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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to notify the physician for a newly developed pressure sore on the left	F 157	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to resident #127 on 2/12/16. The wound nurse assessed the wound on resident #127 notified physician of change in wound. The physician will see resident #127 on weekly rounds on 2/13/16 and change course of treatment according to needs of the wound. The Director of Nursing provided in service education on 2/22/16, for Nurse #4 regarding use of SBAR tool for documentation of resident changes of condition, which includes notification of physician. Current facility residents have the potential to be affected by the deficient practice. A skin audit of current active residents within the facility on 2/17/16. Any new identified areas have been communicated with the physician and new orders in place. Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing, unit managers and wound nurse will review all progress notes during clinical morning meeting to identify any new areas of concern five times a week. The Director of Nursing/ unit managers and wound nurse will review all SBAR change of condition forms during clinical morning meeting five times a week to identify any changes in residents and proper notification to physician. The Director of Nursing, unit	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John P. Walden — TITLE: Administrator — (X6) DATE: 3/4/16

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
	345133	A. BUILDING _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 157	Continued From page 1 great toe of Resident #127 for 6 days for 1 of 3 sampled residents with pressure sores. (Resident #127). Findings included: Resident # 127 was re-admitted to the facility on 07/20/15. The diagnoses listed on a diagnosis list in the electronic medical record indicated type 2 diabetes, a history of venous thrombosis with embolism (a blood clot forming inside a blood vessel), heart disease, chronic kidney disease and anxiety. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/22/16 indicated Resident #127 was severely impaired in cognition for daily decision making and required extensive assistance with activities of daily living. A review of weekly skin observations dated 02/06/16 revealed tip of left great toe black with necrotic tissue with 0.5 centimeter (cm) open area covered with band aid. A review of the monthly physician's orders dated 02/06/16 through 02/29/16 revealed there were no wound treatment orders or pressure sore treatment orders for Resident #127. During an interview on 02/12/16 at 12:16 PM the Wound Care Nurse (WCN) stated Nurse #3 who was assigned Resident #127's care on 02/12/16 had just informed her that morning Resident #127 had a wound on his left great toe. The WCN further stated she was not aware of the wound but she had made a note about it and would assess it. She further stated after she assessed a resident's wounds she referred the resident to the	F 157	managers and wound nurse will review weekly skin assessments completed by hall nurses during morning clinical meeting, five times a week. These audits and reviews will be monitored by the DON/Unit mangers/Wound nurse to identify any changes in skin conditions for residents as orders in place for new areas of concern and the physician has been notified. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 157	Continued From page 2 Surgeon/Wound Care Physician who made facility rounds every Saturday to evaluate them. She explained she was aware Resident #127 had a skin tear on his left toe after 01/17/16 when he bumped his foot while going to the bathroom but she was not aware that Resident #127 had necrotic tissue documented by Nurse #4. The WCN stated Nurse #4 assessed and documented the wound on Resident #127's left toe in the evening after the Surgeon/Wound Care Physician had made rounds and she should have left a note about the necrotic tissue for the WCN or should have reported it directly to her so she could have reported it to the Surgeon/Wound Care Physician. During an observation and interview of wound care on 02/12/16 at 2:30 PM the WCN confirmed Resident #127 had a black area on the tip of his left toe which measured 1.8 cm length x 3.2 cm width. The WCN described the area was soft with fluid under skin. She explained the tissue was black but she did not think it was eschar because the tissue was not hard and it could have been a possible blood blister that expanded but she was not sure. She stated she could not determine what the wound stage was but the Surgeon/Wound Care Physician would have to assess it 02/13/16 during his wound rounds. During an interview on 02/12/16 at 4:00 PM with Nurse #4 she stated she worked on second shift on 02/06/16 and Resident #127 was scheduled for his weekly wound assessment. She explained when she did his weekly skin assessment she discovered he had a band aid on his left great toe and when she removed it there was hard black tissue at the tip of his left toe. She stated she thought it was an old wound and since she usually was not assigned to care for Resident	F 157		

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 157	Continued From page 3 #127 she did not go any further with reporting it. She explained if she had been routinely assigned to care for Resident #127 and saw it had changed or had increased in size she would have reported to the WCN. During an interview on 02/12/16 at 4:40 PM the Director of Nursing stated it was her expectation for nurses to report wounds to the WCN. She stated she expected nurses to follow up on wounds and residents with wounds should be referred to the Surgeon/Wound Care Physician so he could evaluate them during his weekly rounds.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide a medical diagnosis for the use of a physical restraint for 1 of 1 resident (Resident #163). The Findings include: Resident #163 was admitted to the facility on 01/14/16 with diagnosis that included: fracture of ankle, hypertension, asthma, history of falls, and weakness. The most recent comprehensive minimum data set (MDS) dated 01/21/16 indicated that Resident #163 was cognitively	F 221	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to resident # 163. The Director of Therapy assessed #163 for need of ½ side rails. Resident #163 ½ side rails removed and replaced with grab bars on 2/11/16 to help with independence of self transfers. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing/Unit managers/MDS Nurses did a current audit of side rails in the facility has been completed on 2/11/16. Those current residents within the facility with ½ side rails have been assessed for the need of and safety related to their current bedrails. The licensed nurse completed a Restraint/Device assessment on residents identified with ½ rails on 3/4/16, to identify rails as a restraint or enabling device. Care plans were updated to reflect the type of rails and reason for use of rails.	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 221	Continued From page 4 intact and required one person assistance with bed mobility, dressing, toilet use, and bathing. The MDS further indicated that Resident #163 required two person assistance with transfers and had functional limitation in range of motion to one lower extremity. No use of restraint was identified on the MDS. Additional review of the medical record revealed no medical diagnosis or medical symptom for use of the side rails. Review of physician order sheet dated 02/01/16 through 02/29/16 revealed weight bearing as tolerated with walking boot to left lower extremity. Review of care plan dated 02/02/16 read in part Resident #163 was frequently incontinent of bladder related to her disease process and limited mobility, the goal of stated care plan was to have a decrease in frequency of urinary incontinence. Interventions to help reduce urinary incontinence included: ensure resident had unobstructed path to the bathroom. Review of nurse's note dated 02/05/16 at 10:20 AM read in part that Resident #163 was alert and oriented and was able to voice her needs. She was ambulating with walker with staff in room. Review of nurse's note dated 02/06/16 at 10:42 AM read in part that Resident #163 was alert and made her needs known to staff. Resident #163 was up to the bathroom and had failed to call for assistance with transferring. Staff asked resident to call for assistance. Observation on 02/09/16 at 10:09 AM of Resident #163 was walking around in room with rolling walker and boot to left lower leg with no staff present in room.	F 221	Measures put into place to ensure the alleged deficient practice does not recur include. The Director of Nursing in serviced current employed licensed nurses have been in serviced and educated on the facilities policy on side rails and the Restraint/Device assessment on 2/18/16. New admissions and readmissions will be assessed by the Director of Nursing/Unit managers for need of side rails or grab bars and a Restraint/device assessment will be completed. Any need for removal of current side rails or exchange of rails will be communicated with maintenance by the use of TELS. Current residents will be assessed quarterly/annually by the Director of Nursing/Unit managers/MDS Nurses for need of side rails and a side rails assessment completed. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 221	Continued From page 5 Review of nurse's note dated 02/09/16 at 10:41 AM read in part resident #163 transferred independently and ambulated with walker to restroom. Observation on 02/09/16 at 2:15 PM Resident #163 was walking around in room with rolling walker and boot to left lower leg with no staff present in room. Observation on 02/10/16 at 9:15 AM Resident #163 was in the bed with both side rails in the engaged position along both sides of the bed. Resident #163 requested the left side rail be removed so she could use the bedside commode which was directly beside the bed on the left side. Staff was notified of resident request. Observation on 02/10/16 at 10:23 AM of Resident #163 remained in the bed with both side rails in the engaged position along both sides of the bed. Interview with Resident #163 on 02/10/16 at 3:44 PM revealed that the staff put her side rails in the engaged position along both sides of bed at night, usually she would ask them to leave the side rails up not along the sides of the bed "so I could pull up and get some exercise in my arms" . Resident #163 reported that she could not get out of bed with the rails engaged and stated "honey I wouldn't dare climb over the rails I would bust my bottom." Resident #163 further stated that at night she used the "diaper" they put on her because she was not able to get out of bed with the rails engaged. Resident #163 was also not able to put the side rail down when asked to do so.	F 221		

