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
	345063	A. BUILDING _____ B. WING _____ JUL 08 2011	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1804 FOREST HILLS RD BOX 7166 WILSON, NC 27893

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to identify and investigate a bruise of unknown origin for 1 (Resident #151) of 1 sampled resident, and failed to investigate and report one allegation of abuse for 1 (Resident #160) of 1 sampled resident. Findings include: The Abuse Policy, dated 11/10/08, under the section titled " Definitions " the first sentence read in part: " Incident means alleged occurrences or episodes of staff misconduct and injuries of unknown origin. " Under the section titled " Investigation and Reporting Procedures " bullet #3 read in part: " Complete appropriate internal reports. An unusual occurrence incident report and investigation report will be completed for any physical injury. " 1. Resident #151 was admitted to the facility on 03/15/11. Cumulative diagnoses included dementia, agitation, adult failure to thrive, and osteoporosis. Review of the admission Minimum Data Set (MDS) assessment, dated 03/22/11, indicated the resident was cognitively impaired, needed	F 226	**This Plan of Correction (POC) constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by Federal and State Law.** **F-226(483.13)(c): DEVELOP/ IMPLEMENT ABUSE/NEGLECT, ETC POLICIES:** **DEFICIENCY HAS BEEN CORRECTED.** **1. For Resident #151, an investigation of origin of bruise was completed and cause of bruise determined.** **For Resident # 160, an investigation of the alleged abuse was completed. Both the 24-hour and the 5-Day reports were completed and filed with the state.** **Resident #160 was discharged home on 6/28/2011.** **2. All residents have the potential of having an injury of unknown origin occur or experience abuse.**	7/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jack Maguire Lic#2021 | TITLE: ADMINISTRATOR | (X6) DATE: 7/7/2011

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 226	Continued From page 1 extensive to total assistance for activities of daily living. The resident was assessed to be incontinent of bowel and bladder. On 06/12/11 at 5:15PM, Resident #151 was observed in the dining room for the dinner meal. The resident ' s right index finger; the web of the hand between the index finger and thumb; and, the second joint of the thumb were observed to have a bluish purple discoloration and the area appeared to be swollen. On 06/12/11 at 6:45 PM, Resident #151 was observed in the dayroom. The resident ' s right index finger; the web of the hand between the index finger and thumb; and, the second joint of the thumb were observed to have a bluish purple discoloration and the area appeared to be swollen. Review of the weekly skin assessment documentation, dated 06/06/11, read in part: " No new skin issues, skin warm and dry to touch. " Review of the weekly skin assessment documentation, dated 06/13/11, read in part: " No new areas noted to body. " On 06/14/11 at 3:30 PM, Resident #151 was observed sitting in her specialized wheelchair in the hallway at the A hall nurse ' s station. The resident ' s right index finger; the web of the hand between the index finger and the thumb; and, the second joint of the thumb were observed to have a bluish purple discoloration and the swelling of the area of the hand had lessened. On 06/15/11 at 2:00 PM, accompanied by Nurse	F 226	**A 100% skin audit was completed to identify any bruises, skin tears or injuries without a known origin. Investigations were completed for any newly identified finding.** **Additionally, a 100% interview audit was completed of cognitively appropriate residents to identify any experienced but unreported incidents of alleged abuse/neglect.** **3. Nurse #3 was in-serviced regarding the appropriate reporting and documentation of bruises, skin tears or injuries.** **On 6/28/2011, nursing staff was in-serviced on the appropriate reporting and documentation of bruises, skin tears and/or injuries. Facility staff was in-serviced regarding the identification and reporting of alleged or observed resident abuse and/or neglect.**	

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F 226	Continued From page 2 #4, the Resident #151 ' s right index finger; the web of the hand between the index finger and thumb; and, the second joint of the thumb were observed to have a bluish purple discoloration. The swelling of the finger and thumb and hand had dissipated. The Nurse confirmed she was the regular day hall nurse for the resident and had not seen the bruised area previously. On 06/15/11 at 2:15 PM, an interview was conducted with NA #6. The NA stated the staff was to report any bruises, skin tear, or injuries to the charge nurse. On 06/15/11 at 3:30 PM, The Director of Nursing (DON) approached and stated she had spoken to the weekend shift supervisor per phone. The DON indicated the supervisor relayed Nurse #3, who cared for the resident on Sunday (06/12/11), had completed an Unusual Occurrence (UO) form, a form used by the facility to report incidents and accidents, such as falls, skin tears, and bruises including the details of what had occurred. The DON stated she could not locate the UO form and had placed a call for Nurse #3 to call her back. On 06/15/11 at 4:35PM, a phone interview was conducted with Nurse #3. The Nurse indicated she had observed the discolored area on the Resident #151 ' s right hand on 06/12/11. She relayed she had asked the NAs about the discoloration; the NAs had stated it occurred when the resident had fallen the week before; and it had been reported. The Nurse stated, on 06/12/11, when she held the resident ' s hand to examine it; the resident complained of pain; and she had given her pain medication. She relayed	F 226	**4. Random interviews of 5 staff members per week for 3 months will be conducted by the Administrator, DON, ADON and other Department Heads on the facility policy on abuse/neglect and the reporting of bruises, skin tears or injuries.** **Additionally, a random sample of 5 resident interviews per week for 3 months will be conducted by members of the management team to inquire them on any unreported abuse/neglect experienced.** **The results of the random staff and resident interviews shall be presented at the monthly Quality Assurance Committee for recommended action and follow-up for at least 3 months or until there is 100 percent compliance.** **5. Corrective Action will be achieved by 7/8/2011.**	

