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 _____	C 12/05/2013

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 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview and staff interviews, the facility failed to post a sign indicating the location of survey results and post the survey results in a location that was accessible to residents using wheelchairs. The findings included: The resident council president, Resident #101 stated during interview on 12/04/13 at 3:53 PM that she "guessed" the survey results were located in the activity room. On 12/04/13 at 4:14 PM, observations of the front lobby and area where the other required resident information was posted revealed no signage as to the location of the survey results. On 12/04/13 at 4:58 PM, observations of the activity room revealed no sign to the location of the survey results and the surveyor could not locate the survey information.	F 167	F167 1. The deficiency has been corrected. The Survey book was moved to a visible and wheelchair accessible height and a sign has been posted indicating the location of the book. 2. An inspection of the rest of the facility was conducted to ensure that there were not additional survey book locations. A visible and accessible location was established for the Survey Results Book. 3. The Activities Staff were inserviced by the Administrator and the location of the Survey Results book. The Administrator will perform a weekly Audit to monitor that the Survey Results Book is visible and accessible. This audit will be documented on the Survey Book Audit form. Each month during the Resident Council meeting, the location of the Survey Results Book will be announced during the meeting. This will be audited bythe monthly minutes of the Resident Council meeting. This will be conducted for a period of three months. The Survey Book Audit forms will be maintained in the Administrator's office.	

NHL&C Black Mountain MRO DHSR Received DEC 27 2013 by: ggg

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Walder — TITLE: Administrator — (X6) DATE: 12/23/13

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 167	Continued From page 1 On 12/05/13 at 8:50 AM, upon looking at the area where the resident information was posted again, the surveyor noted a gray plastic pocket hanging on the wall over 5 feet from the floor. A blue binder was located in the plastic pocket with the spine upward. The spine of the binder was labeled as having the survey results. The spine of the binder was not visible when the surveyor was standing in front of the plastic pocket. Once the binder was removed, it was noted that the front of the binder had been labeled, however, it was not visible through the gray plastic pocket as the binder was facing backward. There was no way a resident confined to a wheelchair could have reached the binder containing the survey results. On 12/05/13 at 9:44 AM, interview with the Activity Director (AD) revealed Resident #101 was "very much" alert and oriented. She also was noted as being a very active participant with resident council and all the activities before becoming the resident council president a few months ago. The AD further stated that the location of the survey results have not been discussed in resident council meetings. She further stated the location of the posted resident information has moved during remodeling and repainting and she was unsure how long they were in their present location. Interview with the Administrator on 12/05/13 at 10:55 AM revealed the wall on which the survey results were hung had been recently painted, within the last month. He stated there was a sign under the gray plastic pocket which identified that the plastic pocket contained the survey results, however, it must not have been re-hung after the painting and may still be around. The Administrator further stated that all the residents	F 167	4. The results of the Survey Results Book Audit form and the Resident Council meeting minutes will be reviewed monthly in the Quality Assurance Meeting to identify trends and further action for three months. The Quality Assurance Committee will review on a regular basis and provide recommendations as indicated.	1/02/14

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F 167	Continued From page 2 had to do was ask staff to hand them the survey book if they could not reach it.	F 167		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to follow-up with and schedule an appointment to have dentures fitted for 1 of 1 sampled resident with new dentures (Resident #77). The findings included: Resident #77 was admitted to the facility on 02/26/13 with diagnoses that included asthma, anxiety and others. The admission Minimum Data Set (MDS) dated 03/05/13 specified the resident had no impaired cognition and no oral concerns. Review of Resident #77's medical record revealed a dental consultation note dated 09/09/13 that specified the resident complained of pain in lower teeth, requesting that they be extracted and wished to have full false teeth made. A progress note dated 11/11/13 made by the Social Worker specified the resident "was in the middle of a series of dental appointments to be	F 250	**1.** Resident #77 dentures were adjusted by the dentist on December 9, 2013 **2.** An audit was conducted of all Residents by the social worker to determine if any other residents required dental services. **3.** The Social Worker was inserviced by the Administrator on providing medically related social services to schedule appointments as needed. The Nursing staff were inserviced by the DON to utilize the Communication Board in Point Click Care to alert the social worker of resident needs. The social worker will maintain a Denture Fitting Record on residents that receive dentures and/or have reported issues with dentures to track follow up appointment needs. The social worker will interview 10 residents weekly to ask about properly fitting dentures and document this on the Denture Weekly Audit form. It will conducted for 3 Months. The Denture Fitting Records and the Denture Weekly Audit forms will be maintained in the social worker's office.	