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 221	Continued From page 6 Interview with Nurse Aide (NA) #1 on 02/10/15 at 4:03 PM revealed that she took care of Resident #163 on second shift and Resident #163 was able to get up out of bed and ambulate around the room in the evening. NA #1 further stated that she engaged both side rails at night for all of the residents unless they request otherwise. NA #1 also stated that she has not been told any differently about the side rails so that was what she did for all of the residents on her assignment. Interview with the Director of Nursing (DON) on 02/11/16 at 2:48 PM revealed that they normally do not use restraints, the side rails were used as a mobility device. The DON stated that it was up to the resident as to what kind of side rails they wanted, if a resident does not want the side rails they are replacing them with the grab bars. She stated that Resident #163 should not be walking around the room and she would prefer that she call for help. Interview with the Therapy Manager on 02/11/16 at 3:15 PM revealed that Resident #163 had participated several days with therapy and then started to refuse all treatments. Resident #163 had follow up with surgeon and became weight bearing as tolerated, therapy tried again to get Resident #163 to participate with therapy. Resident #163 participation's was off and on so therapy did whatever they could get her to do. When therapy discharged Resident #163 from therapy she was independent in her room, she was able to get up and go to the bathroom and get dressed independently. The Therapy Manager further stated that her gait was pretty good but she had some safety awareness issues. Therapy addressed toileting with her and the resident was toileting pretty regularly, she was	F 221		

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 221	Continued From page 7 also able to independently apply her walker boot. Interview with (NA) #2 on 02/11/16 at 4:26 PM who worked all over the building but had worked with Resident #163 before stated that for "residents that are not in their right mind" she engaged both side rails along both sides of the bed, unless they could request otherwise that was what she did. Interview with (NA) #3 on 02/11/16 at 4:30 PM stated that when she puts residents to bed, unless they request otherwise she engaged both side rails along both sides of the bed.	F 221		
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 repair resident room doors and/or bathroom doors with broken and splintered laminate and wood for 9 of 61 resident rooms. (Resident room #112, #122, #127, #132, #136, #138, #140, #143 and #147). Findings included: 1. a. Observations of room #112 on 02/10/16 at 8:37 AM revealed the bathroom door in the resident's room had broken and splintered laminate on the hinge side of the edges of the bottom half of the door.	F 253	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to the laminate on the edges of the doors in rooms 112, 122,127,132,136,138,140,143,147. Edges of the doors were repaired. Current facility residents have the potential to be affected by the alleged deficient practice A facility wide audit of doors was conducted on 2/15/16 by the Director of Facility Services to ensure that the door laminate was intact. Repairs on doors that had broken laminate was started on 2/15/16.	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 253	Continued From page 8 Observations on 02/11/16 at 10:13 AM revealed the bathroom door in resident room #112 had broken and splintered laminate on the hinge side of the edges of the bottom half of the door. Observations on 02/12/16 at 9:46 AM revealed the bathroom door in resident room #112 had broken and splintered laminate on the hinge side of the edges of the bottom half of the door. b. Observations of room #122 on 02/10/16 at 8:39 AM revealed a metal kick plate attached to the bottom half of the bathroom door was bent with an exposed sharp edge that protruded outward at the hinge side of the door. Observations on 02/11/16 at 1:47 PM revealed a metal kick plate attached to the bottom half of the bathroom door inside resident room #122 was bent with an exposed sharp edge that protruded outward at the hinge side of the door. Observations on 02/12/16 at 9:47 AM revealed a metal kick plate attached to the bottom half of the bathroom door inside resident room #122 was bent with an exposed sharp edge that protruded outward at the hinge side of the door. c. Observations of room #127 on 02/10/16 at 8:41 AM revealed the door of the resident's room had broken and splintered laminate with splinters that protruded outward on the edges of the bottom half of the door. Observations on 02/11/16 at 2:27 PM revealed the door of resident room #127 had broken and splintered laminate with splinters that protruded outward on the edges of the bottom half of the door. Observations on 02/12/16 at 10:27 AM revealed the door of resident room #127 had broken and splintered laminate with splinters that protruded outward on the edges of the bottom half of the	F 253	Measures put into place to ensure the alleged deficient practice does not recur include: A Door Audit Tool will be conducted by the Director of Facility Services on a weekly basis to review 25% of all doors to determine that no laminate is splintered. This audit will be conducted for a period of three months. The results of the Door Audit Tool will be maintained by the Director of Facility Services. Any necessary action will be taken in regards to maintaining the doors. Daily room rounds will be conducted by the Department Heads and the doors will be inspected during these rounds. Any needed repairs will be reported daily and entered into the TELS system. The facility will monitor the its performance to and develop a plan for ensuring that correction is sustained and achieved: The results of the Door Audit Tool will be presented in the monthly QA meeting. The Administrator and/or Maintenance director will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 253	Continued From page 9 door. d. Observations of room #132 on 02/10/16 at 8:43 AM revealed the bathroom door had chipped paint and laminate on the edges of the bottom half of the door. Observations on 02/11/16 at 3:52 PM revealed the bathroom door inside resident room #132 had chipped paint and laminate on the edges of the bottom half of the door. Observations on 02/12/16 at 9:52 AM revealed the bathroom door inside resident room #132 had chipped paint and laminate on the edges of the bottom half of the door. e. Observations of room #136 on 02/10/16 at 8:52 AM revealed the bathroom door had chipped paint and laminate on the edges of the bottom half of the door. Observations on 02/11/16 at 2:59 PM revealed the bathroom door inside resident room #136 had chipped paint and laminate on the edges of the bottom half of the door. Observations on 02/12/16 at 9:59 AM revealed the bathroom door inside resident room #136 had chipped paint and laminate on the edges of the bottom half of the door. f. Observations of room #138 on 02/10/16 at 9:03 AM revealed the bathroom door had chipped paint and laminate on the edges of the bottom half of the door. Observations on 02/11/16 at 1:38 PM revealed the bathroom door inside resident room #138 had chipped paint and laminate on the edges of the bottom half of the door. Observations on 02/12/16 at 10:09 AM revealed the bathroom door inside resident room #138 had chipped paint and laminate on the edges of the	F 253		

