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
	345133	A. BUILDING _____ B. WING _____	C 01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

(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 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 record review, resident, and staff interviews the facility failed to obtain and administer antianxiety medication as ordered by physician for 1 of 3 sampled residents (Resident #2). The findings include: Resident #2 was admitted to the facility on 12/14/15 with diagnosis of: right hip fracture, chronic obstructive pulmonary disease, hypertension, and diabetes mellitus. Resident #2 was discharged from the facility on 12/21/15. Review of most recent minimum data set (MDS) dated 12/21/15 revealed that Resident #2 was cognitively intact and required extensive assistance of one staff member with bed mobility, transfers, toileting, and dressing. No behaviors were identified during the assessment. Review of nurse's notes dated 12/18/15 at 2:15 PM and signed by Nurse #1 indicated that Resident #2 was noted to be very anxious and confused, vital signs were checked and pulse oximetry was noted to be 82% on oxygen. Nebulizer treatment was administered and pulse oximetry was noted to be 88% on oxygen. Resident #2's physician was contacted and gave a verbal order for klonopin 0.5 milligrams (mg) by mouth every 8 hours as needed for anxiety. The note further indicated that Resident #2 was very talkative and had refused care.	F 333	1. The deficiency has been corrected. Resident #2 was discharged from the facility on 12/21/15. 2. Current residents have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) and Unit managers conducted an audit on 1/19/16 of current residents Medication Administration Record (MAR) to identify medications that were not administered as ordered. The physician was notified regarding discrepancies identified and new orders were received. The pharmacy technician conducted a MAR to cart audit on 1/20/16 – 1/21/16 to validate medications were available as ordered. No discrepancies were identified.	

DHSR NH L&C Black Mountain WRO Received JAN 26 2016 by:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John P. Walder | TITLE: Administrator | (X6) DATE: 1/19/16

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 333	Continued From page 1 Review of physician order dated 12/18/15 stated: Clonazepam (klonopin) tablet 0.5 mg give 1 tablet orally every 8 hours as needed for anxiety. Review of nurse's note dated 12/20/15 at 2:26 PM and signed by Nurse #2 indicated that Resident #2 was noted to be confused and mildly agitated. Resident #2's family requested that the resident be given the nerve/anxiety medication that had been ordered. Nurse #2 then documented "klonopin ordered Fri. at 2:15 PM not in our supply." Family stated that they would bring Resident #2's medications from home but when they did, it did not contain klonopin. Review of nurse's note dated 12/21/15 at 2:40 AM and signed by Nurse #3 indicated that Resident #2 was noted to be confused and mildly agitated. Resident #2 had new order for klonopin but none available. Pulse oximetry 93% on 3 liters of oxygen via nasal cannula. Review of nurse's noted dated 12/21/15 at 6:45 AM and signed by Nurse #3 indicated that Resident #2 was noted to have increased confusion, combative, and had decreased pulse oximetry to the low 70's. Physician was notified and verbal order given to send Resident #2 to emergency room for evaluation. Review of medication administration record (MAR) for Resident #2 dated 12/01/15-12/31/15 revealed Clonazepam (klonopin) 0.5 mg give 1 tablet orally every 8 hours as needed for anxiety. There was no staff initials which indicated that Resident #2 received no klonopin for anxiety during her stay at the facility.	F 333	3. The DON and/or unit managers provided inservice education beginning on 1/14/16 for the licensed nurses regarding policies and procedures for ordering and obtaining medications and administering medications as ordered by physician and the implementation of the Medication Availability Log. The DON and/or the unit manager will audit the Medication Log at least 5 times a week to validate medications are received and administered as ordered by the physician. The physician will be notified if discrepancies are identified. The DON and Medical Director reviewed the emergency kit medication list on 1/14/16, to identify the need for frequently used medications and update as necessary. 4. The DON will review the results of audits/reviews to identify patterns/trends will be discussed at the monthly QA meeting for 3 months or until compliance is maintained.	1/25/16

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F 333	Continued From page 2 Interview with Nurse #1 on 01/07/16 at 2:03 PM revealed that she had worked with Resident #2 on 12/18/15 and that she called Resident #2's physician because the patient had become short of breath and agitated and she had given Resident #2 a breathing treatment but it only slightly helped. When she called the physician he ordered klonopin 0.5 mg orally every 8 hours as needed for anxiety. Nurse #1 further indicated that she had phoned Resident #2's physician office and requested that he fax a prescription to the pharmacy so the medication would be delivered to the facility. Nurse #1 indicated that she had faxed the telephone order for klonopin to the pharmacy. Interview with Nurse #2 on 01/07/16 at 2:23 PM revealed that she worked with Resident #2 on 12/20/15, she stated that when she reported to work there was no klonopin available to give to Resident #2, she stated she was not sure why the medication was not there but she had spoken to Resident #2's family and they were going to bring in the medication (klonopin) from home. Nurse #2 stated that when the family finally brought the medication from home it did not contain klonopin and by that time the weekend was almost over so she instructed the family to talk to management staff on Monday morning. Nurse #2 confirmed that she had not called the physician or the pharmacy to try to find out why the medication was not there. Nurse #2 also confirmed that she was aware that the facility had a backup pharmacy but did not indicate why she did not consult them. Nurse #3 could not be reached for interview. Interview with pharmacist on 01/07/16 at 2:38 PM	F 333		