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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	10/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	1. Resident #46 has been discharged From the facility. Resident #27 has Been issued a new Notice of Exclusions Form Medicare Benefits form that was appropriately filled out in all sections. 2. All Notice of Exclusions from Medicare Benefits forms were audited for the past six months and any identified issues were corrected. 3. The Social Worker was inserviced by by the Administrator on the notification process utilizing the Notice of Exclusions from Medicare Benefits form. Weekly audits of the forms will be conducted by the Administrator or designee to ensure that all sections are completed accurately. The results of the audits will be documented on the Weekly Notice of Exclusions from Medicare Benefits Audit Form. 4. The results of the Notice Of Exclusions from Medicare Benefits Audit Form will be reviewed in the monthly QA meeting to identify trends and any need for further action for 3 months. After compliance is achieved, a random monthly audit will performed by the Administrator or designee to monitor any need for further action	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John P. Walder — TITLE: Administrator — (X6) DATE: 11/9/12

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 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 156		

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F 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide 2 of 3 sampled residents with all required information in the Notice of Exclusions from Medicare Benefits. (Residents #27 and #46). The findings are: 1. Review of the Notice of Exclusions from Medicare Benefits revealed Resident #46's medicare benefits were going to end on 05/22/12. The notice did not include the reason the medicare benefits were ending. The section on the notice that allowed for the facility to check the reason the facility believed Medicare would not pay any longer was left blank. Interview on 10/24/12 at 5:11 PM with the social worker who was responsible for sending the	F 156		

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F 156	Continued From page 3 Notice of Exclusions from Medicare Benefits revealed she should have checked the reason on the form but just missed it. 2. Review of the Notice of Exclusions from Medicare Benefits revealed Resident #27's medicare benefits were going to end on 07/12/12. The notice did not include the reason the medicare benefits were ending. In addition, there was no option checked by the resident indicating whether or not she wanted to receive the services and request Medicare review the facility's decision relating to Medicare coverage. Interview on 10/24/12 at 5:11 PM with the social worker who was responsible for sending the Notice of Exclusions from Medicare Benefits revealed she should have checked the reason on the form but just missed it. In addition, she revealed the options were always discussed with the resident and/or responsible party and she failed to make sure Resident #27 checked an option on the form.	F 156		11/22/2012
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide clean floors without dirt accumulation in corners and dust accumulation on baseboards in 6 resident rooms and failed to replace a heavily soiled privacy curtain in 1	F 253	1. Necessary housekeeping services were provided to Rooms 112, 115, 121, 124, 127 and 137. Any buildup of dust was removed from floors and baseboards, the privacy screens were checked for stains and the corners were cleaned.	

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F 253	Continued From page 4 resident room. (Rooms 112, 115, 121, 124, 127, and 137). The findings are: 1. There was a buildup of dust and dirt on floors and baseboards as follows: a. Observation on 10/22/12 at 2:52 PM of Room 112 revealed dust accumulation on the top edge of the baseboards and dirt accumulation in both corners near the door. Additional observations on 10/23/12 at 7:58 AM and 10/25/12 at 9:45 AM revealed the dust and dirt accumulation still present. b. Observation on 10/22/12 at 3:01 PM revealed dust accumulation was present on the top edge of the baseboards and dirt accumulation was observed in both corners near the door. Additional observations on 10/23/12 at 10:20 AM, 10/24/12 at 4:02 PM and 10/25/12 at 9:55 AM revealed the dust and dirt accumulation still present. c. Observation on 10/22/12 at 3:15 PM of Room 121 revealed dust accumulation on the top edge of the baseboards and dirt accumulation in both corners near the door. Additional observations on 10/23/12 at 4:12 PM and 10/25/12 at 9:50 AM revealed the dust and dirt accumulation still present. d. Observation on 10/22/12 at 3:33 PM of Room 127 revealed dust accumulation on the top edge of the baseboards and dirt accumulation in both corners near the door. Additional observations on 10/23/12 at 10:09 AM and 10/25/12 at 9:57 AM	F 253	2. A facility wide audit was conducted to detect loose dust, buildup in corners and cleanliness of privacy screens and any identified issues were corrected. 3. The housekeeping staff were inserviced on proper housekeeping procedures hat included cleaning loose dust, ensuring privacy screens are clean and dust buildup in corners. Each week, ten random room inspections will be conducted by the Director of Housekeeping or designee. The results of the audits will be documented on the Weekly Housekeeping Room Audit sheets for a period of three months. 4. The results of the Weekly Housekeeping Room Audit Sheets will be reviewed in the monthly QA meeting to identify trends and need for further action for 3 months. After compliance is achieved, a random monthly audit will be performed by the Director of Housekeeping or designee to monitor any need for further action	