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 253	Continued From page 10 bottom half of the door. g. Observations of room #140 on 02/10/16 at 9:32 AM revealed the bathroom door had chipped paint and laminate on the edges of the bottom half of the door. Observations on 02/11/16 at 2:32 PM revealed the bathroom door inside resident room #140 had chipped paint and laminate on the edges of the bottom half of the door. Observations on 02/12/16 at 10:32 AM revealed the bathroom door inside resident room #140 had chipped paint and laminate on the edges of the bottom half of the door. h. Observations of room #143 on 02/10/16 at 9:27 AM revealed the bathroom door had broken and splintered laminate on the edges of the bottom half of the door. Observations on 02/11/16 at 3:07 PM revealed the bathroom door inside resident room #143 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 02/12/16 at 10:07 AM revealed the bathroom door inside resident room #143 had broken and splintered laminate on the edges of the bottom half of the door. i. Observations of room #147 on 02/10/16 at 10:36 AM revealed the resident room door and the bathroom door inside the resident's room had broken and splintered laminate on the bottom half of the door. Observations on 02/11/16 at 3:05 PM revealed the resident room door of room #147 and the bathroom door inside the resident's room had broken and splintered laminate on the bottom half of the door. Observations on 02/12/16 at 10:05 AM revealed	F 253		

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 253	Continued From page 11 the resident room door of room #147 and the bathroom door inside the resident's room had broken and splintered laminate on the bottom half of the door. During an environmental tour on 02/12/16 at 5:17 PM with the Environmental Services Director and the Administrator they verified the doors identified were damaged. The Environmental Services Director stated it appeared the doors were hitting the door jams and chipped the wood. He explained department heads and office staff made rounds every morning to identify concerns and repairs that needed to be made and throughout each day staff reported things that needed to be repaired. He stated he and his maintenance man also made rounds throughout each day and staff could report things that needed to be fixed to the receptionist or staff could enter work requests in the computer system. He stated it was his expectation for staff to report damage on doors when they saw them. During an interview on 02/12/16 at 5:20 PM with the Administrator he stated it was his expectation for damage to resident doors and bathroom doors to be reported and they should be fixed.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #163. The licensed nurse completed a side rail/restraint/device assessment on 2/11/16. The side rail was removed and replaced with a grab bar on 2/11/16, which is not a restraint. Resident #163 was discharged home on 2/22/16. The comprehensive assessment completed on 1/21/16 cannot be corrected due to resident discharge home. The resident has	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 278	Continued From page 12 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the use of a physical restraint for 1 of 3 residents (Resident #163). The findings include: Resident #163 was admitted to the facility on 01/14/16 with diagnoses that included: fracture of ankle, hypertension, asthma, history of falls, and weakness. The most recent comprehensive MDS dated 01/21/16 indicated that Resident #163 was cognitively intact and required one person assistance with bed mobility, dressing, toilet use, and bathing. The MDS further indicated that	F 278	been readmitted and new comprehensive assessment will be completed on 2/23/16, and will reflect the accurate coding for restraints. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON), and/or unit managers began an audit on 2/15/16 of current residents with side rails to identify rails as a restraint. The MDS coordinators reviewed restraint coding on the most recent MDS completed for residents identified with side rails that are restraints Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Reimbursement/MDS provided in service education on 3/02/16 for the facility MDS coordinators regarding coding of MDS with regards to restraints. The clinical team and MDS coordinators will assess residents upon admission, readmission, quarterly, annually and significant change to identify need for side rails and will notify MDS coordinators if the side rails are restraints. The MDS coordinators will code MDS accordingly, if side rail is a restraint. The DON will review 10 MDS a month for 3 months to validate coding of restraints are accurate. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 278	Continued From page 13	F 278		

Resident #163 required two person assistance with transfers and had functional limitation in range of motion to one lower extremity. No use of restraint was identified on the MDS.

Review of care plan dated 02/02/16 read in part Resident #163 was frequently incontinent of bladder related to disease process and limited mobility, the goal of stated care plan was to have a decrease in frequency of urinary incontinence. Interventions to help reduce urinary incontinence included: ensure resident had unobstructed path to the bathroom.

Observation on 02/10/16 at 9:15 AM Resident #163 was in the bed with both side rails in the engaged position along both sides of the bed. Resident #163 asked me to remove the left side rail so she could use the bedside commode which was directly beside the bed on the left side. The side rails extended down each side of the bed leaving approximately 12 inches at the head of the bed and 12 inches at the foot of the bed. When the rails were in the up position or not engaged they folded into a grab bar position at the head of the bed. Staff was notified of resident request.

Observation on 02/10/16 at 10:23 AM of Resident #163 remained in the bed with both side rails in the engaged position along both sides of the bed. The side rails extended down each side of bed leaving approximately 12 inches at the head of the bed and 12 inches at the foot of the bed.

