STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING ______ B. WING ______	C 10/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and Pharmacist	F 309	1. Corrective action for resident #5; resident no longer resides in facility. 2. All current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing conducted a 100% audit of all residents that have scheduled and PRN medications ordered. The audit included verifying the order against the actually medication in the cart to ensure availability. 3. Measures put in place to ensure that the alleged deficient practice does not recur include: • On 10/24/2017 the Director of Nursing initiated a nursing staff in-service on the Pain Management and medication availability. This included proper notification to the physician and proper process to notify the pharmacy. • The Director of Nursing or other nursing supervisor, will perform audits of all new pain medication orders for availability 5 times a week for 4 weeks, than 3 times a week for 4 weeks, than weekly for 3 months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William E. Wood ADM AS OF 11/20/17 FOR AVANTE
TITLE: ADMinistrator
(X6) DATE: 12/19/17

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 309	Continued From page 1 interviews, the facility failed to ensure physician ordered pain medication was available when needed for 1 of 3 sampled residents reviewed for pain maintenance (Resident#5). Findings included: Resident #5 was admitted to the facility on 9/26/17 with diagnoses which included: metastatic breast cancer, spinal cord compression, and neurogenic bladder. The hospital discharge summary dated 9/26/17 revealed Resident #5 medication orders included scheduled morphine sulfate extended release (pain medication) 15mg (milligrams) every eight hours and morphine sulfate 15mg every three hours prn (whenever needed) for pain. The review of the hospital's Medication Administration Record (MAR) indicated a scheduled dose of morphine sulfate was administered to the resident on 9/26/17 at 4:38 pm., before she was discharged to the facility. The review of the Admission/Data Collection dated 9/26/17 revealed Resident #5 arrived to the facility from the hospital via family transport on 9/26/17 at 5:00 p.m. The resident's attending physician was notified at 09/26/17 at 7:00 p.m. and the medication orders were confirmed by a physician. The data collection indicated the pharmacy was also notified on 9/26/17 at 7:00 p.m. by way of the integrated/electronic system. Review of the Admission Pain Evaluation dated 9/26/17 at 11:53p.m. indicated Resident #5 had a history of continuous, chronic pain due to her disease process. The resident was able to	F 309	4. The Director of Nursing will analyze the audits/reviews for patterns/trends and report in the Quality Assurance Committee Meeting monthly for three months to evaluate the effectiveness of the plan and will make any needed adjustments based on outcomes/trends identified. 5. The Administrator is responsible for implementing the Plan of Correction. 6. Corrective action will be competed on 11/03/2017	

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F 309	Continued From page 2 verbalize a description of her pain as aching/dull, radiating, shooting, and throbbing. Also pain was worse when medications were not available. An alternative intervention to the medication for the resident's pain was repositioning every 2-3 hour. The review of the Medication Order Summary Report (9/26/17-10/31/17) and the MAR(Sept 2017) indicated Resident #5 was to be administered 15mg of morphine sulfate every four hours as needed for pain beginning 9/26/17 at 11:00 p.m. The resident was to receive scheduled doses of 15mg of morphine sulfate every eight hours beginning 9/27/17 at 6:00 a.m. Review of the September 2017 Pain Assessment MAR indicated Resident #5 was experiencing high levels of sharp pains during the 11:00 p.m.-7:00 a.m. shift. However, there was no documentation on the MAR or in the resident's clinical records indicating the resident was administered the prn or the scheduled morphine sulfate. The Nurse's Note dated 9/27/17 at 7:06 a.m., revealed Resident #5 was observed preparing to leave facility with her family. The Note documented that the resident voiced that she was returning to the hospital so she could continue to receive the pain medication that she was receiving at the hospital because she was in a lot of pain. The nurse documented the resident had not informed staff of being in pain. When staff had been in resident's room, the resident had voiced that her pain was not at the point where she needed pain medication. The resident exited the building alert and oriented, in a wheelchair and accompanied by her family.	F 309		