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F 253	Continued From page 5 revealed the dust and dirt accumulation still present. e. Observation on 10/22/12 at 4:23 PM of Room 137 revealed dust accumulation on the top edge of the baseboards and dirt accumulation in both corners near the door. Additional observations on 10/23/12 at 9:46 AM, 10/24/12 at 1:00 PM and 10/25/12 at 9:59 AM revealed the dust and dirt accumulation still present. f. Observation on 10/23/12 at 10:22 AM of Room 115 revealed dust accumulation on the top edge of the baseboards and dirt accumulation in both corners near the door. Additional observations on 10/24/12 at 11:27 AM and 10/25/12 at 9:47 AM revealed the dust and dirt accumulation still present. An interview on 10/25/12 at 9:55 AM with Housekeeper #1 revealed that housekeeping staff swept and mopped all resident rooms every day. An interview on 10/25/12 at 10:30 AM with the Housekeeping Supervisor revealed that he expected for floors to be free of dirt accumulation in the corners and for baseboards to be free of dust accumulation. He stated it had been difficult to remove some of the dirt visible at the bottom of the baseboards because it had gotten stuck in the floor wax. An interview on 10/25/12 at 1:10 PM with the Administrator revealed that his expectation was for housekeeping staff to remove dirt from the corners and to remove dust from the baseboards.	F 253		

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F 253	Continued From page 6 2. Observation on 10/22/12 at 3:01 PM of the privacy curtain in Room 124 between A and B beds revealed several brown stains approximately 12 to 18 inches up from the bottom of the curtain. Observation on 10/24/12 at 4:02 PM revealed the resident in 124B bed attempting to open the privacy curtain with the multiple brown stains clearly visible. An Interview on 10/24/12 at 4:15 PM with Nurse Aide #1, who is regularly assigned to provide care for the residents in room 124, revealed she first noticed the stains on the privacy curtain about a month ago and assumed it was tobacco spittle because one of the residents in the room dips snuff. An interview on 10/25/12 at 9:55 AM with Housekeeper #1, who is regularly assigned to clean room 124, revealed privacy curtains were checked every day and replaced if they were soiled. She stated she had not noticed the curtain was soiled in room 124 and stated one of the residents is messy with snuff. An interview on 10/25/12 at 10:30 AM with the Housekeeping Supervisor revealed that his expectation was for privacy curtains to be changed whenever they were soiled. An interview on 10/25/12 at 1:10 PM with the Administrator revealed that his expectation was for privacy curtains to be changed whenever they were soiled.	F 253		11/22/2012
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		

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F 312	Continued From page 7 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to keep 1 of 3 sampled resident's fingernails trimmed and cleaned. (Resident # 15). The findings are: Resident #15's diagnoses included contractures and senile dementia. The most recent Minimum Data Set, a quarterly dated 10/15/12, coded him with cognitive impairment and requiring extensive assistance with dressing, bathing and hygiene. The care plan that addressed Resident #15's activity of daily living deficit was last updated on 10/24/12. The care plan stated Resident #15 required extensive to total assistance with personal hygiene care. Resident #15 was observed with long fingernails, some up to a quarter of an inch in length beyond the tip of his finger, and with dark brown debris under most of them as follows: *On 10/22/12 at 11:15 AM he was observed with long fingernails with brown debris underneath. On 10/23/12 at 10:10 AM he was lying in bed with long fingernails, uneven and jagged with brown debris remains under nails. *On 10/24/12 at 8:05 AM when he was repositioned in bed and set up for his breakfast tray, which he fed himself.	F 312	1. Deficiency Corrected. Nail care was provided for resident #15 is receiving the necessary services for activities of daily living 2. An audit was conducted of all resident's finger nails by the Administrative Team. Any identical issues were documented and corrected on the weekly Nail Audit Form 3. Nursing staff were inserviced on providing ADL care to dependent residents . A weekly nail audit will be completed by the Administrative Room Round Team and any identified issues will be reported in the morning meeting. The DON or designee will document the correction date after nail care has been completed on the Weekly Nail Audit Form. These audits will be completed for 3 months. 4. The results of the Weekly Nail Audit Forms will be reviewed monthly at the Quality Assurance Meeting to identify trends and need for further action for a period of 3 months. After compliance is achieved , a random monthly audit will be performed by the DON or designee to monitor need for further action.	