Interview with Resident #163 on 02/10/16 at 3:44 PM revealed that the staff put her side rails in the engaged position along both sides of bed at night but usually she would ask them to leave the side

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 278	Continued From page 14	F 278		

rails up, not along the sides of the bed "so I could pull up and get some exercise in my arms." Resident #163 reported that she cannot get out of bed with the rails engaged and stated "honey I wouldn't dare climb over the rails I would bust my butt." Resident #163 further stated that at night she used the "diaper" they put on her because she is not able to get out of bed with the rails engaged. Resident #163 is also not able to put the side rail down when asked to do so.

Interview with Nurse Aide (NA) #1 on 02/10/15 at 4:03 PM revealed that she took care of Resident #163 on second shift and Resident #163 was able to get up out of bed and ambulate around the room in the evening. NA #1 further stated that she engaged both side rails at night for all of the residents unless they request otherwise. NA #1 also stated that she has not been told any differently about the side rails so that is what she did for all of the residents on her assignment.

Interview with the Director of Nursing (DON) on 02/11/16 at 2:48 PM revealed that they normally do not use restraints, the side rails were used as a mobility device. The DON stated that it was up to the resident as to what kind of side rails they wanted, if a resident does not want the side rails they are replacing them with the grab bars. She stated that Resident #163 should not be walking around the room and she would prefer that she call for help. After reviewing the definition of restraint with the DON she stated that based on definition the side rails would be considered a restraint and should be assessed and coded as a restraint

Interview with the Therapy Manager on 02/11/16 at 3:15 PM revealed that Resident #163 had

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 278	Continued From page 15 participated several days with therapy and then started to refuse all treatments. Resident #163 had follow up with surgeon and had become weight bearing as tolerated, therapy tried again to get Resident #163 to participate with therapy. Resident #163 participation's was off and on so therapy did whatever they could get her to do. When therapy discharged on 02/10/16 Resident #163 from therapy she was independent in her room, she was able to get up and go to the bathroom and get dressed independently. The Therapy Manager further stated that her gait was pretty good but she did have some safety awareness issues. Therapy addressed toileting with her and the resident was toileting pretty regularly, she was also able to independently apply her walker boot. Interview with MDS nurse on 02/12/16 at 3:16 PM stated that she would code a merry walker or a lap buddy that a resident could not release on command as a restraint, she further stated that if a side rail would impede a resident from getting out of bed that would also be a restraint. She did not consider Resident #163's side rails as a restraint. The MDS nurse further stated that if a device is considered restrictive there should be a restraint assessment that would be completed and there should have been a care plan in place.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to resident#117. Resident #117 received nail care/facial hair was removed on 2/12/16.	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 312	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to trim chin hairs and keep nails clean for Resident #117 for 1 of 3 residents sampled for activities of daily living. (Resident #117). Findings included: Resident #117 was re-admitted to the facility on 01/09/16. A review of diagnoses listed in the diagnosis section of Resident #117's electronic medical record included muscle weakness and facial weakness following a stroke and dementia. A review of the admission Minimum Data Set (MDS) dated 02/02/16 indicated Resident #117 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #117 required extensive assistance with personal hygiene. A review of a care plan titled activities of daily living self-care deficit related to dementia, fatigue and confusion indicated goals that Resident #117 would return to prior level of function by next review date. The interventions and approaches were listed in part to break tasks into small segments to facilitate increased independence, praise all efforts of self-care, provide verbal cues for increased participation with self-care, provide extensive total assistance with bathing and showering daily and extensive staff participation was required with personal hygiene. During an observation on 02/10/16 at 10:04 AM Resident #117 was sitting in the hallway in a	F 312	Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing/Unit managers audit all current residents for dirty nails/facial hair has been completed on 2/19/16. Residents identified during the facility audit in need of nail care and/or shaving received nail care and/or were shaved at that time. A care plan was initiated for those residents identified during the audit who had a preference to keep facial hair or refuses nail care and/or shaving. Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing/Unit managers in serviced current nursing staff on provisions of nail care/facial hair removal. In servicing will include education of documenting resident refusals in a progress note. The Director of Nursing/unit managers will observe 5 residents weekly for 4 weeks, then 10 monthly for 3 months to validate nail care/facial hair is being completed in the facility. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 312	Continued From page 17	F 312		

wheelchair. She had long hairs on her chin approximately ¼ to ½ inch in length and the fingers of on her left hand had brown debris under the nails of the middle and ring finger. The fingers of her right hand were balled in a fist on her lap.

During an observation on 02/11/16 at 4:43 PM Resident #117 was lying on her bed in her room and had long hairs on her chin approximately ¼ - ½ inch in length and the middle and ring finger of her left hand had brown debris under each nail. The finger nails on her right hand revealed brown debris under the middle, ring and little fingers.

During an observation on 02/12/16 at 9:51 AM Resident #117 was lying in bed with long chin hairs approximately ¼ to ½ inch length. She had her hands resting on top of a blanket and the fingernails on her right hand had brown debris under the middle, ring and little fingers and the middle and ring finger of her left hand had brown debris under them.

During an interview on 02/12/16 at 2:48 PM with Nurse #3 she stated Resident #117 was more cooperative with some staff during activities of daily living (ADL) care than with others. She stated sometimes Resident #117 did not want her nails cleaned but when she went back later or the next day Resident #117 let her clean her nails. Nurse #3 stated Nurse Aides (NAs) were supposed to document when a resident refused nail care or to have facial hair removed. She further stated sometimes Resident #117 let the nurse trim her chin hairs and clean her nails when she wouldn't let the NAs do it but the nurses relied on the NAs to report when Resident #117 refused. She confirmed she had not received any

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 312	Continued From page 18 report from NAs that Resident #117 had refused to have her chin hairs removed or her nails cleaned during this week. During an observation on 02/12/16 at 2:48 PM Nurse #3 verified 3 fingers on Resident #117's right hand which were the middle, ring and little finger and 2 fingers on her left hand which were the middle and ring finger were all dirty and needed to be cleaned. She also verified Resident #117 had long chin hairs that needed to be shaved. Nurse #3 asked Resident #117 if staff could trim them and Resident #117 rubbed her chin and agreed to have her chin hairs removed and her fingernails cleaned on both hands. During an interview on 02/12/16 at 3:18 PM with Nurse Aide #5 she stated she had provided ADL care to Resident #117 earlier that day. She stated she had asked Resident #117 about trimming her chin hairs but Resident #117 said she did not need them trimmed. She further confirmed she had not cleaned Resident #117's fingernails. She stated NAs were supposed to document on the shower sheet when a resident refused ADL care and report to the nurse but she did not recall if she told the nurse. During an interview on 02/12/16 at 3:31 PM with Unit Manager #1 she explained any time NAs tried to do nail care or trim facial hair and the resident refused they were supposed to tell the nurse. She stated she expected the nurse to attempt to trim facial hair and clean the resident's nails but if they still refused the staff should document the refusal of care in the nurse's progress notes. She confirmed there was no documentation in the progress notes that Resident #117 had refused to have her chin hairs	F 312		