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that she and her supervisor both looked at Resident #151 ' s right hand; saw the discoloration; but, the right index finger and thumb were not swollen. The Nurse stated she had not filled out an UO report because she was under the impression the right hand discoloration had been previously reported. She indicated she worked on the resident ' s hall on weekends. The Nurse confirmed she had worked the previous weekend; and, she had not seen the bruising on the right hand the previous weekend or on Saturday, 06/11/11.

On 06/15/11 at 5:15 PM, an interview was conducted with NA #4. The NA stated she worked with the resident frequently. She indicated she had not seen the area on the Resident #151 ' s right hand until she was asked about it by the surveyor in the dining room on Sunday evening (06/12/11). The NA relayed she told the surveyor she had not seen it before; but, she would report it to the nurse and she did. She stated the NAs were to report any skin problems, such as bruises, to the charge nurse. The NA revealed the resident can become agitated at times.

On 06/15/11 at7:00 PM, an interview was conducted with Nurse #2. The Nurse relayed she had not seen the bruised area on Resident #151 ' s right hand before this date. The nurse confirmed she was the regular nurse on the resident ' s hall on the evening shift.

On 06/15/11 at 7:15 PM, an interview was conducted with the DON. The DON stated her expectations were for the staff to report all injuries by completing an UO report form and confirmed she had not received the report for the

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F 226	Continued From page 4 area on Resident #151 ' s right hand. She indicated the UO report was utilized to investigate an injury, how it occurred, and put interventions in place, as needed, to attempt to prevent a reoccurrence. The DON relayed she would review the UO reports and would follow up on the incident or accident upon receipt of the report. 2. An interview with Resident #160 on 6/13/11 at 4:13pm revealed that she was handled roughly by a Nursing Assistant (NA) during her bath on Saturday 6/11/11. During the bath, the NA was lifting Resident #160 left arm. Resident #160 indicated to stop the bath due to her arm was hurting. The NA ignored Resident #160 and continued with the bath. Resident #160 indicated she had reported this to staff on 6/12/11. An interview with the Social Worker (SW) on 6/14/11 at 4:58pm revealed the incident with Resident #160 was reported to her on 6/13/11. The SW indicated it was documented and reported immediately to the Director of Nursing (DON). It was reported that Resident #160 was in pain during care. The NA said she was in a hurry and continued with the bath. The NA worked for an agency. The agency was contacted and the NA was taken off assignment at this time. A record review revealed a facility resident concern form dated 6/13/11 was completed. It	F 226		

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F 226	Continued From page 5 indicated the event occurred on 6/11/11. A 24-Hour and 5-Day report could not be produced. A record review of the facility policy tilted " Neglect and Abuse " dated 11/10/08 revealed the facility must follow local and state guidelines for reporting and always report to the State Survey and Certification Agency. Allegations of abuse should be reported immediately. The word immediately was described as soon as possible but ought not to exceed 24 hours after discovery of the incident. An interview with the DON on 6/15/11 at 2:06pm indicated the incident was just reported to her on 6/13/11. The DON had started an investigation on 6/14/11. She did not realize she needed to complete a 24-Hour and 5-Day report for this incident due to there was no injury. An interview with the Assistant Director of Nursing (ADON) on 6/15/11 at 3:28pm revealed that she would expect staff to report allegations of abuse immediately and complete a 24-Hour and 5-Day investigation report.	F 226		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to check placement of a gastrostomy tube prior to medication administration for 1 of 2 sampled residents with	F 281	**F-281(483.20)(k)(3)(i): SERVICES PROVIDED MEET PROFESSIONAL STANDARDS:** **DEFICIENCY HAS BEEN CORRECTED.** 7/8/11 1. **Resident #85 was assessed for the proper placement of the gastrostomy tube. The resident experienced no adverse reactions.**	

