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 _____	C 12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	**1804 FOREST HILLS RD 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		12/27/13

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

Electronically Signed | 12/23/2013

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.

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 _____	C 12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1804 FOREST HILLS RD 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 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy, staff interview and family interview, the facility failed to submit a 24 hour report for 1 of 3 residents (Resident #2), reviewed with allegations of abuse. The findings included: 1. The facility policy entitled "Abuse and Neglect" dated 01/05/2010, indicated all alleged violations involving mistreatment, neglect or abuse would be reported to the state agency. The policy read in part, "A. Report immediately via fax, to the appropriate agency a) Immediately means as soon as possible but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter state timeframe requirement." Resident #2 had diagnoses including Alzheimer's disease, and chronic psychosis with visual hallucinations. The quarterly Minimum Data Set (MDS) dated 9/25/2013 revealed the resident had severe cognitive impairment, and was dependent on staff for all activities of daily living. Review of a General Nursing Note dated 12/11/2013 at 1:05 PM, indicated that at approximately 10:35 AM, the Director of Nursing (DON) heard Resident#2 shouting for someone to help her. The nursing note included, "This nurse asked the resident what was wrong and she responded, 'They are trying to kill me. I am clear and I know they are trying to kill me.' " The nursing note also included, "When this nurse asked how they tried to kill her, (Resident#2) stated, 'I know how. I am clear and God knows how they tried to kill me.' "	F 225	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 waas cited correctly. This POC is submitted to meet requirements established by Federal and State Laws. F-225: 483.13 (c)(1)(ii)-(iii), (c)(2) - (4); Investigate/Report Allegations/Individuals. DEFICIENCY CORRECTED. A. Corrective action taken for the affected resident. For the affected resident, resident #2, a 24-hour initial report was submitted to the Health Care Personnel Registry of the N.C. Department of Health and Human Services via fax on 12/12/2013 at 19:58 hours. A 5-Working Day Report was submitted to the Health Care Personnel Registry on 12/17/2013. B. Corrective action taken for those residents having the potential to be affected by the deficient practice. The facility has determined that all residents have the potential to be affected by the possibility of the non-reporting of reportable occurrences on a timely basis.	

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 _____	C 12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1804 FOREST HILLS RD 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 225	Continued From page 2 During an interview on 12/11/2013 at 5:50 PM a family member indicated that she and another family member met with the DON on 12/9/2013 to talk about bruising on Resident #2. The family member said, "I told (DON) that mom said 'They're killing me.' " and indicated the resident seemed fearful. On 12/12/2013 the facility provided an investigation regarding Resident #2's bruising and allegation, but were unable to provide a copy of the 24 hour report about an allegation of abuse. During an interview on 12/12/2013 at 5:29 PM, the Administrator indicated that a thorough investigation had been conducted. They believed the bruising was caused by the resident bumping against the siderail but a 24 hour report had not been done. The Administrator said, "It is my expectation that we follow the training regarding reporting of allegations of abuse." He indicated a report would be filed. The DON was interviewed via phone on 12/13/13 11:42 AM. The DON said they believed the bruising was caused by the resident bumping against the side-rail, but a 24 hour report had not been done about the resident's allegation because Resident#2 was severely cognitively impaired. The DON indicated Resident#2, "said, 'They are trying to kill me.' When I asked her who was trying to kill her she said all of them, even (the attending physician) who was right there." The DON indicated she would ensure a report was sent for all allegations of abuse in the future.	F 225	On 12/11/2013 the Director of Nursing conducted mandatory all nursing staff meetings. At these meetings she in-serviced the staff on the facility policy on reportable incidents and allegations of abuse being reported timely including the following: * Resident abuse/neglect * Diversion of resident/facility drugs * Fraud against resident/facility * Misappropriation of facility/resident property * Injury of unknown source. On 12/13/2013 the Avante Regional VP or Operations for the North Region in-serviced the Administrator of Avante at Wilson on the Company policy on abuse and neglect and responsibilities for timely reporting Allegations/Incidents including but not limited to those listed above. On 12/13/2013 the Administrator in-serviced the Avante at Wilson Management team on the identical topic and focal points as listed above here in item B. On 12/24/2013 educational information was included in the Employee Newsletter distributed this day with paychecks to all employees. The materials were yet another reminder about the facility policy and procedure relating to reportable allegations and incidents being reported and and reported timely to DHHS.	

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 _____	C 12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1804 FOREST HILLS RD 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 225	Continued From page 3	F 225	C. Measures Implemented and/or Systemic Changes made to ensure that deficient practice will not reoccur. * In-service training listed in B above. * Going forward there will be a reminder placed in each Employee Payday Newsletter on staff responsibilities to identify and timely report to management any reportable allegations/incidents of abuse. * A notice has been placed on the Guest and Family Member Bulletin Board about timely reporting of any allegations/incidents to management. * The Administrator has added to his daily morning meeting formal agenda a reminder about reportable allegations/incidents duties and responsibilities for daily discussion and any necessary timely reporting. * Through the facilities QIS process, residents and family members are surveyed weekly, through questionnaires and interviews, about issues related to abuse and reportable allegations/inncidents. * A document has been posted by the employee time clock reminding staff of everyone's responsibility to timely report, per facility protocol, reportable allegations/incidents for reporting to State and investigation purposes. D. How the facility plans to monitor its performance to assure ongoing	

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 _____	C 12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1804 FOREST HILLS RD 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 225	Continued From page 4	F 225	compliance is sustained. The facility will utilize all the measures listed above in Item C on a daily basis to monitor compliance with reportable allegation/incident reporting. Further, the Administrator, or his designee, will on a weekly basis, make random rounds asking residents and/or family members and staff if they have experienced or observed any incidients which could be considered as requiring reporting to the Health Care Personnel Registry of DHHS. For the next three month period, than random per Committee discretion, the results of the QIS screening interviews of residents and visitior on abuse as well as the Administrator's weekly QAPI tracking of resident, family and staff interviews on abuse and reporting of same, will be presented at the monthly Quality Assurance Performance Improvement Committee meeting for compliance monitoring and any audit modification directives. E. Date Corrective Action Completed: Corrective action was completed on or before 12/24/2013.	