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F 312	Continued From page 8 *On 10/24/12 at 10:35 AM when he was up in the hall in a wheelchair after he received morning care by Nurse Aide (NA) #2. *On 10/24/12 at 11:33 AM while in the dining room drinking from a cola can. *On 10/24/12 at 12:16 PM while in the dining room feeding himself lunch. *On 10/24/12 at 2:45 PM while transferred back to bed by two nurse aides. On 10/24/12 at 2:49 PM, Nurse #3 stated nursing assistants complete nail care anytime morning or afternoon. On 10/24/12 at 2:52 PM, interview with NA #2 revealed she took care of Resident #15 during first shift on 10/22/12, 10/23/12 and 10/24/12 this week. She stated nails were to be checked every day during morning care and care given as needed. NA #2 further stated she had not tried to cut or clean Resident #15's nails this week but she did acknowledge his nails needed trimming and cleaning. On 10/24/12 at 2:55 PM, Nurse #3 looked at Resident #15's fingernails and stated they should have been trimmed and cleaned and that he sometimes ate with his fingers. She further stated residents' nails are checked every week. On 10/24/12 at 3:01 PM interview with the Director of Nursing revealed nail care was looked at during daily rounds by administrative staff and weekly during a quality assurance monitoring system. Nail care was to be provided as needed. Review of the documented quality assurance monitoring rounds revealed no administrative rounds for Resident #15 and his section for last	F 312		

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F 312	Continued From page 9 week. On 10/25/12 at 1:46 PM the Assistant Director of Nursing stated she observed Resident #15's nails on 10/24/12 and acknowledged they needed trimming and cleaning. She stated she provided care at that time.	F 312		11/22/2012
F 364 SS=B	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to serve hot food items hot for 2 of 15 residents interviewed for food palatability (Residents #86 and #11). The findings are: 1. Resident #86 was admitted to the facility on 5/23/12 and readmitted on 9/11/12 with diagnoses that included pneumonia and a urinary tract infection. The admission Minimum Data Set (MDS) dated 9/14/12 specified the Resident's cognition was not impaired and that she was independent with eating. On 10/23/12 at 10:00 AM, Resident #86 was interviewed and reported she ate her meals in her room but the food was often served cold. She specified the food was cold almost daily. She	F 364	1. Residents #11 and #86 are receiving foods at proper temperatures. 2. All residents are receiving food that is at proper temperatures. Tray delivery lists were reviewed and rearranged to assure timely delivery.	

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F 364	Continued From page 10 stated that she had not reported her concern to the facility. She stated she preferred her food to be served hot because it tasted better. On 10/24/12 at 11:30 AM until 1:20 PM a continuous observation was made of the lunch meal service and meal tray delivery system for the facility. Observations of the tray line service revealed the cook measured the temperature of the hot food items prior to meal service that revealed the items were above the required 135 degrees Fahrenheit. The cook was interviewed and reported that she monitored food temperatures at the beginning of the tray line to ensure food was served hot. She added that plate warmers were also utilized to help maintain the temperature of food. Observations revealed two plate warming units to heat plates and insulated bases. Both warming units were observed to be on and in use. The warming unit for the insulated plate bases was observed and noted to have two stacks of bases. Both stacks were noted to have bases stacked past the inside of the warming unit by as many as nine bases. The bases that were outside of the warming unit were not warm to touch. At 11:45 AM dietary aide #1 unplugged the warming unit for the insulated bases. Dietary aide #1 was interviewed and stated it was her usual practice to unplug the insulated base warming unit when starting tray line because the electrical cord was not long enough to reach from the wall to the tray line. At 11:50 AM the cook unplugged the warming unit for the plates. The cook was interviewed and reported it was her usual practice to unplug the machine because it made the plates too hot to touch. The cook was	F 364	3. Cooks were inserviced on the warming Units for plates and bases to remain plugged in during the entire tray line process. Nursing staff were inserviced on closing meal cart doors and tray delivery process. A random weekly interview of ten residents will be performed by the Dietary Manager regarding food temperature and documented on the Food Temperature Interview Form. Any identified issues will be reported in the morning meeting. A random weekly audit of the tray line will be completed by the Dietary Manager of six different meals to verify warming units are in use and documented on the Warming Unit Audit Form. These audits will be completed for three months. 4. The results of the Food Temperature Interviews and the Warming Unit Audits will be reviewed in the monthly Quality Assurance Meeting to identify trends for a period of three months.	

