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
	345227	A. BUILDING ______ B. WING ______	C 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT REIDSVILLE	543 MAPLE AVENUE REIDSVILLE, NC 27320

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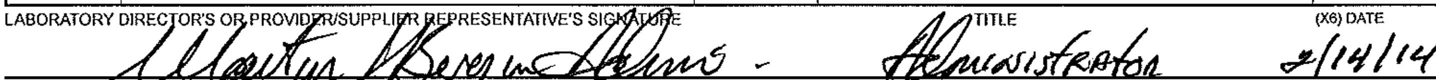
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation the facility failed to place a cap on the end of a peripherally inserted central catheter (PICC) for 1 of 1 residents (Resident # 162) looked at with PICC lines. Findings included: The record review indicated Resident #162 was admitted on 1/10/14 for an extended antibiotic treatment course. Resident #162 arrived to the facility with a PICC intact. On 1/27/14 at 10:00 AM, Nurse #1 was observed disconnecting the residents intravenous (IV) antibiotic, flushing the PICC line, clamping the PICC line, and then leaving the end of the PICC line open with no cap. There was no cap noted in the residents room. An interview with Nurse #1 was conducted on 1/27/14 at 2:30 PM. Nurse #1 stated when an IV	F 328	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907 **F-328** **How corrective action will be accomplished for those affected.** Resident #162's PICC line cap was replaced immediately by the nurse on 1/28/14. **How corrective action will be accomplished for those residents having potential to be affected.** Current residents with PICC lines were reviewed by the Assistant Director of Nursing finding no other residents with a PICC line that was missing the cap. **What measures will be put in place/systemic changes made to ensure correction.** The Director of Nursing Services re-educated the current licensed staff on the proper protocol for maintaining a PICC Line.	2/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Administrator — (X6) DATE 2/14/14



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 328	Continued From page 1 antibiotic was completed she was to flush the line with 10 milliliters of normal saline and clamp off the line. Nurse #1 stated that was all that needed to be done with Resident #162 ' s PICC line. An interview with the Director of Nursing (DON) on 1/28/14 at 2:40 PM was conducted. The DON was shown Resident #162 ' s PICC line uncapped and stated her expectation was the PICC line would be capped.	F 328	**F-328 Continued:** **How the facility plans to monitor its performance to make sure that solutions are ensured.** The Director of Nursing and the Nurse Management Team will review current residents with a PICC line to ensure caps are in place. The Director of Nursing or Assistant Director of Nursing will complete daily visual audits x 2 weeks then weekly visual audits x 4 weeks to ensure caps are in place on the PICC Line. These audit reports will be brought to the Quality assurance committee meeting x 2 months at which time the Committee will determine if continued monitoring is recommended. **End of POC**	

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is type II-(111) construction , one story with a complete automatic sprinkler system. The Deficiencies determined during the survey area as follows:	K 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	
K 018 SS=F	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: Based on observation on Wednesday 2/12/14 at	K 018	K -018 1) How Corrective action will be accomplished for those found to have been effected. The B-4 and B-8 are scheduled to be replaced on 2/27/14; the laundry door strike plate was replaced immediately on 2/12/14. 2) How corrective action will be accomplished for those having potential to be affected by the same practice. The maintenance director or assistant have conducted visual inspections of the other doors and strike plates within the facility and didn't find any other doors or strike plates needing repair. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The Maintenance director will add this to the preventive maintenance program to ensure continued compliance.	2/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/27/14

