</p> <p>A nursing note dated 12/22/13 at 01:36 AM stated Neomycin continued due to elevated ammonia without signs/ symptoms of adverse reaction. Confusion continued.</p> <p>A nursing note dated 12/22/13 at 4:36 PM stated a nursing assistant found Resident #4 outside in the back parking lot. Resident #4 said she was going to the store. No injuries were noted. Resident #4 was brought back into the building safely.</p> <p>A nursing note dated 12/22/13 at 8:30 PM stated a wanderguard bracelet was placed on Resident #4 ' s wrist. The nursing note did not document if the wanderguard was replaced at that time.</p> <p>An incident report dated 12/22/13 at 4:30 PM stated a nursing assistant noticed Resident #4 outdoors near the back parking lot. No injuries were noted. Mental status before occurrence was noted as alert/ disoriented and same after occurrence. Action taken: Keep closer eye on resident. Suggest wanderguard bracelet be applied again.</p> <p>A witness statement dated 12/22/13 by NA #3 said she was getting something out of her car. When she got out of her car, she saw Resident #4. When she asked her where she was going, Resident #4 said she was going to the store. NA#3 told her she could not go to the store and she would take Resident #4 out of the rain. Resident #4 said no and NA #3 knocked on the D hall door and the nurse helped NA #3 get Resident #4 inside the building.</p> <p>A nursing note dated 12/23/13 at 01:49 AM stated</p> | F 323 | | | |

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| F 323 | <p>Continued From page 9</p> <p>Resident #4 continued to be confused. Unable to locate wanderguard bracelet on patient (Resident #4). Patient was unable to recall when/ where/ if she removed it. There was no notation that a wanderguard bracelet was reapplied at that time.</p> <p>A review of laboratory results revealed Resident #4 ' s ammonia level on 12/23/13 was 58.</p> <p>On 12/31/13 at 4:50 PM, Nurse #3 stated the elopement on 12/22/13 occurred around 4:00 PM. She stated Resident #4 did not have a wanderguard bracelet on when she was found outside. Nurse #3 said she thought Resident #4 used to have one on but her legs were swelling so they took it off. She was not sure when the wanderguard bracelet had been removed. She stated she had never seen Resident remove any wanderguard bracelets. Nurse #3 said she put a wanderguard bracelet on Resident #4 ' s left wrist when she came back in the building. Nurse #3 said she did not think they figured out which door Resident #4 went out but she was in the back parking lot (employee parking lot). She thought it was cloudy that day and might have been lightly raining. Resident #4 was wearing her jacket. She said no alarms went off to alert them that Resident #4 had gone out of the building.</p> <p>A nursing note dated 12/25/13 at 11:38 AM stated Resident #4 went out the door unattended. She was returned to the facility and placed on every fifteen minute checks.</p> <p>An incident report dated 12/25/13 stated Resident #4 exited the facility unattended. No apparent injury was noted. Resident #4 was placed on every fifteen minute checks.</p> | F 323 | | | |

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| F 323 | <p>Continued From page 10</p> <p>A witness statement dated 12/25/13 by Nurse # 4 stated Resident #4 was noted outside and was returned by the receptionist.</p> <p>A nursing note dated 12/26/13 at 1:43 PM stated a wanderguard bracelet was attached to Resident #4 and was placed on the back of her wheelchair out of her view to prevent her from removing the bracelet.</p> <p>On 12/31/13 at 3:42PM, receptionist #2 stated she was working on 12/25/13 when Resident #4 went out of the building. She stated Resident #4 came up to the receptionist desk around 9:00 AM. She was between the receptionist desk and the Administrator 's office. Receptionist #4 said the wanderguard alarm usually goes off when they are in that area but the alarm did not go off at that time. Resident #4 went toward the front door of the lobby. She was dressed in a patient gown and lightweight jacket. It was very cold that day. Receptionist #2 stated she got up and turned Resident #4 around and told her she needed to go back to her room. She watched Resident #4 go down D hall like she was going back to her room. Receptionist #2 said around 10:00 AM, she was at her desk typing, looked up and saw Resident #4 going past the front door in the parking lot at the front of the building. She stated she went out, talked to Resident #4 and brought her back in the building. She said she thought Resident #4 must have gone out the side door on d hall (employee door). No alarms had gone off when Resident #4 exited the building or when she brought her back in the front door. Receptionist #2 said she did not see her leave the building but Resident #4 could not have been outside the building more than ten to fifteen minutes. Receptionist #2 stated Resident #4</p> | F 323 | | |