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 312	Continued From page 19 trimmed or her nails cleaned. During an interview on 02/12/16 at 3:34 PM with the Director of Nursing she confirmed she did not see any nurse's progress notes where Resident #117 had refused to have her chin hairs trimmed or nails cleaned. She stated it was her expectation if a resident refused to have chin hairs trimmed or nails cleaned the NA should report it to the nurse and the nurse should go and attempt to do it. She stated if the resident would not permit the nurse to provide the care they should document it.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to assess, obtain physician's orders and initiate treatment for a newly developed pressure sore on the left great toe of Resident #127 for 6 days for 1 of 3 sampled residents with pressure sores. (Resident #127). Findings included:	F 314	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to. The wound nurse assessed the wound for Resident #127 on 2/11/16, notified physician and received an order for treatment. The resident was seen by the wound care physician on 2/13/16. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing/Unit managers/Wound nurse completed a skin audit of current active residents within the facility on 2/25/16. No new skin issues were identified. Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing/or the Unit manages will review resident progress notes, new admission skin assessments, SBAR notes, and weekly skin assessments during clinical morning meeting at least 5 days a week to identify documentation of new wounds and validate the physician has been notified and treatment orders received.	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 314	Continued From page 20 Resident # 127 was re-admitted to the facility on 07/20/15. The diagnoses listed on a diagnosis list in the electronic medical record indicated type 2 diabetes, a history of venous thrombosis with embolism (a blood clot forming inside a blood vessel), heart disease, chronic kidney disease and anxiety. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/22/16 indicated Resident #127 was severely impaired in cognition for daily decision making and required extensive assistance with activities of daily living. A review of a care plan indicated Resident #127 had the potential for pressure ulcer development related to disease process and immobility. A review of weekly skin observations dated 01/17/16 revealed steri strip intact to left great toe skin tear. The report also revealed there was no redness or edema noted, no other skin issues noted and toenails were thick. A review of weekly skin observations dated 01/31/16 revealed steri strip intact to right great toe and no other skin issues noted. A review of weekly skin observations dated 02/06/16 revealed tip of left great toe black with necrotic tissue with 0.5 centimeter (cm) open area covered with band aid. A review of the monthly physician's orders dated 02/06/16 through 02/29/16 revealed there were no wound treatment orders or pressure sore treatment orders for Resident #127.	F 314	The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 314	Continued From page 21	F 314		

During an interview on 02/11/16 at 9:25 AM with the Wound Care Nurse (WCN) she stated Resident #127 had a pressure sore on his right heel in the past but it had healed. She further stated Resident #127 was not currently receiving any wound care treatments.

During a follow up interview on 02/12/16 at 12:16 PM the WCN stated Nurse #3 who was assigned Resident #127's care on 02/12/16 had just informed her that morning Resident #127 had a wound on his left great toe. The WCN further stated she was not aware of the wound but she had made a note about it and would assess it and would have the Surgeon/Wound Care Physician evaluate it when he made rounds on 02/13/16. She also stated the documentation dated 01/31/16 which indicated a steri strip to right great toe was incorrectly documented and should have been for the left great toe. She explained the process for notification for new wounds was for nurses to report them to her and she wrote the resident's name and wound location down and she assessed them. She stated they also used a stop and watch reporting form the Nurse Aides (NAs) could fill out and turn into the nurse when they saw skin breakdown or any changes in the resident's condition. She further stated after she assessed a resident's wounds she referred the resident to the Surgeon/Wound Care Physician who made facility rounds every Saturday to evaluate them. She explained she was aware Resident #127 had a skin tear on his left toe after 01/17/16 when he bumped his foot while going to the bathroom but she was not aware that Resident #127 had necrotic tissue documented by Nurse #4. The WCN stated Nurse #4 assessed and documented the wound on Resident #127's left toe in the evening after the

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 314	Continued From page 22	F 314		

Surgeon/Wound Care Physician had made rounds and she should have left a note about the necrotic tissue for the WCN or should have reported it directly to her. She stated Nurse #4 had documented on 02/06/16 that Resident #127 had necrotic tissue on his left toe and if Nurse #4 had left her a message she would have assessed the wound when she got to work on 02/08/16 but she didn't since she didn't know about it. She stated nurses were supposed to document the condition of a skin tear, what it looked like and if there was drainage or not.

During a second follow up interview on 02/12/16 at 2:15 PM the WCN explained the resident's physician who was also the medical director of the facility had directed her to write orders for antibiotic cream for new wounds until the Surgeon/Wound Care Physician could evaluate the resident. She further explained the resident's physician did not write orders for wound care but wanted a referral to the Surgeon/Wound Care Physician for evaluation and treatment.

During an observation and interview of wound care on 02/12/16 at 2:30 PM the WCN confirmed Resident #127 had a black area on the tip of his left toe which measured 1.8 cm length x 3.2 cm width. The WCN described the area was soft with fluid under skin. She explained the tissue was black but she did not think it was eschar because the tissue was not hard and it could have been a possible blood blister that expanded but she was not sure. She stated she could not determine what the wound stage was but the Surgeon/Wound Physician would have to assess it tomorrow during his wound rounds.

