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	495151	A. BUILDING _____ B. WING _____	R-C 04/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(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
{E 000}	Initial Comments .	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 02/20/18 through 02/23/18, was conducted 04/09/18 through 04/10/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. No complaints were investigated during this survey. The census in this 120 certified bed facility was 101 at the time of the survey. The survey sample consisted of 15 Resident reviews (Residents 101 through 115).	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician's orders for one of 15 residents in the survey sample, R105 (Resident # 105). The facility staff failed to complete a weekly skin assessment for R105, as ordered by the	{F 684}	1. Resident #105 has had a weekly skin assessment completed. 2. A 100% audit of all residents completed on by 4/24/2018 by Director of Nursing (DON) and designee to ensure weekly skin assessments have been completed as ordered by the physician.	4/25/18

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

Electronically Signed | 04/18/2018

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{F 684}	Continued From page 1 physician. Findings include: R105 was admitted to the facility on 01/31/18 originally, with the most current readmission on 03/09/18. Diagnoses for R105 included, but were not limited to: HTN (high blood pressure) DM (diabetes mellitus), chronic kidney disease, peripheral vascular disease, anxiety, chronic atrial fibrillation, and a history of pressure ulcers. The most current MDS (minimum data set) assessed the resident with a cognitive score of "7" indicating severe impairment in daily decision making skills. The resident was also assessed as requiring extensive to total assistance from staff for all ADL's (activities of daily living). This MDS additionally assessed the resident with a stage 4 pressure ulcer (present upon original admission) and as measuring 14.0 X 5.0. R105's physician's orders were reviewed and included an order for, but not limited to: "...Weekly skin assessment Mondays 7-3 every day shift..." The resident's weekly skin assessments were reviewed. A weekly skin assessment dated 04/09/18 documented, "...Skin Conditions (list all areas NEW or OLD)..." The skin assessment included a body image front/back with corresponding numbers to accurately identify the location any type of area of concern and has a description area to address additional details of any issues. This assessment for R105 documented an open area to right groin, a central line catheter to left chest and open area to sacrum and open area to buttocks. The	{F 684}	3. 3. Inservice training of Licensed nursing staff initiated on 4/17/2018 by DON regarding completion of weekly skin assessments to ensure pertinent description including color, drainage, size, and any odor are within the clinical record. An audit of weekly skin assessments to be completed by DON or designee three times per week to ensure pertinent description are within the clinical record. 4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meting for review and revisions as the committee determines.	

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{F 684}	Continued From page 2	{F 684}		

assessment did not provide any additional information such as the size (length/width/depth) and/or color. No other type of pertinent descriptive information was found on the weekly skin assessment to ensure an accurate assessment was completed or to ensure monitoring and/or evaluation of the skin concerns were progressing and or digressing.

R105's clinical record was reviewed for 'weekly wound progress reports'; this resident did not have any wound care assessments completed at all.

The resident's CCP (comprehensive care plan) documented, "...admitted with stage IV [4] ulcer to sacrum and coccyx
wound...assess/record/monitor wound healing. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD...Follow facility policies/protocols for the preventions/treatment of skin breakdown...Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.."

The DON (director of nursing) and the administrator were made aware of concerns in a meeting with the survey team on 04/10/18 at approximately 4:15 p.m. The DON stated that the skin assessment for R105 was done. The DON was made aware that the skin assessment was initiated, but was not completed for the resident and did not include pertinent details. The DON further stated that the resident is seen weekly by the wound clinic and "they" document the size

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{F 684}	Continued From page 3 and everything. The DON was made aware that the resident's plan of care was not being followed and that the resident's last documentation from the wound clinic was on 03/27/18. The DON stated that they are here today. A policy was requested at this time on skin/wound assessments The DON presented the a policy and stated, '...our company doesn't want our nurse's doing skin assessments on wounds, because a lot of our nurses are LPN's [licensed practical nurses). The DON was asked how do you ensure accurate assessment information on these resident's with skin issues and/or pressure wounds. The DON stated that they are being seen by the wound clinic. The policy was presented and reviewed and documented, "Pressure Ulcer Treatment...review the resident's care plan...assessing the resident and the pressure ulcer...Stage IV full thickness tissue loss...often include undermining and tunneling...Further description...the depth...varies by location...can extend into muscle and/or supporting structures...Documentation: The following information should be recorded in the resident's medical record: ...All assessment data (i.e., color, size, pain, drainage, etc.) when inspecting the wound...Report other information in accordance with facility policy and professional standards of practice..." No further information and/or documentation was presented prior to the exit conference on 04/10/18 at 4:45 p.m.	{F 684}		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	{F 755}		4/25/18