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F 364	Continued From page 11 observed to use her hands to handle the plates. She was unaware of a suction device for removing hot plates. Both warming units remained unplugged during the tray line from 11:45 AM to 1:20 PM. On 10/24/12 at 12:50 PM the cart containing Resident #86's meal tray arrived on the hallway. Resident #86 was served her tray at 12:56 PM and was interviewed. She specified the food was not hot enough but did not wish to complain. On 10/24/12 at 1:10 PM a test tray was sampled with the Dietary Manager (DM) the food was warm but not hot. During this time the DM was interviewed and reported she had not been aware of concerns with cold food. She added she monitored the temperatures of food weekly and had not observed problems. She was not aware dietary staff unplugged the warming units for tray line and added she would expect them to be in use throughout the tray line to help maintain food temperature. 2. On the most recent Minimum data Set, a quarterly dated 08/21/12, Resident #11 scored a 12 out of 15 on the brief interview for mental status indicating some cognitive impairment. She was coded as having no delirium and no behaviors and being independent with eating. Resident #11 was observed eating lunch in the main dining room on 10/22/12. Resident #11 stated during interview on 10/24/12 at 10:48 AM that half the time the food was not served at the correct temperature and it was too cold. Observations were made of tray delivery service in the main dining room on 10/24/12. At 12:04	F 364		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	10/25/2012

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

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F 364	Continued From page 12 PM the first cart was delivered to the dining room with 15 trays. As trays were served, the door to the insulated cart was left open. At 12:10 PM, 6 trays remained in the first cart for residents who were not in the dining room. At 12:14 a second cart with 16 trays was delivered to the dining room. At 12:23 PM the trays on the two carts are rearranged and 6 trays are sent to the hall. At 12:21 PM a third cart arrived in the dining room. Again staff rearrange trays and sent another cart to the hall at 12:25 PM with some trays left from the cart sent to the dining room originally at 12:04 PM. Interview with Nurse Aide #3 on 10/24/12 at 12:29 PM revealed that the trays come to the dining room for residents who normally eat in the dining room. When residents do not go to the dining room, then the trays are rearranged for the various halls and sent to be delivered to the halls.	F 364		11/22/2012
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 controlled drugs in sufficient detail to enable an accurate reconcillation; 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.	F 431	1. Deficiency Corrected. Resident #128 received a new bottle of Latanoprost and the expired bottle was discarded on 10/24/12. The two bottles of expired eyes drops that were not in use were removed from the cart and appropriately discarded on 10/24/12 2. All medication carts were inspected for any expired eye drops and any identified issues were corrected.	

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F 431	Continued From page 13 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 on observation and staff interviews the facility failed to discard 3 bottles of expired eye drops with 1 bottle currently in use on 2 of 4 medication carts. (Resident #128). The findings are: A. Medication cart A on the ICF unit was observed on 10/24/12 at 3:50 PM. A bottle of latanoprost 0.005% eye drops (used for glaucoma) for Resident #128 was observed available for use. The date opened was documented on the bottle as 09/05/12. At this time Nurse #1 stated she was not sure how long the eye drops were good after opening and presented a Recommended Minimum Medication Storage sheet. Review of this sheet revealed,	F 431	3. Nurse's were inserviced on proper storage parameters, checking expiration dates, and medications being removed from carts when medication is discontinued to return to pharmacy. A random weekly audit will be conducted by the DON or designee of medication carts to look at 10 medication expiration dates. These audits will be documented on the Medication Expiration Date Audit Form. These audits will be completed for a period of three months. 4. The results of the Medication Expiration Date Audit Form will be reviewed in the monthly QA meeting to identify trends and need further action for 3 months. After compliance is achieved, a random monthly audit will be performed by the DON or designee to monitor and any need for further action	

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F 431	Continued From page 14 based on manufacturer package inserts, any unused portion of these eye drops should be discarded after 6 weeks of opening. Review of the Medication Administration Record for Resident #128 revealed the Resident received the expired eye drops on 10/24/12 at 10:00 AM. B. Medication cart B on the ICF unit was observed on 10/24/12 at 4:00 PM. A bottle of tetrahydrozoline eye drops was observed on the cart available for use. The date opened on the bottle was 05/28/10 and had a manufactures expiration date of 08/12. Another bottle of tetrahydrozoline eye drops was observed on the cart available for use. The date opened on the bottle was 08/28/10 and had a manufactures expiration date of 08/12. At this time Nurse #2 stated neither of the eye drops were currently in use and all nurses were responsible for checking the medications on the carts to ensure they have not expired. During an interview on 10/24/12 at 5:00 PM, the Director of Nursing (DON) stated that pharmacy came in monthly to do quality assurance checks but all nurses were responsible to check their carts for expired medications. During a follow up interview on 10/25/12 at 3:15 PM, the DON stated her expectations were for the medication nurses to check the dates of any medications prior to administration, remove the expired or discontinued medication from the cart and then take appropriate action to obtain a new medication.	F 431	**Filing the Plan of Correction does not Constitute an admission that the Deficiencies alleged, did, in fact, exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality resident care.**	11/22/2012