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F 250	Continued From page 3 fitted for dentures." A second dental consultation report dated 11/20/13 specified the resident received her new dentures and recommended they be adjusted as needed. A nurse's entry dated 11/20/13 made by Nurse #1 specified the resident had difficulty eating with her new dentures due to the dentures being loose. A second entry made by Nurse #1 also dated 11/20/13 specified the resident was refusing to wear dentures because they were too big and the nurse observed that the dentures appeared "to float" in the resident's mouth. On 12/02/13 at 3:00 PM Resident #77 was interviewed and reported that she was having difficulty eating because she was unable to wear her new dentures. She explained that for 2 weeks she has not been able to wear her new dentures because they were too big. She added that she was ashamed for people to see her without teeth. Resident #77 stated that the Social Worker was aware that her new dentures were too big. The Resident stated that to her knowledge nothing had been done to have the new dentures fitted. On 12/04/13 at 8:30 AM the Social Worker was interviewed and reported that Resident #77 had received new dentures on 11/20/13 and needed an appointment to have them fitted. The Social Worker confirmed that no appointment had been scheduled for Resident #77 to have her new dentures fitted and added that she had it on her "to-do" list. On 12/04/13 at 2:35 PM a second interview was conducted with the Social Worker and she	F 250	4. The results of the Denture Weekly Audit and any current Denture Fitting Records will be reviewed in the monthly Quality Assurance meeting to identify trends and the need for further action for 3 months. A random monthly audit will then be performed by the social worker to monitor any need for further action.	1/02/14

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F 250	Continued From page 4 explained that she was responsible for scheduling dental appointments that included scheduling follow-up fittings for residents with new dentures if needed. She stated that when a resident received new dentures she routinely followed-up with them after a few days to a week to determine if the resident needed an appointment to have the dentures fitted. In the case of Resident #77 she stated she had not followed-up with the resident since she had received her new dentures on 11/20/13 because she had been busy with the recent holiday. She added the she saw and spoke with Resident #77 at least every other day but could not recall if she had observed Resident #77 wearing her new dentures. The Social Worker stated that she was unaware Resident #77's new dentures did not fit properly. On 12/05/13 at 1:20 PM the Administrator was interviewed and reported that he expected all appointments and follow-ups to be conducted and scheduled as quickly as possible.	F 250		
F 253 SS=E	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 maintain wheelchairs and tube feeding poles in a clean, sanitary, and orderly manner for 6 residents residing on 2 of 4 halls (Resident# 4, 15, 28, 38, 65, and 129).	F 253	1. The deficiency has been corrected. All equipment for Residents #4, #15, #38,#28,#65,#129 was cleaned or replaced. 2. An audit of the entire facility was conducted and any issues related to wheelchairs, gerichairs, overbed tables and IV poles were made.	