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F 281	Continued From page 6 gastrostomy tubes observed during medication pass (resident #85). Findings include: The facility's policy Administering Medications through an Enteral Tube, revised April 2010, read in part: "for gastrostomy tubes, check placement and gastric contents: a. attach 50 to 60 ml (milliliter) syringe containing approximately 10cc (cubic centimeters) air. b. Ausculate the abdomen (approximately 3 inches below the sternum) while injecting the air from the syringe into the tubing. c. Listen for "whooshing" sound to check placement of the tube in the stomach." Resident #85 was admitted to the facility on 2/11/11 with multiple diagnoses including cerebrovascular accident, dysphagia, and percutaneous endoscopic gastrostomy (PEG) tube. Observation of medication pass on 6/15/11 at 8:50AM revealed nurse #2 prepared to administer one aspirin 81mg (milligram) tablet, one multivitamin with minerals tablet, and one Percocet (oxycodone/acetaminophen) 2.5/325mg (narcotic analgesic) tablet by gastrostomy tube (GT). The nurse crushed the medications and dissolved them in water. Nurse #2 flushed the GT with 60ml of water, administered the medications by gravity flow, and then flushed the GT again with 60ml of water. The nurse did not check the placement of the GT prior to administering the medications. Record review of the resident's medication administration record revealed an entry dated 2/11/11 which read "verify PEG placement every shift."	F 281	**2. An audit of all residents with gastrostomy tubes was conducted to assure appropriate tube placement. All tubes were found to be appropriately placed.** **3. Nurse #2 was in-serviced regarding the facility protocol with respect to gastrostomy tube placement and procedure to check tube placement prior to medication administration.** **Licensed nursing staff was in-service on the facility protocol on gastrostomy tube placement and the checking for gastrostomy tube placement prior to medication administration.** **For all residents with gastrostomy tubes, a notation has been made in their MAR for the purpose of notification to the nursing staff of the facility protocol regarding the checking of the placement of gastrostomy tube prior to each medication administration. This will also occur with any new admissions with gastrostomy tubes.**	

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F 281	Continued From page 7 In an interview on 6/15/11 at 1:20PM, nurse #2 stated she was trained when hired and on the floor with the training nurse. The nurse stated she had also received in-service training on administering medications per GT. She stated "I usually check the tube placement but I was nervous today and forgot." In an interview on 6/16/11 at 10:04AM, the Director of Nursing stated the staff was trained when hired by the Staff Development Coordinator and with the nurses on the floor. She stated it was a nursing standard to check tube placement before administering medications. Her expectation was for the staff to always check placement before administering any medications.	F 281	**4. The DON, ADON or Nursing Supervisor will perform 5 random observations of gastrostomy tube medication administrations per week for 3 months. Results of these observation audits shall be presented at the monthly Quality Assurance Committee for recommended action and follow-up for the next 3 months or until a 99% compliance rate is achieved.** **5. Corrective Action will be achieved by 7/8/2011.**	
F 323 SS=D	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 record review and staff interviews, the facility staff failed to put the bed and chair alarm in place and failed to check if the alarms were in working order for 1 (Resident #151) of 4 sampled residents who had a history of falls. The findings include:	F 323	**F-323(483.25)(h): FREE OF ACCIDENT HAZARDS, SUPERVISION, DEVICES.** **DEFICIENCY HAS BEEN CORRECTED.** 7/8/11 **1. For Resident #151, assurance was made while the survey team was still present that their bed and wheelchair was equipped with properly operational alarms.** **2. A 100% audit was completed of residents care planned for chair and/or bed alarms to assure for their proper placement and operational condition.**	

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F 323	Continued From page 8 Resident #151 was admitted to the facility on 03/15/11. Cumulative diagnoses included dementia, adult failure to thrive, and osteoporosis. Review of Resident #151 ' s admission fall risk assessment, dated 03/19/11, revealed a score of 17. The assessment form indicated a total score of 10 or above identified the resident as being at high risk for falls. Review of the admission Minimum Data Set (MDS) assessment, dated 03/22/11, indicated the resident was cognitively impaired, needed extensive to total assistance for activities of daily living. The sitting and standing balance portion of the assessment revealed the activities in that section did not occur for Resident #151. The resident was assessed to be incontinent of bowel and bladder. The assessment indicated the resident had a history of falls; had a fracture related to a fall in 6 months prior to admission. Review of Resident #151 ' s care plan, dated 03/28/11, revealed one of the areas of concern was the resident was at risk for fall due to her history of frequent falls at home prior to admission, decreased mobility, incontinence and the use of psychotropic medication. The goal was that Resident #151 would not have a fall with injury through next review date. An intervention listed in the care plan was to have bed and chair alarms. Review of a fall incident report for Resident #151, dated 03/29/11 at 1:05 PM, revealed the resident was being fed by a staff member and the staff member left the room, Per the report the staff	F 323	**3. Staff was in-serviced on the appropriate placement, use and maintenance of bed/chair alarms for residents.** **4. The DON, ADON and Nursing Supervisors will conduct 5 random observations per week for 3 months of resident bed and/or chair alarms to ensure for their proper placement and operation. Results of these observation audits shall be presented at the monthly Quality Assurance Committee for recommended action and follow-up for the next 3 months or until a non-compliance rate of ≤ 1% is achieved.** **5. Corrective Action will be achieved by 7/8/2011.**	

