STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 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 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 staff interview and record review the facility failed to accurately code the Comprehensive Minimum Data Set (MDS) for PASRR (preadmission Screening and Resident Review) Level II reason for 1 of 1 residents reviewed with a PASRR Level II status (Resident	F 278	F 278 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #5. The MDS coordinator modified MDS assessment	11/21/16

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

Electronically Signed | 11/18/2016

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F 278	Continued From page 1 #5). The findings included: Resident # 5 was readmitted 4/30/14 and had cumulative diagnoses including seizure disorder, schizophrenia, anxiety, and depression. Resident #5 also had a PASRR Level II number (____ B) with no expiration date. Review of a message dated 4/29/14 from the hospital to the facility revealed " since pt (patient) was admitted due to medical tx (treatment) needed and has no changes to mental health she may keep her existing pasrr " . Review of the Annual Minimum Data Set (MDS) assessment dated 7/29/16 revealed Resident #5 was cognitively impaired. Resident #5 ' s PASRR Level II section for " has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or related condition " was coded correctly as yes however the reason for the resident ' s Level II status was coded as " yes " for " Mental Retardation " but coded incorrectly as " no " for " serious mental illness " . During interview with the Director of Nursing on 10/27/16 at 3:00 PM she reviewed the 4/29/14 letter from the hospital. The DON acknowledged that with a diagnoses of schizophrenia and the reference to mental health related PASRR status contained in the letter, the residents MDS should be coded yes for Level II PASRR and serious mental illness. During interview with the MDS Coordinator on 10/27/16 at 3:05 PM she indicated that she was new to doing the MDS at this facility and was in the process of getting access to current and accurate PASRR information. She also revealed that she had not been aware that Resident #5 ' s MDS had previously been coded incorrectly.	F 278	with ARD of 7/29/16, on 11/01/16, to reflect accurate PASRR information. Current facility residents have the potential to be affected by the alleged deficient practice. The MDS coordinator completed an audit on 11/16/16, for current facility residents, to validate that residents with a Level 2 PASSR were coded correctly on the MDS. Assessments identified as inaccurate were modified and transmitted to the state and accepted on 11/17/16. Measures put into place to ensure the alleged deficient practice does not recur include: The Social Worker and/or designee will notify the MDS coordinator when a resident has a Level 2 PASSR, to assure accurate coding on the MDS. The Director of Nursing (DON) will review MDS comprehensive assessments weekly for 4 weeks then monthly for 3 months to validate that the MDS assessment is coded accurately to reflect the Level 2 PASSR. 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.	

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F 278	Continued From page 2	F 278	"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"	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to update a care plan for contracture	F 280	F 280 Deficiency corrected	11/21/16

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F 280	Continued From page 3 management for Resident #2 for one of nine care plans reviewed. The findings included: Resident #2 was admitted to the facility on 2/17/2006 with diagnoses including hemiplegia due to a stroke. The Minimum Data Set (MDS), a quarterly, dated 9/16/16 indicated Resident #2 had impairment on one side of the upper and lower extremity. The care plan dated 9/20/16 did not address the right hand contracture, use of splint or passive range of motion (PROM) exercises. Review of the monthly orders for October 2016 included restorative nursing for PROM with skin checked, and a splint applied up to 8 hours daily. The original order, dated 2/15/16 included restorative nursing program RUE (right upper extremity) splint application after morning care and off with evening care to reduce further progression of contracture and maintain skin integrity 6x (times) week for 12 weeks. Observations on initial tour 10/24/16 at 11:00 AM revealed Resident #2 had a hand splint in his opened drawer to the bedside table. His right hand was in a closed fist. Observations on 10/26/16 at 9:40 Am revealed Resident #2 did not have the splint applied to his right hand. Interview on10/27/2016 at10:18 AM with the restorative aide revealed Resident #2 was no longer on case load. She explained he kept	F 280	Corrective action has been accomplished for the alleged deficient practice in regards to Resident #2. Resident was referred to OT on 11/2/16 for assessment of contracture of right hand and appropriate interventions and splinting. The MDS coordinator initiated a Contracture management care plan on 11/2/16. Current facility residents have the potential to be affected by the alleged deficient practice. The DON, ADON, MDS coordinator and Rehab Program manager identified current facility residents with contractures and/or decreased ROM on 11/16/16, to validate that a care plan for contracture management was in place and appropriate interventions were included. A care plan for contracture management was initiated for residents identified that did not have a care plan. Measures put into place to ensure the alleged deficient practice does not recur include: The DON and/or Rehab program manager provided in service education for nursing staff beginning on 11/16/16, regarding notification of licensed nurse and/or therapy staff if decreased ROM is identified or if resident is non-compliant with contracture management interventions such as splinting. The DON, ADON, MDS coordinator and	

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F 280	Continued From page 4 refusing to wear the splint. The resident did allow PROM when he wore the splint. Interviewed with the MDS nurse who currently supervises restorative was conducted on10/27/2016 at 1:30 PM revealed she reviewed the physician ' s orders, chart information and did observations of the resident when completing an assessment. Further interview revealed she missed the information resident #2 had restorative previously, and he had no care plan for contracture management. Interview with the Director of Nursing on 10/27/16 at 3:30 PM revealed she would expect the care plan to include a problem of contractures and approaches for management of the contracture.	F 280	Rehab program manager will observe/assess new admissions and readmission residents for contractures and/or decreased ROM and will implement appropriate interventions for contracture management. The DON, MDS coordinator and Rehab Program manager will observe/assess residents with contractures and/or decreased ROM monthly to validate continued splint and/or contracture management and will update care plan as necessary to reflect resident's current status. The Director of Nursing will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. "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."	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 318		11/21/16