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F 253	Continued From page 5 The findings included: On 12/02/13 at 11:10 AM a tour of the facility commenced with initial observations. The subsequent observations each day revealed the following environmental concerns: Resident #4 residing in a room shared by 4 residents revealed Resident #4 was occupying a wheelchair with debris and food substance on the cushion and both armrests. Observations noted as follows: 1) 12/02/13 at 1:01 PM wheelchair dirty with debris and food substance 2) 12/03/13 at 9:11 AM wheelchair dirty with debris, food substance, and sides of seat cushion soiled 3) 12/04/13 at 7:47 AM wheelchair remains dirty with debris and food substance Resident #15 residing in a room shared by 4 residents revealed a blue geriatric chair with white colored dried particles on the bilateral neck pad cushions as well as on the armrests; right and left sides. Observations noted as follows: 1) 12/03/13 at 2:51 PM dried spills on right side of cushion by head and on the side of the geriatric chair 2) 12/04/13 at 7:45 AM dried spills on right side of cushion by head and on the side of the geriatric chair 3) 12/04/13 at 8:27 AM dried spills on right side of cushion by head and on the side of the geriatric chair 4) 12/04/13 at 11:21 AM dried spills on right side of cushion by head and on the side of the	F 253	**3.** The Facilities Manager was Inserviced on cleaning and monitoring of equipment that include wheelchairs, gerichairs, overbed tables and IV poles. The Facilities Manager will conduct a random audit of 10 rooms each week to review the cleanliness of wheelchairs, gerichairs, IV poles and the condition of overbed tables using the Equipment Audit form. This will be conducted for three months These forms will be maintained in the Facilities Manager office. **4.** The results of the Equipment Audits will be reviewed at the monthly Quality Assurance Committee Meeting to identify trends and further action for three months. A random monthly audit will be performed by the Facilities Manager to monitor any need for further action.	1/02/14

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F 253	Continued From page 6 geriatric chair 5) 12/04/13 at 2:45 PM dried spills on right side of cushion by head and on the side of the geriatric chair 6) 12/05/13 at 9:20 AM dried spills on right side of cushion by head and on the side of the geriatric chair Resident #28 residing in a room shared by 4 residents observed Resident #28 was occupying a wheelchair in the hallway outside the resident room revealed the right side of the cushion with dried food spills, left side of wheelchair with food crumbs and debris, and soiled bilateral armrests. Observations noted as follows: 1) 12/02/13 at 3:55 PM soiled roll of armrests and dried food spillage on cushion 2) 12/03/13 at 9:13 AM dried spills on roll of armrests, cushion, and down side of wheelchair Resident #38 residing in a room shared by 2 residents revealed Resident #38's bedside table with the laminate peeling and the wood was showing. Observations noted as follows: 1) 12/03/13 at 9:47 AM laminate off of bed side table Resident #65 residing in a room shared by 4 residents revealed Resident #65's tube feeding pump, base of the pole, and the pole coated with tube feeding medication; Total Parenteral Nutrition (TPN). The geriatric chair cushion noted to have dried food spillage and ripped vinyl on the armrests.	F 253		

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F 253	Continued From page 7 Observations noted as follows: 1) 12/02/13 at 12:23 PM tube feeding pole dried spillage and geriatric chair dirty on right side with ripped vinyl on armrests 2) 12/03/13 at 3:38 PM tube feeding pole dried spillage and geriatric chair dirty on right side with ripped vinyl on armrests 3) 12/04/13 at 8:25 AM tube feeding pole, base of pole, and pump dried spillage and dried spillage on geriatric chair with ripped vinyl on armrests 4) 12/04/13 at 1:57 PM AM tube feeding pole, base of pole, and pump dried spillage and dried spillage on geriatric chair with ripped vinyl on armrests 5) 12/05/13 at 9:00 AM tube feeding pole, base of pole, and pump dried spillage and dried spillage on geriatric chair with ripped vinyl on armrests Resident #129 residing in a room shared by 2 residents revealed Resident #129 was occupying a wheelchair with debris and dried food substance on the seat cushion and both armrests. Observations noted as follows: 1) 12/02/13 at 12:52 PM dried food on seat cushion 2) 12/03/13 at 11:09 AM frame of wheelchair with dried spills On 12/05/13 at 10:11 AM housekeeper #1 was interviewed. She stated she had not noticed the wheelchairs on her hallway needing to be cleaned. She further stated she was unsure of who would clean the resident equipment and/or the tube feeding pole. In addition, she was uninformed of the process or a schedule for	F 253		