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member returned to the room and found the resident between the bed, bedside table and wheelchair. A statement on the report read as: " Had chair alarm, didn ' t go off, so changed batteries. " An action to prevent potential for reoccurrence read in part: " Make sure chair alarm is working. " The nurse, who was on duty at the time of this fall, no longer worked at the facility

An interview, on 06/15/11 at 7:00 PM, was conducted with the Director of Nursing (DON). The DON stated that the alarm did not sound (referring to the 03/29/11 fall) and the batteries needed to be changed. She indicated she had another resident ' s alarm fail at a later date and had instructed the night shift Nurse Aides (NAs) to check the alarms once a week to assure the batteries were working in the alarm.

An interview, on 06/16/11 at 2:30 PM, was conducted with the DON. She indicated she had no mechanism in place to assure the alarm batteries had been checked. She stated on 06/15/11, she had the evening supervisor remind the NAs on night shift to check batteries on resident ' s bed and chair alarms once a week.

Review of a fall incident report for Resident #151, dated 05/04/11 at 4:45 PM, indicated the resident was found by therapist and nurse in the resident ' s doorway of her room. The documentation in the report revealed the chair alarm was not in place at the time of the fall.

An interview, on 06/15/11 at 7:00 PM, was conducted with Nurse #2, the nurse on duty at the time of the fall on 05/04/11. The nurse confirmed

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the chair alarm was not on the chair at the time of the fall. She indicated it was the NAs responsibility to make sure the alarm was in place when the resident was in the chair.

The NAs who was assigned to Resident #151 on 05/04/11 was an agency nurse aide and was not available for an interview.

A phone interview, on 06/23/11 at 10:30 AM was conducted with the DON. She stated prior to the fall of 06/03/11, the Resident #151 was in a regular wheelchair, and an alarm was to be used on the bed and chair for the resident. The DON relayed at the time of the 03/29/11 incident; the 05/04/11 incident; and, the 06/03/11 incident, the Kardex, a facility form used by the NAs to review information about the care needs of a resident and identified residents with an alarm, for Resident #151 would have listed the resident to have both a bed and chair alarm.

Review of a fall incident report for Resident #151, dated 06/03/11 at 8:30 AM, indicated the resident was found sitting on the mat next to her bed. One of the interventions listed on the report was to " assure the bed alarm was in working order. "

An interview, on 06/15/11 at 2:00 PM, was conducted with Nurse #4, the nurse on duty at the time of the fall on 06/03/11 8:30 AM. The nurse indicated the resident was in bed.
She relayed the resident was found sitting next to the bed and the bed alarm did not sound at the time of the fall. She stated it was the NAs responsibility to make sure the alarm was in place and in working order.

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AVANTE AT WILSON	1804 FOREST HILLS RD BOX 7166 WILSON, NC 27893

(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 323	Continued From page 11	F 323		

A phone interview, on 06/23/11 at 1:45PM, was conducted with NA #8, the NA listed as the person assigned to the Resident #151 on the 06/03/11 incident report. The NA stated she was not assigned to the resident, but was passing trays. She relayed she responded to a call light that was on for Resident #151 ' s room. When she entered the room, she indicated she found the resident on the floor. The NA confirmed the resident had been on the bed, had scooted onto the bed mat on the floor at the side of the bed and was attempting to get to her wheelchair. She said the bed alarm was not sounding at that time. The NA relayed she had been at the facility for about a month and did received instructions in orientation regarding checking the alarms. She indicated she was instructed to make sure the alarm was in working order and to assure the alarms were in place and on the bed or chair before placing the resident in the bed or chair.

An interview, on 06/16/11 at 1:46 PM, was conducted with NA #1. The NA stated she would make sure the alarm was working; and, make sure there were batteries in the alarm. She indicated she would check the alarm when she came on duty, before she left and probably in the middle of the shift.