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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K 018	Continued From page 1 approximately 9:00 AM onward the following deficiencies were noted: 1) Resident room corridor door B-4 did not close smoke tight. (gap between door and frame at the top) 2) Resident room corridor door B-8 is delaminating and not maintained in good condition. 2) B-Hall Clean Linen corridor door is missing the strike plate and does not close smoke tight. 42 CFR 482.41(a)	K 018	K-018 Continued 4) How the facility plans to monitor its performance to make sure that solutions are sustained. The Maintenance Director will present the monthly reports (x 3 months) to the Quality Assurance Committee to determine if continued monitoring is necessary.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 2/12/14 at approximately 9:00 AM onward the following deficiencies were noted: 1) The smoke barrier was observed as noncompliant: specific findings include the smoke wall on lower B-Hall has holes/penetrations that was not sealed in order to maintain the required fire resistance rating of the	K 025	K -025 1) How Corrective action will be accomplished for those found to have been effected. The smoke barrier on lower B-Hall was sealed on February 13th, 2014. 2) How corrective action will be accomplished for those having potential to be affected by the same practice. The maintenance director or assistant will conduct visual inspections of the other smoke barrier walls and determined that no other areas need to be sealed. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The Maintenance director or assistant will inspect these areas when any work is scheduled that would penetrate these smoke barrier walls.	2/28/14

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K 025	Continued From page 2 smoke barrier. 42 CFR 483.70(a)	K 025	K-025 Continued 4) How the facility plans to monitor its performance to make sure that solutions are sustained. The Maintenance Director will present the monthly reports (x 3 months) to the Quality Assurance Committee to determine if continued monitoring is necessary.	
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: Based on observation on Wednesday 2/12/14 at approximately 9:00 AM onward the following deficiencies were noted: 1) During the inspection and testing of the facility fire alarm system, that consisted of multiple components, the automatic dialer component, when placed in trouble from phone line failure a visual trouble signal was not provided. 42 CFR 482.41(a)	K 052	K -052 1) How Corrective action will be accomplished for those found to have been effected. The visual trouble signal was repaired on February 21st, 2014. 2) How corrective action will be accomplished for those having potential to be affected by the same practice. The maintenance director or assistant will activate the visual trouble signal during the schedule Fire drills monthly. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The Maintenance director will add this to the preventive Maintenance program for a monthly check.	2/28/14
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056		

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K 056	Continued From page 3 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Wednesday 2/12/14 at approximately 9:00 AM onward the following deficiencies were noted: 1) In the MDS office in the area were the water heater tank is located a sprinkler head will need to be installed in order to provide coverage for the the area. 42 CFR 482.41(a)	K 056	K-057 Continued 4) How the facility plans to monitor its performance to make sure that solutions are sustained. The Maintenance Director will present the monthly reports (x 3 months) to the Quality Assurance Committee to determine if continued monitoring is necessary. K-056 1) How Corrective action will be accomplished for those found to have been effected. The head is scheduled to be added to the area in the MDS office on February 28th 2014. 2) How corrective action will be accomplished for those having potential to be affected by the same practice. The maintenance director has determined that there are no other areas within the facility that would require an additional sprinkler. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The Maintenance director will add this to the preventive Maintenance program for a monthly check. 4) How the facility plans to monitor its performance to make sure that solutions are sustained. The Maintenance Director will present the monthly reports (x 3 months) to the Quality Assurance Committee to determine if continued monitoring is necessary.	2/28/14
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Wednesday 2/12/14 at approximately 9:00 AM onward the following deficiencies were noted: 1) The smoke damper located in the smoke wall on C-Hall near resident room C-10 was not operational at the time of the survey.	K 104		

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FORM APPROVED
OMB NO. 0938-0391

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K 104	Continued From page 4 42 CFR 483.70(a)	K 104	K -104 1) How Corrective action will be accomplished for those found to have been effected. The Smoke damper on C-Hall near resident room C-10 was repaired on February 19th 2014. 2) How corrective action will be accomplished for those having potential to be affected by the same practice. The maintenance director has determined that there are no other smoke dampers in need of repair. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The Maintenance director will ensure this is part of the preventive Maintenance program, documenting monthly on the operation of dampers. 4) How the facility plans to monitor its performance to make sure that solutions are sustained. The Maintenance Director will present the monthly reports (x 3 months) to the Quality Assurance Committee to determine if continued monitoring is necessary.	2/28/14