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| F 323 | <p>Continued From page 11</p> <p>could manipulate her wheelchair all by herself and moved very fast in her wheelchair.</p> <p>On 12/31/13 at 5:27 PM, Nurse #4 stated Resident #4 was more agitated than usual on 12/25/13. She said the receptionist came and told her that Resident #4 had gone out the employee side door. Nurse #4 stated she could not find the wanderguard bracelet on Resident #4 when they brought her back into the building. Nurse #4 said she place Resident #4 on every fifteen minute checks until they put a wanderguard bracelet on her the next morning. When asked if Resident #4 usually wore a wanderguard bracelet, Nurse #4 stated she had been wearing one " for a good while " and had it on her ankle but her ankle swelled so nursing staff had put it on her wrist. She said nursing staff checked every shift to make sure it was there. Nursing documented placement and function on the Medication Administration Record (MAR). Nurse #4 said she had not checked for the wanderguard bracelet that morning. She said she had not seen Resident #4 take the bracelet off but she knew Resident #4 had taken it off in the past.</p> <p>A review of the November 2013 MAR revealed no record of monitoring for placement and function of wanderguard bracelet.</p> <p>A review of the December MAR revealed monitoring for placement every shift and function every night shift was initiated on 12/26/13. Documentation was noted that the wanderguard bracelet was functioning and in place on Resident #4 ' s wheelchair all shifts on 12/26/13 through 12/30/13.</p> | F 323 | | | |

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| F 323 | <p>Continued From page 12</p> <p>Physician orders were reviewed and revealed a physician ' s order dated 12/26/13 which stated check wanderguard placement every shift and function every night shift.</p> <p>On 12/30/13 at 5:50 PM, receptionist #1 stated there was a receptionist in the front lobby seven days a week and worked until 7:00PM. She said she notified the nurse on A hall when she was leaving for the day so the nurse could lock the front door and set the front door alarm with a key.</p> <p>On 12/30/13 at 5:55 PM, Administrative staff #1 stated there was always an alarm that went off for the wanderguard bracelets. He stated Resident #4 would cut off the wanderguard bracelet and one day last week, they were talking about where they could place the wanderguard bracelet so she would not cut it off.</p> <p>On 12/30/13 at 6:00 PM, the maintenance supervisor stated the front doors did not have an automatic lock on them. Nursing staff locked the door. An alarm would go off when the door was locked and alarm was activated. An observation of how the alarm worked was conducted. The nurse from A hall came to the front door and locked the door on the left side. She raised the handle on the right side and also activated the alarm by using a key in the keypad on the right side of the door. She demonstrated that the outside doors would open and there was a doorbell on the wall just inside those doors for people to ring for assistance. When she opened the inner door, a very loud alarm sounded and she said that was what sounded if someone was trying to exit the building from the inside. She said she usually locked the doors between 7:30 and 8:00 PM.</p> | F 323 | | | |

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| F 323 | <p>Continued From page 13</p> <p>On 12/31/13 at 8:20 AM, Nurse #5 stated Resident #4 could propel herself in the wheelchair and go all over the facility. Nurse #5 said Resident #4 used a wanderguard bracelet and it had been placed on her wrist and on her ankle in the past. He said Resident #4 would remove her bracelet from her wrist and staff were aware and knew she could do that.</p> <p>On 12/31/13 at 8:57AM, Nurse #6 stated both of the elopement care plans were in place and active. She said Resident #4 becomes more confused when her ammonia levels are elevated. Nurse #6 said Resident #4 has had a wanderguard bracelet since June 2011. She stated recently, Resident #4 decided she did not want it on at all. Staff had placed the wanderguard bracelet on her wheelchair because she needed her wheelchair to get around. Nurse #6 said she had checked for the wanderguard bracelet on 12/26/13 and it was on the back of her wheelchair at that time.</p> <p>On 12/31/13 at 9:20 AM, Administrative staff #2 stated, per the elopement policy, all people on risk for elopement had wanderguard bracelets on them. If a resident attempted to elope, nursing staff would notify her and the Administrator immediately. The nurse would document the elopement and, if the resident was injured, Administrative staff #2 would come to the facility. She said the family and physician were also notified of the elopement. Administrative staff #2 stated that documentation for monitoring for function and placement of the wanderguard bracelet was located on the MAR. She said functioning of the wanderguard bracelet is done by using a monitor and the light on the monitor</p> | F 323 | | |