During an interview on 02/12/16 at 4:00 PM with

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 314	Continued From page 23 Nurse #4 she stated she worked on second shift on 02/06/16 and Resident #127 was scheduled for his weekly wound assessment. She explained when she did his weekly skin assessment she discovered he had a band aid on his left great toe and when she removed it there was hard black tissue at the tip of his left toe. She stated she thought it was an old wound and since she usually was not assigned to care for Resident #127 she did not go any further with reporting it. She explained if she had been routinely assigned to care for Resident #127 and saw it had changed or had increased in size she would have reported to the WCN. During an interview on 02/12/16 at 4:40 PM the DON stated it was her expectation for nurses to report wounds to the WCN and NAs should fill out the stop and watch forms and to report to nurses if they saw skin tears or new wounds. She stated she expected nurses to follow up on wounds and residents with wounds should be referred to the Surgeon/Wound Care Physician so he could evaluate them during his weekly rounds.	F 314		
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.	F 328	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to transporting of oxygen cylinders. Administrator and/or Maintenance director provided in service education for staff beginning on 3/9/16, regarding proper transport of oxygen cylinders.	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 328	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a compressed oxygen cylinder during transport for one of one observations (Resident #42). The findings included: Review of Material Safety Data Sheet (MSDS) for the safe handling and transport of portable oxygen cylinders dated 07/22/99, revealed canisters of compressed gas should be handled with care. The cylinders should be protected from physical damage and should not be rolled, dragged or dropped. The safety dated sheet indicated empty cylinders held residue of compressed oxygen and should also be considered dangerous. Movement of the oxygen cylinders should be accomplished when the cylinders are secured in a suitable hand cart. On 02/09/16 at 11:43 AM the Director of Nursing (DON) was observed entering Resident #42's room carrying a full compressed oxygen cylinder and then existing the room with the empty cylinder and carried the cylinder up the hall in the direction of the nurses' desk without a hand truck. She was observed carrying the cylinder by a ring on top of the cylinder. No hand cart was used. On 02/11/16 at 12:39 PM an interview was conducted with the DON. The DON revealed the facility oxygen administration policy reads that oxygen cylinders should be strapped to a stand and she interpreted this as the bags on the wheelchairs. The DON further revealed the	F 328	Current facility residents have the potential to be affected by the alleged deficient practice. Administrator and/or Maintenance director provided in service education for staff beginning on 3/9/16, regarding proper transport of oxygen cylinders. The Director of Nursing and unit managers conducted an audit on 3.9.16, of resident rooms to assure oxygen cylinders were secured and transported properly. Measures put into place to ensure the alleged deficient practice does not recur include: An Oxygen Transport Audit Tool will be conducted the Director of Facility Services and/or Administrator, to monitor proper transport of oxygen cylinders for 3 residents weekly then 5 monthly for 3 months. The facility will monitor the its performance to and develop a plan for ensuring that correction is sustained and achieved: The results of the Oxygen Transport Audit Tool will be presented in the monthly QA meeting. The Director of Facilities Services/ Administrator will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review monthly QA for 3 months or until compliance is maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 328	Continued From page 25 therapists always use the hand carts for the oxygen cylinders when they are working with residents. The DON explained oxygen cylinders should always be secured and transported within the facility on an oxygen handcart. The DON revealed when empty cylinders are replaced with full cylinders, they should be transported with a hand cart. The DON confirmed she carried a full oxygen cylinder from the nurses station down the hall to the residents room in her hands and carried the empty tank back to the nurses station to place in the storage rack and verified she did not use a the wheeled handcart for transport. The DON further stated she should have used a handcart to transport the oxygen cylinders, but she was in a hurry to help out the NAs. On 02/11/16 at 3:11 PM an interview was conducted with Nurse Aide #4 (NA#4). She indicated she was present in the room when the exchange of oxygen cylinders occurred. NA #4 acknowledged the DON carried the oxygen cylinder into Resident $42's room and exchanged it for the empty oxygen cylinder. NA #4 acknowledged that she often would carry oxygen cylinders by hand and further revealed she should use the wheeled hand cart for transporting oxygen cylinders.	F 328		
F 364 SS=E	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.	F 364	Corrective action has been accomplished for the alleged deficient practice in regards to serving pureed food. Garnishment was added to provide an attractive appearance to the pureed food plates.	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 364	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to serve pureed food in an attractive manner for 1 of 1 meal observation. The findings included: On 02/12/16 at 11:48 AM observations were made of the lunch meal service. During the observations, the morning cook began plating pureed food. The pureed lunch meal consisted bread, crab cakes, fried okra and mashed potatoes. Each food item was kept in a serving pan. The morning cook identified each food item. Observations of the pureed food revealed the pureed bread was beige, the pureed crab cakes were light brown, the mashed potatoes were white and the pureed fried okra was brown. At 11:50 AM the morning cook used a scoop to serve the pureed crab cake, pureed fried okra, pureed bread, and pureed mashed potatoes. The scooped food kept its form on each plate. Observations of the plates of pureed food revealed each plate had 5 formed scoops of food beige, light brown, white and brown on the plate. There was no garnish included on the plate. On 02/12/16 at 12:05 PM 13 pureed meal trays were delivered to the halls for lunch. On 02/12/16 at 2:50 PM the Dietary Manager (DM) was interviewed and reported that attempts were made to serve attractive meals that varied in color and looked pleasing. She stated that if food items were bland looking especially with the pureed foods, they would sprinkle parsley flakes to enhance the food's appearance. The DM	F 364	Current facility residents have the potential to be affected by the alleged deficient practice. Dietary staff were inserviced on 2/12/16 in regards to providing garnishments to pureed food plates and ensuring the overall appearance of the pureed food is maintained. Measures put into place to ensure the alleged deficient practice does not recur include: The Dietary Services Manager will conduct a Pureed Plate Audit three times a week for two months to ensure that pureed food is served with garnish and does not appear bland. Any necessary modifications to the pureed food plates will be made. The results of the audit will be maintained in the Dietary Services Manager's office. The Administrator and/or Dietary Services Manager will review the audits for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 364	Continued From page 27 reported that the pureed lunch meal served on 02/12/16 did look bland and should have had garnish.	F 364		