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{F 755}	Continued From page 4 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on medication pass observation, staff interview, and clinical record review, the facility staff failed to ensure medications were available for administration for one of 15 resident's in the survey sample, Resident #114 (R 114).	{F 755}	F755: 1) Lexapro and Tegretol are now available for Resident #114. 2) A 100% audit of all residents with orders for Lexapro and Tegretol was	

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{F 755}	Continued From page 5 R114 did not have physician ordered Lexapro 10 MG (milligrams) and Tegretol 200 Mg available for distribution (Lexapro is a medication for depression and Tegretol is a medication used for seizures). The Findings Include: R114 was admitted to the facility on 01/23/18 with diagnoses of depression and seizure disorder. The most current MDS (minimum data set) was a quarterly assessment dated 3/9/18. R114 was assessed with a cognitive score of 7, indicating moderately cognitively intact. During medication pass observation conducted on 4/10/18 at 8:50 AM, license practical nurse (LPN #1) began pulling R114's medications for distribution. LPN #1 verbalized to the surveyor that Lexapro or Tegretol was not on the medication cart. LPN #1 then went to the facilities medication emergency medication box and was able to retrieve Tegretol 200 MG dose, but was unable to administer the Lexapro, as there was none in the emergency supply box. During the medication pass observation the surveyor asked what the process is for reordering medications. LPN #1 verbalized that when supply is getting low the nurse can reorder the medication via computer or call the pharmacy because some medications can't be reordered via computer. Lexapro was given later in the day (at 10:00 AM, according to a nursing note), but outside the time limit for the medication to be given.	{F 755}	completed on 4/16/2018 to ensure availability. 3) 3) In-service training of Licensed Nursing Staff that includes the proper process to obtain medication that is not in the medication cart, as per the steps of: a. Check that stat box for the missing medication b. Check for already filled medication in the medication cart or med room over flow medications c. If you still do not have the medication, call the doctor that is on call to obtain an order to hold the medication until it arrives d. Call the pharmacy for a stat delivery was initiated on 4/17/2018 by the DON. A weekly audit of all residents with orders for Lexapro and Tegretol will be completed weekly to ensure that medications are available on the medication carts to be completed by DON or designee for a period of 30 days to ensure availability. 4) The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.	

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{F 755}	Continued From page 6	{F 755}		

R114's clinical record was reviewed on 4/10/18. According to the medication administration record (MAR), Tegretol was not given once on 4/8/18 and twice on 4/9/18. Documentation in the progress notes for these dates evidenced that medication was not available and was on order from the pharmacy.

On 4/10/18 at 3:00 PM an interview with the LPN (LPN #2) who wrote the nursing notes on 4/9/18 was conducted. LPN #2 verified that she had wrote the nursing notes and did not give the Tegretol as it was unavailable. LPN #2 also verbalized that Tegretol was ordered, but did not arrive during her shift.

Policies were retrieved from the facility regarding timeliness of medications given and recording process of medications.

The policy for timing of medications to be given documented : "Medications are administered within 60 minutes of the scheduled time [...] Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. Both medications were scheduled to be given at 8:00 AM each morning and Tegretol to be given also to be given at 12:00 PM and 4:00 PM each day.

The policy for reordering medications from the pharmacy documented, "Reorder medications three to four days in advance of need [...] to assure an adequate supply is on hand."

04/10/18 4:30 PM the above information was provided to the director of nursing and administrator.