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F 253	Continued From page 8 cleaning wheelchairs or resident equipment. On 12/05/13 at 10:19 AM housekeeper #2 was interviewed. She stated she had never cleaned any of the resident wheelchairs and/or any resident equipment. She further stated she was unaware of the process or a schedule for cleaning any resident equipment including wheelchairs. On 12/05/13 at 11:30 AM the Facility Services Director was interviewed. He stated he was unaware of a cleaning schedule for the wheelchairs, geriatric chairs, tube feeding poles, and/or any other resident equipment. In addition, he stated he was unaware housekeeper #3 had a cleaning schedule and had been cleaning the wheelchairs on Fridays. He further stated the cleaning of resident equipment was being done by verbal communication from direct care staff to housekeeping/maintenance staff. He had not been informed of how many requests for cleaning wheelchairs and/or resident equipment had been made. On 12/05/13 at 12:25 PM housekeeper #3 was interviewed. She had cleaned the geriatric chair in room 109 and stated "the chair really needed to be cleaned long before today." She stated she was unaware the wheelchairs and resident equipment needed to be cleaned. She revealed she had been cleaning the wheelchairs on Fridays. However when the new supervisor took over the housekeeping department, about 2 months ago, another employee was cleaning the wheelchairs. On 12/05/13 at 12:25 PM a tour of the facility was conducted with the Administrator. He	F 253		

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F 253	Continued From page 9 acknowledged the wheelchairs, geriatric chairs, and other resident equipment needed to be cleaned, sanitized, and maintained. He revealed verbal communication as well as a communication tool on their computer system could be utilized. In addition, he stated he was unaware of how many requests for cleaning wheelchairs or resident equipment had been made. He further stated his expectation was for housekeeping staff to maintain the cleanliness of the facility as well as resident equipment in the facility.	F 253		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to store an ice scoop in a clean container and failed to ensure dented cans were not stored ready for use. The findings included: 1. An initial tour of the kitchen was made on 12/02/13 at 11:05 AM with the Dietary Manager (DM). During the tour, observations were made of	F 371	1. The deficiency has been corrected. All dented cans were separated in labeled location. The ice scoop was rewashed on 12/4/13. 2. The Dietary Services Manager completed an audit of the dry storage room to ensure that dented cans were not stored ready for use and that the ice scoop and container that was stored was clean on 12/4/13.	

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F 371	Continued From page 10 the dry good storage area that revealed 4 canned items stored ready for use. Closer observations of the cans revealed they had extensive damage along the rims. The DM was interviewed and stated that she was new. She added that all staff were responsible for putting up stock and should inspect cans for signs of damage. The DM reported that she had a designated box for damaged canned goods but with revealed the box was no longer in place. She added that any canned good item with dents or damage should be removed and placed in the designated box and not stored on the shelf. The DM removed the dented cans from the storage racks. 2. On 12/04/13 at 11:15 AM additional observations of the facility's kitchen were made. The ice scoop was noted to be in use for the lunch meal preparation that included scooping ice into residents' cups. The ice scoop and its container were observed with the Dietary Manager (DM). The ice scoop container was comprised of three pieces, the scoop, a plastic insert with trays for water accumulation and the plastic container mounted to the ice machine. Observations of the ice scoop revealed the scoop was stored inside the container. The plastic insert had water accumulation in the bottom trays and the ice scoop tip was in the water. Closer observations of the plastic insert revealed black debris floating in the water. The plastic insert was removed with the DM present, the water was poured out. The bottom of the plastic tray was noted to have a black film covering the plastic. The DM was able to wipe the black debris off with a paper towel. During this time the DM was interviewed and stated that the ice scoop and insert were to be	F 371	3. The Dietary Manager and dining service staff were inserviced by the Administrator on the proper storage of dented cans and the cleaning schedule for the ice scoops and container. The Dietary Manager will conduct a bi-weekly audit of all canned goods using the Dented Can Audit form. Bi weekly audits will be made to monitor the cleaning of the ice scoop and container using the Ice Scoop Cleaning Audit form. This will be monitored for three months. The Dented Can Audit form and the Ice Scoop Cleaning Audit forms will be maintained in the Dietary Manager's office. 4. The results of the Dented Can Audit form and of the Ice Scoop Cleaning Audit form will be reviewed in the monthly Quality Assurance Meeting to identify trends and necessary further action for three months. The This will be reviewed monthly by Dietary Services Manager through regularly scheduled inspections.	1/02/14