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 clean cookware and failed to keep ingredient bins clean. The findings included: On 02/09/16 at 8:00 AM an initial tour of the kitchen was made with the new Dietary Manager (DM). The DM explained that she was new in her role but was familiar with the kitchen operation. a. During the tour, the 3-compartment sink was set-up with chemical solution. Beside the sink were utensils and cookware drying. The DM reported that the morning cook had used the sink to clean the items. On 02/09/16 at 8:08 AM the DM tested the chemical solution in the sink and the test strip revealed there was no chemical solution in the water mixture. The DM pulled the	F 371	Corrective action has been accomplished for the alleged deficient practice in regards to the ingredient bins and chemical sink. The ingredient bins were cleaned on _2/9/16 and the dispenser was repaired on 2/10/16 to allow for proper solution flow to the chemical sink. Current facility residents have the potential to be affected by the alleged deficient practice Dietary staff were in serviced on 2/9/16 on maintaining cleanliness in the dietary area including the ingredient bins and testing the solution in the sinks. Measures put into place to ensure the alleged deficient practice does not recur include: An ingredient bin audit will be conducted by the Dietary Services Manager or cook five times a week for two months. Any corrective action will occur in regards to maintaining the ingredient bins. A Sanitizer Sink Audit will conducted by the Dietary Services Manager or cook five times a week for two months to ensure proper functioning of the dispenser and chemical solution to the sink. Any necessary adjustments that are necessary will be made to ensure proper chemical flow to the sink.	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 371	Continued From page 28 monthly log and no entry had been made for 02/09/16 that documented the solution had been tested prior to use. On 02/12/16 the Dietary Manager was interviewed and explained that she spoke with the morning cook who stated she did not check the chemical solution in the 3-compartment sink prior to use. The DM stated that she contacted the representative for the chemical company. The representative came on site and notified the DM that the chemical tubing was kinked, blocking flow and the valve was broken and was replaced. The DM stated that the morning cook was expected to check the solution concentration prior to use and notify her of concerns. b. During the tour, observations were made of the plastic dry ingredient bins. The ingredient bin used to store flour had sticky build-up along the lid of the bin. Observations made of the plastic bin used to store breadcrumbs also had brown sticky build-up on the lid of the bin. The DM was present for the observations and stated the bins were supposed to be cleaned after every shift. The DM touched the dirty lids and agreed they were not clean. On 02/12/16 at 2:50 PM the Dietary Manager was interviewed and reported that dietary staff were expected to keep kitchen equipment clean. The weekly cleaning schedule was reviewed but did not specify the ingredient bins were to be cleaned after each shift. The DM stated that she was aware the weekly cleaning schedule did not include everything in the kitchen and that she had	F 371	The results of the ingredient bin audit and Sanitizer Sink Audit will be presented in the monthly QA meeting. The Administrator and/or Dietary Services Manager will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 371	Continued From page 29 been working to develop a new cleaning schedule.	F 371		
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 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.	F 431	Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to resident #79. The Director of Nursing removed medication from bedside on 2/11/16. Expired insulin and Rolaids on SNF B cart were removed and discarded per facility policy on 2/11/16. Nurse #1 removed the expired medications from ICF A cart and discarded medications per facility policy. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing/Unit managers completed an audit of the medication carts and medication rooms on 2/15/16. The Director of Nursing/Unit managers/MDS nurses completed an audit of current residents' room for any medication at the bedside on 2/15/16. No new medications were found at the bedsides of current residents. Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing and/or unit managers provided in services for current licensed nurses, beginning on 2/15/16, regarding dating and labeling of medications and guidelines for expiration of medication. The Director of Nursing/unit managers will do bi-weekly audits of the medication carts and medication rooms, for 4 weeks then weekly for 3 weeks to validate	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 30 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to remove a medication left at bedside for 1 of 1 resident (Resident #79) and failed to remove expired medication from 2 of 4 medication carts. The findings included: 1. Review of facility policy titled "Self-Administration of Medication" dated September 2003 read in part. "A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician." Resident #79 was readmitted to the facility on 01/29/16 with diagnosis that included: non-Alzheimer's dementia, heart failure, hypertension, and chronic obstructive pulmonary disease. Review of the most recent comprehensive minimum data set (MDS) dated 02/05/16 indicated that Resident #79 is cognitively intact and required one person assistance with activities of daily living. Review of physician orders for Resident #79 dated 02/01/16 through 02/29/16 revealed the following: Fluticasone propionate nasal spray 50 micrograms (mcg) per spray. One spray to each nostril every 12 hours. There was no order that indicated this medication could be left or kept at bedside. Review of care plan for Resident #79 revealed no care plan for keeping/storing medications at bedside.	F 431	medication dating and labeling of medications and expired medications have been removed. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 31 Observation of Resident #79's room on 02/10/16 at 5:04 PM revealed a box of fluticasone propionate nasal spray 50 mcg on a shelf that was on the left side of the bed. Observation of Resident #79's room on 02/11/16 at 10:00 AM revealed a box of fluticasone propionate nasal spray 50 mcg on a shelf that was on the left side of the bed. Observation of Resident #79's room on 02/11/16 at 4:48 PM revealed a box of fluticasone propionate nasal spray 50 mcg on a shelf that was on the left side of the bed. Interview with Resident #79 on 02/11/16 at 4:30 PM revealed that she is not sure how long the nasal spray had been on her shelf on the left side of her bed, Resident #79 further stated that the nurses bring a bottle into the room and administer the medication twice a day. Interview with Nurse #1 on 02/11/16 at 4:34 PM who was responsible for taking care of Resident #79 stated that no one on the hall kept medications in their room and no one was able to self-medicate. Nurse #1 also stated that if a resident wished to self-medicate the medication would have to be kept in a locked box to keep the wandering resident from accessing the medication. Interview with the Director of Nursing (DON) on 02/11/16 at 4:48 PM revealed that Resident #79 was not able to have the medication at bedside. The DON stated that if a resident wished to keep a medication at bedside they would have to be assessed to ensure that they were safe to	F 431		