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{F 755}	Continued From page 7 No other information was provided prior to exit conference on 4/10/18.	{F 755}		
{F 759} SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5% during the medication pass and pour observation. The facility had three medication errors out of 28 opportunities, which resulted in a medication error rate of 10.7%. Findings include: A partial medication pass and pour observation was conducted on 04/10/18 at approximately 9:00 a.m., with LPN (Licensed Practical Nurse) # 3. LPN # 3 prepared medications for R115 (Resident # 115). The LPN prepared medications for R115, which included the following medications: one Norvasc 5 mg (milligrams) tablet, one Aspirin 81 mg (enteric coated) tablet, one Celexa 20 mg tablet, one Namenda 10 mg tablet, and one Aricept 10 mg tablet. A total of 5 pills were dispensed into the medication cup. The pills were then counted and the LPN stated, "I should have six." The LPN then counted the medication cards on top of the medication cart	{F 759}	F759 1) Physician (MD) was notified on 4/10/2018that Resident #115 did not receive Celexa and cholecalciferol as indicated. No new orders were received. MD notified on 4/10/2018 that Resident #114 did not receive physician ordered Lexapro as prescribed. No new orders were received. Neither resident #115 nor #114 experienced a negative effect of the identified medication errors 2) All residents have the potential to be at risk for medication errors. 3) Licensed Practical Nurse (LPN) #3 and LPN#1 Inserviced by DON by 4/23/2018 Inservice training for Licensed Nursing staff was initiated on 4/17/2018 to include the proper procedures to follow if a medication is not in the cart and the new eight rights of a medication pass by DON. A weekly audit of 3 medication passes to be completed by DON, Pharmacy nurse consultant, or designee for a period of 30 days to ensure medication error rate is less than 5%.	4/25/18

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{F 759}	Continued From page 8 and looked at the computer. The LPN put the medication cards back into the medication cart and proceeded to R115's room to administer the medication (5 pills). The medications were administered to the resident. A medication reconciliation for R115 was completed at approximately 9:45 a.m. The current physician's order for R115 documented an order for the resident to have, Celexa 20 mg tablet by mouth once a day and to be given with Celexa 10 mg tablet once a day by mouth (to be given with Celexa 20 mg) for a total dose of Celexa 30 mg. The resident's orders also included an order for, cholecalciferol 1000 units one tablet every day. The LPN failed to administer the Celexa 10 mg with the Celexa 20 mg tablet to give the resident a total dose of 30 mg (Celexa) as ordered by the physician and the LPN failed to administer the physician ordered cholecalciferol 1000 unit tablet. R115's MARs (medication administration records) were then reviewed for April 2018. The MARs documented that LPN # 3 administered the Celexa 10 mg tablet and the cholecalciferol 1000 unit tablet. On 04/10/18 at 11:00 a.m., the LPN was interviewed regarding the above information. The LPN confirmed that a total of 5 pills were counted for R115. The LPN was asked to pull up the resident's orders on the computer and asked to look at the Celexa order. The LPN stated that, she was not aware that the Celexa order for a total dose of 30 mg and included another pill to	{F 759}	4) The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.	

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{F 759}	Continued From page 9	{F 759}		

make that 30 mg. The LPN was asked to pull R115's Celexa card(s) from the med cart for review. The LPN pulled out one card for Celexa, which was for Celexa 20 mg. The LPN was asked if that was the only card of Celexa. The LPN stated, "Yes" and then looked again and pulled out a brand new card (no medication removed) of Celexa 10 mg and stated, "It was in there, turned around backwards."

The LPN was then asked about the resident's cholecalciferol and opened the stock medication drawer and showed a bottle of cholecalciferol 1000 unit tablets. The LPN stated that she did not know how she missed that.

This portion of the medication pass and pour observation contained two medication errors out of 15 opportunities.

The remaining medication pass and pour observation was completed on another unit by another surveyor.

During a medication pass observation conducted on 4/10/18 at 8:50 AM, licensed practical nurse (LPN #1) began pulling R 114's medications for distribution. LPN #1 verbalized to the surveyor that Lexapro was not on the medication cart. LPN #1 then went to the facilities medication emergency medication box and was unable to administer the Lexapro, as there was none in the emergency supply box.

During the medication pass observation the surveyor asked what the process is for reordering medications. LPN #1 verbalized that when supply is getting low the nurse can reorder the medication via computer or call the pharmacy

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{F 759}	Continued From page 10 because some medications can't be reordered via computer. This portion of the medication pass and pour observation included one medication error out of 13 opportunities. The total medication pass observation included, three errors out of 28 opportunities; the facility's medication error rate was 10.7%. The administrator and DON (director of nursing) were made aware of the medication pass and pour observations, in a meeting with the survey team on 04/10/18 at approximately 4:45 p.m. No further information and or documentation was presented prior to the exit conference on 04/10/18 at 4:45 p.m.	{F 759}		