An interview, on 06/16/11 at 1:50 PM, was conducted with NA #2, who was caring for Resident #151 this date. The NA relayed the NAs were responsible to make sure an alarm had batteries in it; and, the alarm was working. The NA stated she checked the alarm before she used it for the resident She indicated she was responsible to make sure the alarm was attached

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F 323	Continued From page 12 to the resident ' s bed; to keep a check on the resident with an alarm; and, if you heard an alarm, to go check on the resident right then. An interview, on 06/16/11 at 1:55 PM, was conducted with NA #3. The NA indicated any time an alarm goes off the NA would need to respond to the alarm right then. She relayed she was responsible to make sure an alarm was working if putting the resident in the chair. The NA stated the alarm will beep when you sit the resident down on the chair. She indicated if the alarm was on a bed, she would place her hand on the pad and when she removed her hand, the alarm would sound. The NA relayed the nurse would inform her if she had a new resident on an alarm and the information would also be on the Kardex. An interview, on 06/16/11 at 2:05 PM, was conducted with the Assistant Director of Nursing (ADON). The ADON relayed she went individually to staff members and demonstrated how the alarm pad worked when they recently received a new type of alarms. She indicated new staff received information regarding the alarms from the NA they are assigned to during orientation. The ADON stated the nurse on the hall had a meeting at the beginning of the shift with the NAs so they will know who has an alarm. She indicated the information was also placed on the Kardex. The ADON stated the Kardex form was updated frequently even daily when needed. She also stated the charge nurse keeps new batteries on the medication cart and the NAs are to accessed new batteries from the nurse. An interview, on 06/16/11 at 2:30 PM, was	F 323		

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F 323	Continued From page 13 conducted with the DON. The DON indicated it was her expectation for the staff to check the alarm to make sure it was in place on the bed or chair and functioning before they put the resident in the bed or chair if an alarm was in use. She relayed she would have to determine how to track when the alarm batteries were checked weekly by the night NAs. She stated training was done on an individual basis with regards to the expectations.	F 323		
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 observation, record review, and staff interviews, the facility failed to ensure residents were free from significant medication errors for 1 of 10 sampled residents observed during medication pass (resident #159). Findings include: Resident # 159 was admitted to the facility on 6/8/11 with multiple diagnoses including thrombocytopenia (low platelet count), coronary artery disease, cerebrovascular accident, and gastro-intestinal (GI) prophylaxis. Record review of the resident's clinical record revealed physician orders dated 6/8/11 for Aspirin 325mg (milligram) every other day, Clopidogrel 75mg every other day, and Famoditine 40mg daily before breakfast. Aspirin and clopidogrel are antiplatelet agents that decrease platelet aggregation and inhibit the formation of blood clots, and are used to treat	F 333	**F-333 (483.25)(m)(2): RESIDENTS FREE OF SIGNIFICANT MED ERRORS.** **DEFICIENCY HAS BEEN CORRECTED.** **1. For resident #159, the resident was evaluated for any adverse reactions and there were none. MAR was reviewed and corrected for the appropriate scheduling of anticoagulants. Nurse #2 was in-serviced regarding medication errors with emphasis on administration of anticoagulants. Doctor was notified and orders remained as originally written.** **2. A 100% MAR audit was completed on all residents receiving anticoagulants for appropriate scheduling/administration of anticoagulants. All were in compliance with physician orders.**	7/8/11

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F 333	Continued From page 14 cardiovascular and/or cerebrovascular disease. Famotidine is an acid reducing agent used as preventative treatment to reduce the risk of developing GI ulcers or bleeding. Lexicomp's Drug Information Handbook, 14th edition, stated in part: "Aspirin - Warnings/Precautions - use with caution in patients with platelet and bleeding disorders...Adverse Reactions - as with all drugs which may affect hemostasis, bleeding is associated with aspirin...risk is dependent on multiple variables including dosage, concurrent use of multiple agents which alter hemostasis, and patient susceptibility. Clopidogrel - Warnings/Precautions - use with caution in patients who may be at risk of increased bleeding...use caution in concurrent treatment with other anti-platelet drugs, bleeding risk is increased." The resident's hospital transfer/discharge summary dated 6/8/11 read in part: "noted to have some mild thrombocytopenia...platelet count prior to discharge was 133,000...due to thrombocytopenia as previously described above his aspirin was changed to every other day as was his Plavix (clopidogrel) with rotating dose...continued monitoring of his platelet count." Observation of medication pass on 6/15/11 at 9:25AM revealed nurse #2 administered one aspirin 325mg tablet. Review of the resident's medication administration record (MAR) revealed an entry dated 6/9/11 which read "Aspirin 325mg every other day." Review of the MAR revealed the	F 333	**3. Licensed nursing staff was in-serviced on medication administration protocols with MAR scheduling of anticoagulants.** **4. The DON, ADON and Nursing Supervisors will review all new anticoagulant orders to ensure for proper transcription of orders to the MAR. .Results of the review will be maintained on a tracking log.** **Each week for the next 3 months, 5 random audits of the MAR's of residents receiving anticoagulants will be completed by the DON, ADON and Nursing Supervisors to ensure for appropriate scheduling and administration of anticoagulants.** **5. Corrective Action will be achieved by 7/8/2011.**	