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F 371	Continued From page 11 washed twice daily. The DM verified with the cook that the ice scoop and insert had been already washed that day but was unable to explain why the insert remained dirty. The DM removed the ice scoop and plastic insert and had them re-washed.	F 371		
F 431 SS=E	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 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	F 431	1. The 3 bottles of expired stock were Removed from the medication room on 12/5/13. 2. Medication storage rooms were inspected for any other expired medications. Any identified issues were corrected.	

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	345133	A. BUILDING _____ B. WING _____	C 12/05/2013

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 431	Continued From page 12 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove three bottles of expired stock medications from the cabinets in one of two medication storage rooms. The findings included: On 12/05/13 at 9:00 AM, an observation of the medication cabinet in the medication storage room on the 100-129 Hall revealed three bottles of Calcium 500mg. chewable tabs with expiration dates of November 2013. Two of the bottles were unopened and one bottle had been opened with approximately three-fourths of the tablets remaining. Each bottle contained sixty tablets when unopened. On 12/05/13 at 9:15 AM an interview was conducted with Nurse #2, who was the Unit Manager. She stated that all nurses who use the medication room were responsible for rotation of the stock and removal of out of date stock. She stated the pharmacy used by the facility also checked the medication rooms periodically and removed out of date stock and medications no longer in use. She acknowledged her expectation was that the nurses who accessed the medication room and used the stock medications should remove the out of date medications as they found them. Nurse #2 verified the presence of the out of date calcium.	F 431	3. Nursing staff were inserviced by the Director of Nursing or by Administrative Nursing staff on checking expiration dates in mediation storage rooms. A monthly audit of the medication storage room will be conducted by the Nurse Supervisor and documented on the monthly Medication Storage Room Log. Any identified issues will be corrected. The DON and or Administrative Nurses will conduct a weekly audit of medication storage rooms and check 10 medications each week. This audit will be documented on the Weekly Medication Storage Room Audit. It will be conducted for 3 months. 4. The results of the Weekly Medication Storage Room Audit will reviewed in the monthly Quality Assurance Meeting to identify trends and need for further action for three months. After compliance is achieved a random monthly audit will be performed by the DON or Nursing Administrative staff to Monitor any need for further action.	1/02/14

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F 431	Continued From page 13 On 12/05/13 at 9:25 AM an interview was conducted with Nurse #3, medication nurse for rooms 116-129. She stated she did not check the medication storage area for out of date medications. She revealed she checked the medications as she removed them from the medication room, but she did not go through the entire stock of medications. She acknowledged the night shift nurse has more time and was responsible for checking and rotating stock. Nurse #3 further stated when out of date medications were found, they were placed in a plastic container and returned to the pharmacy. On 12/05/13 at 9:30 AM an interview was conducted with Nurse #4, medication nurse for rooms 100-115. She stated she did not check the medication room for out of date medications. She further stated she believed the Unit Manager was responsible for checking medications. Nurse #4 acknowledged she checked the dates of medication as she removed them from the medication room and placed them in her med cart, but did not check stock in the medication room. On 12/5/13 at 9:35 AM an interview was conducted with Nurse #5, medication nurse for rooms 130-146. She stated the night shift usually put up new stock medications and rotated stock. Nurse #5 further stated all nurses that used the medication room should have observed for out of date medications. On 12/5/13 at 10:45 AM an interview was conducted with the DON. She stated the pharmacy checked the medication carts and medication rooms for expired medications on a monthly basis and provided the facility with a	F 431		

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F 431	Continued From page 14 report of medications that were approaching their expired dates, as well as removing out of date medications. The DON further stated it was her expectation that the nurses rotated and checked stock medications for expiration dates as they added and removed medications from the medication room.	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.**	