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 32 administer the medication as ordered. The DON further stated that if a medication was kept at bedside it would have to be kept in a locked box. She believed the staff left the medication there by mistake and she would have expected them to put the medication back on the medication cart and to never leave it at bedside. 2. Review of the facility policy titled, "Storage of Medications" dated September 2003 read in part: "No discontinued, outdated, or deteriorated medications are available for use in this facility." "All such medications are destroyed." 2 a. Observation of cart B on the short term rehab section of the facility on 02/12/16 at 11:02 AM revealed the following: · One bottle of Rolaids that contained an expiration date of 09/2015. · A vial of Lantus insulin that was opened 01/14/16. An interview with Medication Aide #1 on 02/12/16 at 11:02 AM who was responsible for the SNF cart B revealed that Lantus insulin was good for 28 days and was expired and should have been removed from the medication cart. 2 b. Observation of hall 1 medication cart on the long term section of the facility on 02/12/16 at 11:25 AM revealed the following: · One bottle of Bacid probiotic that contained no resident name and an expiration date of 1/2016. · One Haldol 5 milligram (mg) tablet that contained no resident name and an expiration date of October 2015. · Two Ranitidine 75 mg that contained no resident name and an expiration date of 08/2015.	F 431		

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 33 An interview with Nurse #2 on 02/11/16 at 11:25 AM who was responsible for ICF hall 1 medication cart revealed that nurses are supposed to go through the medications carts on a daily basis to check for expired medications. Nurse #2 further stated that she had not gone through the medication cart thus far on that shift. An interview with the Director of Nursing (DON) on 02/12/16 at 3:04 PM revealed that the unit managers and supervisors check the medication carts weekly for expired medications and they check the medication rooms monthly for expired medications. The DON also stated that the pharmacy came once a month and was in the facility on 01/23/16 and checked the medication carts and rooms for expired medications. The DON stated that she expected the unit managers and supervisors to check the carts weekly and discard expired medication per the facility protocol.	F 431		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520	Deficiency corrected The Administrator and Director of nursing provided in service education for the Interdisciplinary team (IDT) regarding the facility QAA program which includes developing, implementing, monitoring and maintaining interventions to promote quality of care and quality of life. (A)Corrective action has been accomplished for the alleged deficient practice in regards to the laminate on the edges of the doors in rooms 112, 122,127,132,136,138,140,143,147. Edges of the doors were repaired.	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 520	Continued From page 34 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for three recited deficiencies which were originally cited in April 2015 on a recertification survey and complaint survey and on the current recertification survey. The deficiencies were in the area of housekeeping and maintenance services, activities of daily living and food procurement, and storage and preparation of food. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. a. F253 Housekeeping and Maintenance Services: Based on observations and staff interviews the facility failed to repair resident	F 520	(B) Corrective action has been accomplished for the alleged deficient practice in regards to resident#117. Resident #117 received nail care/facial hair was removed on 2/12/16. (C) Corrective action has been accomplished for the alleged deficient practice in regards to the ingredient bins and chemical sink. The ingredient bins were cleaned on 2/9/16 and the dispenser was repaired on 2/10/16 to allow for proper solution flow to the chemical sink. (A))Current facility residents have the potential to be affected by the alleged deficient practice A facility wide audit of doors was conducted on 2/15/16 by the Director of Facility Services to ensure that the door laminate was intact. Repairs on doors that had broken laminate was started on 2/15/16. (B) Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing/Unit managers audit all current residents for dirty nails/facial hair has been completed on 2/19/16. Residents identified during the facility audit in need of nail care and/or shaving received nail care and/or were shaved at that time. A care plan was initiated for those residents identified during the audit who had a preference to keep facial hair or refuses nail care and/or shaving. (C) Current facility residents have the potential to be affected by the alleged deficient practice Dietary staff were in serviced on 2/9/16 on maintaining cleanliness in the dietary area including the ingredient bins and testing the solution in the sinks.	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 520	Continued From page 35 room doors and/or bathroom doors with broken and splintered laminate and wood for 9 of 59 resident rooms. (Resident room #112, #122, #127, #132, #136, #138, #140, #143 and #147). The facility was recited for F253 for failing to repair resident room and/or bathroom doors with broken and splintered laminate and wood. F253 was originally cited during a recertification and complaint survey on 04/20/15 for failure to repair a hole in the wall, a hole in a resident bathroom door, clean privacy curtains in 2 resident rooms and failed to clean a sit to stand lift for providing maintenance and housekeeping services. b. F 312: Activities of Daily Living: Based on observations, record reviews and staff interviews the facility failed to trim chin hairs and keep nails clean for Resident #117 for 1 of 3 residents sampled for activities of daily living. (Resident #117). During the recertification and complaint survey of 04/20/15 the facility was cited for failure to shower residents who required assistance with activities of daily living for 2 of 4 sampled residents (Resident #149 and #5). On the current recertification survey of 02/12/16 the facility was cited for failure to trim chin hairs and keep a residents fingernails clean. c. F 371: Food procurement, storage, preparation and service: Based on observations, staff interviews and record review the facility failed to clean cookware and failed to keep ingredient bins clean. During the recertification and complaint survey of 04/20/15 the facility was cited for failure to keep	F 520	(A)Measures put into place to ensure the alleged deficient practice does not recur include: A Door Audit Tool will be conducted by the Director of Facility Services on a weekly basis to review 25% of all doors to determine that no laminate is splintered. This audit will be conducted for a period of three months. The results of the Door Audit Tool will be maintained by the Director of Facility Services. Any necessary action will be taken in regards to maintaining the doors. Daily room rounds will be conducted by the Department Heads and the doors will be inspected during these rounds. Any needed repairs will be reported daily and entered into the TELS system. (B) Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing/Unit managers in serviced current nursing staff on provisions of nail care/facial hair removal. In servicing will include education of documenting resident refusals in a progress note. The Director of Nursing/unit managers will observe 5 residents weekly for 4 weeks, then 10 monthly for 3 months to validate nail care/facial hair is being completed in the facility. (C) Measures put into place to ensure the alleged deficient practice does not recur include: An ingredient bin audit will be conducted by the Dietary Services Manager or cook five times a week for two months. Any corrective action will occur in regards to maintaining the	

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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET 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 520	Continued From page 36 the beverage station floor clean and the walk-in freezer and walk-in cooler free from food in the floor. On the current recertification survey of 02/12/16 the facility was cited for failure to clean cookware and failed to keep ingredient bins clean. During an interview on 02/12/16 at 5:29 PM the Administrator explained a Quality Assessment and Assurance committee meeting was held after the recertification and complaint survey on 04/20/15 and discussed the action plans to correct the deficiencies. He stated he thought the breakdown that caused the repeated deficiencies was probably caused because the scope of corrective action was too narrow. He explained they had not looked at the citations comprehensively so the scope of action and monitoring for compliance was too low. He further stated they had corrected the issues that were cited on the 04/20/15 recertification and complaint survey but there were related issues that were still present and their Quality Assessment and Assurance Committee was not as comprehensive as it needed to be.	F 520	ingredient bins. A Sanitizer Sink Audit will conducted by the Dietary Services Manager or cook five times a week for two months to ensure proper functioning of the dispenser and chemical solution to the sink. Any necessary adjustments that are necessary will be made to ensure proper chemical flow to the sink. (A)The facility will monitor the performance to and develop a plan for ensuring that correction is sustained and achieved: The results of the Door Audit Tool will be presented in the monthly QA meeting. The Administrator and/or Maintenance director will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. (B) The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. (C) The results of the ingredient bin audit and Sanitizer Sink Audit will be presented in the monthly QA meeting. The Administrator and/or Dietary Services Manager will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Will review in monthly QA for three months or until compliance maintained.	3/11/16

" 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 in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."