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F 309	Continued From page 3 Review of the facility's Against Medical Advice (AMA) form revealed Resident #5 discharged from the facility on 9/27/17 at 6:45am. The MAR indicated the resident did not receive the scheduled 6:00 a.m. dosage of morphine sulfate ER on 9/27/17. There was no reported treatment of Resident #5 by hospital emergency department on 9/27/17. During an interview on 10/6/17 at 10:00 a.m., the Director of Nursing (DON) stated Resident #5 was admitted to the facility after 5:00 p.m. on 9/26/17 and discharged from the facility early the next morning. The DON stated that staff notified her via telephone at 2:00 a.m. on 9/27/17 the resident had contacted her family and was leaving AMA because she said she could not get her "marijuana" and pain medications. The nurses informed the DON the resident's narcotics had not been delivered and were waiting for delivery from the backup pharmacy. The DON indicated she advised the nurse to inform the resident the facility was attempting to obtain the narcotic medication as soon as possible. The DON revealed the facility did not maintain an emergency kit (E-kit) for narcotics. She stated the only pain medications the facility maintained in stock was tylenol (325 and 500mg) and 200mg Ibuprophen. The DON stated that she told the nurse (can't remember which nurse) to call the backup pharmacy how long before facility receive the resident's narcotic. The DON stated approximately 5:30 a.m.-6am, the nurse notified her via telephone Resident #5 was leaving AMA to go home. DON stated to her knowledge, no one notified MD of res' c/o pain, but her expectation was whenever a resident complained of pain and the resident's pain medication was	F 309		

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

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F 309	Continued From page 4 not available then the nurse should have notified the Physician. DON stated during this survey, she attempted to telephone the nurse that was on duty on third shift on 9/26/17; but was unsuccessful. On 10/6/17 three unsuccessful attempts were made to contact the third shift Staff Nurse #2 who assisted Resident #5 on 9/26/27. During a telephone interview on 10/6/17 at 4:20 p.m., the Registered Pharmacist (RPh) revealed the pharmacy received the fax from the facility consisting of Resident #5's list of physician ordered medications on 9/26/17 at 11:21 p.m. The RPh indicated any medication orders received after 5:00 p.m. also required facility notify pharmacy by phone and would be delivered between 7:00 p.m. - 9:00 p.m. Any pharmacy calls after 9:00 p.m. with emergency needs would be forwarded to the pharmacy's on-call location which would notify the back-up pharmacy closest to the facility. During an interview on 10/6/17 at 4:55 p.m., Staff Nurse #1 (SN#1) revealed on 9/26/17 he was notified by the hospital of Resident #5's arriving to facility via family transport. SN#1 stated he was also informed by the hospital staff that the resident's pain was hard to management and she had had the use of a pain pump while in the hospital. The resident was administered pain medication before leaving the hospital. SN#1 was admitted to the facility on 9/26/17 with her hospital discharge summary which included her medication list. SN#1 stated the resident's assessment was completed and resident visited with her without any complaints of pain throughout the shift. SN#1 indicated he faxed the	F 309		