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| F 323 | <p>Continued From page 14</p> <p>turns green which shows the wanderguard bracelet is functioning properly. The facility only had one monitor to check for functioning of the bracelet. She stated there should have been documentation on the chart for placement and function of the wanderguard bracelet.</p> <p>On 12/31/13 at 9:20 AM, Administrative staff #2 said Resident #4 had recently broken five (5) of the wanderguard bracelets. She said nursing staff had applied the wanderguard bracelet to Resident #4 ' s wrist and Resident #4 had broken five of them. Nursing staff had told her over a month ago that Resident #4 was pulling the wanderguard bracelets off. They had changed the site of the wanderguard bracelet to Resident #4 ' s non-dominant wrist in November but that did not work. In December, they had placed the wanderguard bracelet on the ankle but Resident #4 ' s ankle became swollen so they placed it back on the wrist area. Administrative staff #2 stated she told the nursing staff to make sure that Resident #4 did not wander out of the building. She stated the last one was broken on December 20 something and was not sure of exact date. She said the last wanderguard bracelet was applied to the back of the wheelchair arm.</p> <p>On 12/31/13 at 11:47 AM, Administrative staff #3 stated Resident #4 had worn a wanderguard bracelet for a long time. Nursing staff on the floor were supposed to check for function and placement of the wanderguard bracelet every shift and record on the MAR that the wanderguard had been checked. She said there were new wanderguard bracelets available on each medication cart so they could be replaced if they were not functioning properly. The monitor (a wireless portable device for testing</p> | F 323 | | | |

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| F 323 | <p>Continued From page 15</p> <p>wanderguard ID signaling device bracelets and for testing working operation for wanderguard ID door monitors and door alarms) to check the wanderguard for functioning was kept on the A hall at the nursing station or in the med cart. Administrative staff #3 said the monitor was not working and they had ordered a new one that day. She said she had not been aware the monitor was not working until 12/31/13. She also stated there were no wanderguard bracelets available in the building-none on the medication carts.</p> <p>On 12/31/13 at 12:00 noon, Resident #4 's wheelchair was taken to the front lobby door and the wanderguard alarm sounded appropriately. The alarm also sounded appropriately when the wheelchair was taken to the D hall side door (employee door). Resident #4 was not in the building at the time and had been admitted to the hospital on 12/30/13 due to an elevated ammonia level and lethargy.</p> <p>On 12/31/13 at 12:15 PM, the person who ordered supplies stated she had not been aware that there were no extra wanderguard bracelets in the building and that the wanderguard monitor was not working until 12/31/13 and had ordered both today as well as some extra wanderguard bracelet straps. An invoice dated 12/31/13 at 8:46AM was noted for a universal door/ trigger tester for the wanderguard bracelets and another invoice dated 12/31/13 at 7:49 AM was noted for four (4) signaling devices and ten (10) wristbands.</p> <p>On 12/31/13 at 4:00 PM, Administrative staff #2 stated the wanderguard bracelet was replaced on 12/9/13-wanderguard was good, just needed</p> | F 323 | | | |

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| F 323 | <p>Continued From page 16</p> <p>straps. She indicated nursing staff said the bracelet was found on the floor. She stated she expected nursing staff to document in the nursing notes when they replaced the wanderguard bracelet along with the location of the wanderguard. She said nursing staff has wanderguards in the med carts for replacement if needed but Resident #4 had broken five of the wanderguards and facility has had to order more. She also stated that resident had been on hourly monitoring since October 2013. The paper was posted on her door and every staff member was supposed to document on the paper every hour. Administrative staff #2 said they tried every fifteen checks around September and was changed to hourly checks in October. When asked regarding care planning and changes if needed, she said the care planning team (MDS coordinators) was present in the morning meetings. Resident #4 had been discussed in morning meeting in December and that was where they decided to put the wanderguard on the wheelchair.</p> <p>On 12/31/13 at 4:15 PM, Administrative staff #6 stated Resident #4 's care plan stated to have the wanderguard on at all times and if she was taking them off, nursing staff needed to put another one on. If she was exhibiting the behavior of taking them off, the social worker would be the one to care plan that behavior and that must have been why the social worker added to the care plan 11/14/13. She said she learned that resident was taking off the bracelets in December (week of Christmas) and the bracelet was moved to the back of her wheelchair.</p> <p>On 1/2/14 at 9:30 AM, Administrative staff #1 stated the side door (employee door) was not locked during the day and the alarm was turned</p> | F 323 | | | |