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F 333	Continued From page 15 aspirin had been charted as given daily since 6/9/11 rather than every other day. Record review of the laboratory section of the resident's clinical record revealed a complete blood count (CBC) dated 6/14/11. The CBC results revealed a platelet count of 150,000 per uL (microliter), normal range of 150,000 - 450,000 per uL. In an interview on 6/15/11 at 5:33PM, nurse #2 reviewed the MAR and acknowledged the order indicated aspirin was to be given every other day, but had been given daily since 6/9/11. The nurse stated it was an oversight on her part. She indicated she would call the physician and complete a medication error report. In an interview on 6/16/11 at 1:52PM, the Director of Nursing (DON) stated the staff was trained when hired and with another nurse during orientation. She stated the staff attended a healthcare academy, which included a class on the five medication rights and reducing medication errors. She indicated the staff was trained to double check the MARS when giving medications. The DON stated the nursing supervisors and the pharmacy staff completed medication pass observations. Her expectation was for the staff to follow the five rights of medication administration and give medications according to the physicians' orders.	F 333		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431	**F-431(483.60)(d)(e): DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS.** **DEFICIENCY HAS BEEN CORRECTED.** **1. The refrigerators in Medication Rooms A and B for the storage of drugs and biological have been replaced with new frost free ones.**	7/8/11

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F 431	Continued From page 16 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based upon observations and staff interviews the facility failed to maintain medicine storage refrigerator temperatures between 36 degrees to 46 degrees fahrenheit for 2 of 2 medicine storage rooms.	F 431	**2. The refrigerators in Medication Rooms A and B for the storage of drugs and biological have been replaced with new frost free ones.** **3. The daily temperature monitoring log has been updated to reflect the acceptable and safe numeric temperature ranges and with information on who to notify if the temperature is outside the acceptable operational range. Additionally, licensed nursing staff has been in-serviced on refrigerator temperature compliance standards.** **4. In addition to the nursing staff performing the daily temperature monitoring of the refrigerators in both Med Room A and Med Room B, the DON, ADON or Nursing Supervisors will daily for 3 months audit/monitor the refrigerator temperatures. Results of this daily audit will be presented to the Quality Assurance Committee for recommended action and follow-up for the next 3 months or until a non-compliance rate of ≤ 1% is achieved.** **5. Corrective Action will be achieved by 7/8/2011.**	

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F 431	Continued From page 17 Findings Include: An observation on 6/16/11 at 8:12am in medicine storage room B revealed the medicine storage refrigerator temperature to be 29 degrees fahrenheit. The Director of Nursing (DON) was present during the observation. There were insulin vials and suppository medications in the medicine storage refrigerator. An interview on 6/16/11 at 8:14am with the DON revealed the medicine storage refrigerator temperature should be at least 32 degrees fahrenheit. The DON said she would have someone look at the refrigerator today. An observation on 6/16/11 at 10:58am in medicine storage B revealed the medicine storage refrigerator temperature was 29 degrees fahrenheit. Nurse Supervisor #1 was present during the observation. The insulin vials and suppositories remained in the refrigerator. An interview with Nurse Supervisor #1 on 6/16/11 at 11:00am revealed the temperature should be between 34 degrees to 46 degrees. She indicated the thermometer may be broken and would have to get a new thermometer. An observation on 6/16/11 at 11:16am in medicine storage room A revealed the medicine storage refrigerator temperature to be 32 degrees farienthiet. Nurse #1 was present during the observation. There were insulin vials and 2 intravenous 0.9% Sodium Chloride Bags located in the medicine storage refrigerator. There was heavy ice buildup in the freezer section of the	F 431		

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	345003	A. BUILDING _____ B. WING _____	06/16/2011

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F 431	Continued From page 18 refrigerator. Three nutritional supplements were frozen into the ice buildup and could not be extracted. A record review of the facility medication storage temperature logs dated from March 2011 to June 2011 revealed temperatures out of range from 30 degrees to 34 degrees fahrenheit. An Interview with the Pharmacist on 6/16/11 at 12:25pm revealed that intravenous fluids and insulin were not typically refrigerated. A temperature of 29 degrees fahrenheit would be too low to store insulin products.	F 431		

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	345063	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/06/2011

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/6/11 at approximately noon the following corridor door was non-compliant, specific findings include; kick down on the DON's office, across from laundry. There is no impediment to closing of the doors.	K 018	**This Plan of Correction (POC) constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by Federal and State Law.** K – 018: No door closure impediment. DEFICIENCY CORRECTED ***What corrective action (s) will be accomplished by the facility to correct the deficient practice?*** The "kick-down" device" on the office door of the Director of Nursing was removed 7/7/2011. ***How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken:*** Facility doors were checked to identify any additional door(s) which may have been equipped with any device which was an impediment to the door closing. There were none. ***What measures will be put in place or what systemic changes will you make to ensure the deficient practice does not recur:***	7/22/11
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029	The inspection and checking of doors for any device which is an impediment to the door being able to close has been added to the monthly PMP (preventive maintenance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mel Mogueis Lic#2021 | TITLE: ADMINISTRATOR | (X6) DATE: 7/22/2011