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F 309	Continued From page 5 resident's narcotic prescriptions to the pharmacy as soon as the resident was admitted because the pharmacy required a hard prescription for all narcotics and he was aware he would need the narcotics for the resident as soon as possible because the facility did not have a narcotics emergency kit (E-kit)	F 309		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to administer the accurate dosage of valium (anxiety medication) as ordered by the Psychiatric Nurse Practitioner for 1 of 3 sampled residents (Resident #4). Findings Included: Resident #4 was admitted to the facility on 2/18/17 with diagnoses which included: paraplegia, delusional disorders, dementia, psychosis, schizoaffective disorder, anxiety disorder, major depressive disorder, post-traumatic stress disorder, and bilateral above knee amputations. Review of the Physician's Order dated 6/10/17 indicated Resident #4 was to receive diazepam (valium) 10 mg (milligrams) every eight hours as	F 333	1. Corrective action for resident #4; Nurse involved her employment was terminated on 09/06/2017. Resident #4 was assessed with no negative outcomes. 2. All current facility residents have the potential to be affected by the alleged deficient practice. 3. Measures put in place to ensure that the alleged deficient practice does not recur include: • On 10/24/2017 The Director of Nursing initiated in-service on the policy on Administering Medications, The 10 Rights of Medication Administration, Preventing Medication Errors. • The Director of Nursing or other nursing supervisor, will perform 2 Medication Pass Audits weekly for 3 months.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 333	Continued From page 6 needed for anxiety related to anxiety disorder. Review of the Social Services Quarterly Review dated 8/22/17 revealed Resident #4 received weekly psychotherapy and was seen by a Psychiatrist. Review of the Quarterly Minimum Data Set (MDS) dated 8/22/17 indicated Resident #4 was cognitively intact. The Care Plan was updated on 816/17 to include: resident was verbally & physically aggressive, non-compliant with manual lift transfers, became impatient while staff attended other resident's care, used racial slurs, badgers nursing, peers and NAs to the point at times was stalking related to delusional disorder, post-traumatic stress disorder, neurocognitive disorder. Interventions included: administer medications as ordered; monitor/document for side effects and effectiveness. The review of the Controlled Medication Utilization Record revealed Resident #4 was administered two doses (20mg) of diazepam (valium) on 8/30/17, 9/1/17, and 9/4/17. A review of the Incident Report dated 9/5/17 revealed a staff nurse gave Resident #4 more medication than was documented in the electronic medication administration record. The staff nurse stated the Nurse Practitioner (NP) had instructed her to give the resident "two pills" instead of one. The staff nurse failed to write an order per the NP's verbal statement and failed to document the total amount given. As Follow-up, the resident was observed for increased lethargy, decrease in activities, none noted. Actions taken to prevent potential for reoccurrence: the Director of Nursing (DON) or the Assistant Director of	F 333	4. The Director of Nursing will analyze the audits/reviews for patterns/trends and report in the Quality Assurance Committee Meeting monthly for three months to evaluate the effectiveness of the plan and will make any needed adjustments based on outcomes/trends identified. 5. The Administrator is responsible for implementing the Plan of Correction. 6. Corrective action will be completed on 11/03/2017	

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F 333	Continued From page 7 Nursing (ADON) only, would be allowed to take narcotic cards and sheets. During an observation and interview on 10/6/17 at 3:05 p.m., Resident #4 was propelling himself in a motorized wheelchair in hallway. The resident was alert, verbal and friendly. The resident stated he was on his way to smoke a cigarette outside; a catheter bag was noted hanging from front of wheelchair seat (privacy side facing outward). During an interview on 10/6/17 at 4:15 p.m., the DON revealed that several weeks prior, the ADON was auditing the medication carts and reviewing narcotic sheets when she noticed the narcotic sheet for Resident #4 had marked/scratched out markings. The ADON conducted a reconciliation and the medication error was found. The DON stated she investigated the finding as the diversion of 20mg of valium versus 10mg valium. The findings of the investigation revealed on two or three different occasions the nurse was incorrectly administering 20mg of valium to Resident #4 instead of the 10mg as ordered. The Psychiatric NP recalled verbally instructing the nurse to administer two pills to Resident #4 instead of one pill, thinking she (NP) was only increasing the medication to 10mg. The DON stated as a result, she (DON) concluded the staff nurse did not follow facility's policy and procedures, the standards of the nurse practice act and the physician's order . The DON confirmed that the staff nurse did not write a verbal physician's order for the valium increase and did not document the correct amount administered to the resident on the Medication Administration Record and progress note. She also revealed the staff nurse was terminated. The resident was observed and monitored for side	F 333		

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F 333	Continued From page 8 effects which there were none. The DON stated that to prevent a reoccurrence of medication errors with narcotics, only she could remove the narcotic sheet from the narcotic box to verify counts; then she (DON) would sign off with another nurse signing as a witness.	F 333		