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| F 323 | <p>Continued From page 17</p> <p>off when going on and out; however, if a resident had a wanderguard alarm on, the alarm will sound when they go near the door. An observation of the alarm system was conducted using a resident who had a wanderguard bracelet on her wrist and a loud alarm sounded when the door was approached by the resident who had a wanderguard bracelet on. The alarm sounded until a staff member reset the alarm.</p> <p>On 1/2/14 at 3:00 PM, Administrative staff #2 stated she had the following twenty four hour (24) reports with the following information noted: 12/9/13 Resident #4 was started on hourly rounds. On 12/23/13, Resident #4 removed wanderguard and needs new one; eloped Saturday (12/22/13). On 12/25/13, Resident #4 went out of the building-every fifteen minute checks. Administrative staff #2 said she had looked but was unable to find hourly round sheets for 12/9/13, 12/22/13 and 12/25/13.</p> <p>The Administrator was notified of the Immediate Jeopardy on 12/31/13 at 5:33PM.</p> <p>The facility presented a credible allegation of compliance on 1/2/14 at 6:30 PM. which included:</p> <p>Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>It is the practice of this facility to provide nursing services relevant to maintaining a safe environment for all residents. It is the practice of this facility to assess all residents to determine what safety interventions are necessary to prevent elopement. Those residents who have been identified as an elopement risk by the facility</p> | F 323 | | | |

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| F 323 | <p>Continued From page 18</p> <p>interdisciplinary team inclusive of the physician, nursing staff, and social worker will have appropriate interventions care planned and implemented with the goal of maintaining safety and minimizing the risk for elopement.</p> <p>Corrective action has been achieved for Resident #4 due to being in hospital. Resident # 4 was discharged to hospital on December 30th 2013. Upon return of resident #4, the facility will assess resident for elopement risk and follow facility policy and procedure.</p> <p>How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:</p> <p>All other facility residents with impaired cognition that do not understand the safety implications for elopement behavior have the potential to be affected by the same alleged deficient practice.</p> <p>All facility residents were assessed for Wandering and Elopement behaviors on December 31, 2013 by members of nursing administration inclusive of the Director of Nursing, Assistant Director of Nursing, and Licensed Practical and Registered Nurses. The assessment tool is inclusive of evaluation of cognition, physical functioning, history of wandering, and diagnoses.</p> <p>Any and all residents identified as an Elopement/Wandering risk has had a care plan created or reviewed to determine appropriate interventions necessary to meet the intended goal of providing safety through minimizing the risk of elopement.</p> <p>Address what measures will be put in place or</p> | F 323 | | |

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| F 323 | <p>Continued From page 19</p> <p>systemic changes made to ensure that the deficient practice will not occur:</p> <p>In-service education was provided to all facility personnel on the current policy for Wandering and Elopement beginning on December 31, 2013 and completing on January 1, 2014. In-service education completed by the facility educator and was inclusive of:</p> <p>Inclusive list of all residents identified as being at risk for Wandering and Elopement will be maintained at each nurse 's station. Members of Administrative Nursing including the Director of Nursing, Assistant Director of Nursing, Resident Care Management Director, and other members of the IDT will review the cumulative list weekly to determine if those identified residents are still exhibiting behaviors indicative of a risk for wandering and elopement. All staff who sees any resident having exit seeking behaviors will report the behaviors to residents nurse. Staff will also try and redirect resident. Nurse will evaluate resident for elopement risk and follow facility policy and procedure for elopement risk.</p> <p>Residents deemed at risk will have wanderguard bracelet placed for safety and monitoring.</p> <p>Facility will keep extra bracelet on med carts at all times. In the absence of bracelet, facility will provide one on one monitoring until available. Extra bracelets were ordered on 12/30/13.</p> <p>Date of Completion: January 2, 2014</p> <p>Immediate Jeopardy was removed on 1/2/14 at 6:30 PM. Observations of residents with wanderguard bracelets revealed bracelets were</p> | F 323 | | |

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

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FORM APPROVED
OMB NO. 0938-0391

| 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 01/02/2014 |
|---|---|--|---|----------------------|---|
| 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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| F 323 | Continued From page 20 appropriately placed on the residents and/or on wheelchairs. Interviews with direct care staff and licensed staff confirmed they had received in-servicing on responding to the alarm system, monitoring of the wanderguard alarm bracelets, checking the bracelets for functioning and appropriate documentation and what to do if the bracelets did not function properly and/or were not in place on residents who wore the wanderguard bracelets. The location of the book containing the names of residents who wore the wanderguard bracelet was in place at A/B hall and C/D hall nursing stations. Documentation was provided by the facility that a new monitoring device and a supply of extra wanderguard bracelets had been ordered. Checks of the wanderguard door alarms were conducted and the alarms functioned properly. | F 323 | | | |