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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	345083	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/06/2011

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K 029	Continued From page 1 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/6/11 at approximately noon the following hazardous area was non-compliant, specific findings include; door to the dryer side of laundry did not close and latch tightly in it's frame.	K 029	program). Any device identified/found shall be removed. Further, members of the maintenance and environmental services teams have been in-serviced on the identification of any device on a door which may be an impediment to its closure and who to report it to for removal. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The results of the monthly preventive maintenance program (PMP) inspections of doors for any device which may be an impediment to its closure shall be presented to the facility monthly Safety Committee and Quality Assurance Committee for the next three months to assure for ongoing compliance. Continued monitoring will be determined by the Quality Assurance Committee. ***Date the corrective action will be completed:*** Corrective action was completed on 7/22/2011. **K – 029: Self-closing/latching doors.** DEFICIENCY CORRECTED ***What corrective action (s) will be accomplished by the facility to correct the deficient practice?***	7/22/11
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/6/11 at approximately noon the following exit access items were non-compliant, specific findings include; A. The exit access doors in the interior courtyard had passage hardware that could be locked. B. The kitchen door was equipped with a slide bolt.	K 038		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

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K 050	Continued From page 2 varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By document review on 7/6/11 at approximately noon the following fire drills were noncompliant, specific findings include; the last four fire drills on third shift for 2010 & 2011 were held between 6:00 AM and 6:40 AM only. Fire drills are to be held at unexpected times.	K 050	The fire rated door for the dryer room has been repaired to achieve self closing and self latching compliance when released. ***How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken:*** All facility doors required to fully close and securely latch upon release have been inspected. No additional doors were found to be in non-compliance. ***What measures will be put in place or what systemic changes will you make to ensure the deficient practice does not recur:*** The inspection and checking of doors for proper self closing and self latching operational compliance has been added to the monthly PMP (preventive maintenance program).	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by:	K 052	***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The results of the monthly preventive maintenance program inspections of self closing/self latching doors will be presented at the facility monthly Safety Committee and the Quality Assurance Committee for each of the next three monthly meetings. Continued monitoring will be determined by the Quality Assurance Committee.	

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K 052	Continued From page 3 42 CFR 483.70(a) By observation on 7/6/11 at approximately noon the following fire alarm/fire protection items were non- compliant, specific findings include; A. When testing the fire alarm system, the component for the phone lines to the fire alarm panel could not be tested for trouble. The facility was not familiar with the location of the phone lines and/or a disconnect was not provided at the panel. B. Documentation for smoke detector sensitivity testing was not available. C. The fire extinguisher, located in the outside electrical/telephone room, had not been inspected for the annual inspection in June 2011. Other fire extinguishers located in the facility recently had their annual inspection.	K 052	***Date the corrective action will be completed:*** Corrective action was completed on 7/22/2011. **K – 038; Egress access.** DEFICIENCY CORRECTED *A. Exit access doors in the interior courtyard had locks.* *B. 1 Kitchen door had slide bolt.* ***What corrective action (s) will be accomplished by the facility to correct the deficient practice?*** 1. The courtyard door passage hardware has been replaced with non-locking hardware. 2. The slide-blot hardware has been removed from the kitchen door.	7/22/11
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) At the time of survey, the facility was using the corridor as a return air plenum. Note: If a waiver is requested, the provider must certify that the following conditions are met: (1) Air handling units must be equipped with smoke detectors. (2) There must be a complete corridor smoke detection system. (3) Smoke detectors must be wired to the fire alarm system. (4) Fire alarm	K 067	***How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken:*** An audit of facility doors was conducted and no additional doors were identified with non-compliant passage hardware or slide-bolts. ***What measures will be put in place or what systemic changes will you make to ensure the deficient practice does not recur:*** The inspection and checking of doors for egress access passage hardware compliance and for slide-bolts or other non-compliance locking	

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
	345063	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1804 FOREST HILLS RD BOX 7156 WILSON, NC 27893

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K 067	Continued From page 4 system must shut down all air handling units when activated.	K 067	hardware has been added to the monthly PMP (preventive maintenance program). ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The results of the monthly preventive maintenance program inspections of doors for egress access passage hardware compliance and for non-compliant locking hardware devices will be presented to the facility monthly Safety Committee and the Quality Assurance Committee for each of the next three monthly meetings. Continued monitoring will be determined by the Quality Assurance Committee. ***Date the corrective action will be completed:*** Corrective action was completed on 7/22/2011.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/6/11 at approximately noon the following operational inspection and testing was non-compliant. Specific findings include: documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate	K 144	<u>K – 050: Fire drills – unexpected times:</u> DEFICIENCY CORRECTED ***<u>What corrective action (s) will be accomplished by the facility to correct the deficient practice?</u>*** The confidential fire drill schedule has been revamped to assure for the conduction of all drills at various unexpected times on the various shifts going forward (see attachment A).	7/22/11

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	345063	A. BUILDING _____ B. WING 01 - MAIN BUILDING 01	07/06/2011

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AVANTE AT WILSON	1804 FOREST HILLS RD BOX 7156 WILSON, NC 27893

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Date the corrective action will be completed:

Corrective action was completed on 7/22/2011.

K – 052: Fire Alarm System Testing: 7/22/11
DEFICIENCY CORRECTED

1. Phone line trouble test.
2. Smoke detector sensitivity testing.
3. Fire extinguisher inspection.

What corrective action (s) will be accomplished by the facility to correct the deficient practice?

1. Simplex Grinnell on 7/22/2011 has validated the phone lines to the fire alarm panel and tested for appropriate operation.
2. Smoke detector sensitivity testing was conducted and completed by Simplex Grinnell on 7/21/2011 demonstrated full compliance (see attachment B).
3. Fire extinguisher inspection has been completed for the 1 extinguisher in the phone mechanical room.

How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken:

1. Phone line testing has been added to monthly alarm system check.
2. Current annual Simplex Grinnell maintenance

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AVANTE AT WILSON	1804 FOREST HILLS RD BOX 7156 WILSON, NC 27893

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agreement has been modified to include annual detector sensitivity testing per standard.

3. The location of each facility fire extinguisher has been documented on a facility floor plan for use to assure that all required extinguishers are present and charge checked on the monthly and annual inspections (see attachment C).

What measures will be put in place or what systemic changes will you make to ensure the deficient practice does not recur:

1. Phone line testing has been added to monthly fire panel/alarm system check.
2. Current annual Simplex Grinnell maintenance agreement has been modified to include annual detector sensitivity testing.
3. The location of each facility fire extinguisher has been documented on a facility floor plan to assure that all required extinguishers are present and
4. inspected for charge on a monthly and annual basis.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

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AVANTE AT WILSON	1804 FOREST HILLS RD BOX 7166 WILSON, NC 27893

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			1. Results from monthly system testing and 2. Results of monthly fire extinguisher inspections will be presented to the facility monthly Safety Committee and the Quality Assurance Committee for each of the next three monthly meetings. Continued monitoring will be determined by the Quality Assurance Committee. Simplex Grinnell has already been requested to schedule the facility for the 2012 sensitivity testing of the detectors. The report of this year's testing on 7/21/11 will be presented at the next meeting of the Safety Committee and the Quality Assurance Committee. ***Date the corrective action will be completed:*** Corrective action was completed on 7/22/2011.	
			K – 067: HVAC compliance. ***What corrective action (s) will be accomplished by the facility to correct the deficient practice?*** The corridors are functioning as the return air plenum. This is currently under waver and a 12-month waver extension is requested due to the following conditions that are in place to meet standards/code requirement compliance: 1. Air handlers are currently appropriately equipped with duct detectors.	Waver

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	345063	A. BUILDING _____ B. WING 01 - MAIN BUILDING	07/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1004 FOREST HILLS RD BOX 7166 WILSON, NC 27893

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			2. There currently is in place a complete corridor smoke detector system throughout the building. 3. All detectors in the item #2 system are currently tied into the fire alarm system, and 4. The current fire alarm system does shut down the air handlers when in alarm mode. **Date the corrective action will be completed:** 12-month waver extension requested via separate letter on 7/22/2011 to DHHS Division of Health Services Regulation, Construction Section.	
			K – 144: Generator Inspection/Exercise: DEFICIENCY CORRECTED **What corrective action (s) will be accomplished by the facility to correct the deficient practice?** Engineers of Watson Electric completed generator load test per standards. **How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken:** Watson Electric engineers trained facility maintenance staff on how to calculate load percentage as a percentage of the EPS nameplate rating and run the load test for	7/22/11

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monthly testing of at least 30 minutes. Documentation altered to reflect testing result tracking per standards.

What measures will be put in place or what systemic changes will you make to ensure the deficient practice does not recur:

The emergency power generator system is tested monthly under calculated load standards to assure for proper operation and results documented.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

The results of the weekly and monthly testing of the generator will be brought to the monthly Safety Committee and Quality Assurance Committee for each of the next three monthly meetings for testing compliance tracking/monitoring. Continued monitoring will be determined by the Quality Assurance Committee.

Date the corrective action will be completed:

Corrective action was completed on 7/22/2011.