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F 318	Continued From page 5 with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide restorative services to manage contractures for one of one residents with contractures. Resident #2. The findings included: Resident #2 was admitted to the facility on 2/17/2006 with diagnoses including hemiplegia due to a stroke. The Minimum Data Set (MDS), a quarterly, dated 9/16/16 indicated Resident #2 had impairment on one side of the upper and lower extremity. The care plan dated 9/20/16 did not address the right hand contracture, use of splint or passive range of motion (PROM) exercises. Review of the monthly orders for October 2016 included restorative nursing for PROM with skin checked, and a splint applied up to 8 hours daily. The original order, dated 2/15/16 included restorative nursing program RUE (right upper extremity) splint application after morning care and off with evening care to reduce further progression of contracture and maintain skin integrity 6x (times) week for 12 weeks.	F 318	F 318 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #2. Resident #2 was referred to OT on 11/2/16 for assessment of contracture of right hand and appropriate interventions and splinting. The MDS coordinator initiated a Contracture management care plan on 11/2/16. Current facility residents have the potential to be affected by the alleged deficient practice. The DON, ADON, MDS coordinator and Rehab Program manager identified current facility residents with contractures and/or decreased ROM, to validate that a care plan for contracture management was in place and appropriate interventions were included. A care plan for contracture management was initiated for residents identified as necessary. Measures put into place to ensure the alleged deficient practice does not recur include:	

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F 318	Continued From page 6 Observations on initial tour 10/24/16 at 11:00 AM revealed Resident #2 had a hand splint in his opened drawer to the bedside table. His right hand was in a closed fist. Observations on 10/26/16 at 9:40 Am revealed Resident #2 did not have the splint applied to his right hand. Interview on10/27/2016 at10:18 AM with the restorative aide revealed Resident #2 was no longer on case load. She explained he kept refusing to wear the splint. The resident did allow PROM when he wore the splint. Further interview she did not remember when the resident was discontinued from therapy. Follow up interview with the restorative aide on 10/27/16 at 10:30 AM revealed March 31st 2016 was the last time she worked with Resident #2. The nurse over the program at that time told her to discontinue the splint. That nurse no longer works at the facility. Review of the restorative summary dated 3/31/16 indicated restorative was to continue the program as needed for Resident #2. The restorative aide explained she was not aware the nurse had written to continue the program and followed the verbal instructions that had been given to her. Interviewed with the MDS nurse who currently supervises restorative was conducted on10/27/2016 at 1:30 PM revealed she became responsible for restorative sometime during the summer. She had reviewed some residents with contractures but not this resident. Further interview revealed therapy would need a referral from nursing.	F 318	The Region Nurse provided in service education on 11/10/16, regarding restorative services, to include the types of restorative programs, identifying residents for the program, monitoring and documentation requirements for residents that are on a restorative program. The DON and/or Rehab program manager provided in service education for nursing staff beginning on 11/16/16, regarding notification of licensed nurse and/or therapy staff if decreased ROM is identified or if resident is non-compliant with contracture management interventions such as splinting. The DON, ADON, MDS coordinator and Rehab program manager will observe/assess new admissions and readmission residents for contractures and/or decreased ROM and will implement appropriate interventions for contracture management. The DON, MDS coordinator and Rehab Program manager will observe/assess and identify residents with contractures and/or decreased ROM monthly to validate continued splint and/or contracture management and will update or initiate a care plan as necessary to reflect resident's current status. The Director of Nursing will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 318	Continued From page 7 Interview on10/27/2016 at 1:46 PM with the therapy manager revealed Resident #2 had not been referred back to therapy for a screen or an evaluation when he was discontinued from restorative. Further interview revealed there was no communication with therapy the resident was discharged from restorative. She explained therapy could have completed a screen to see if he would wear the splint, if something was wrong with the splint, or if it didn't fit right. Interview with the Director of Nursing on 10/27/16 at 3:30 PM revealed she would expect the restorative nurse supervisor to get an order and the physician to sign it when a resident was discharged from restorative. Further interview revealed she would expect the nursing to refer the resident back to therapy for any additional options available for the resident in contracture management.	F 318	"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."	
F 520 SS=D	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 action to correct identified quality deficiencies.	F 520		11/21/16

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F 520	Continued From page 8 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 observation, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to implement, monitor and revise, as needed, the action plan developed for the recertification survey dated 11/4/2015 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies regarding the right to participate in planning care - revise care plan (F280) and increase/prevent decrease in range of motion (F318). The findings included: This tag is cross-referenced to: F280. The Right to Participate in Planning Care - Revise Care Plan: Based on staff interviews and record reviews the facility failed to update a care plan for contracture management for Resident #2 for one of nine care plans reviewed. F318. Increase/Prevent Decrease in ROM: Based on observations, staff interviews and record review the facility failed to provide restorative services to manage contractures for one of one residents with contractures. (Resident #2). An interview conducted with the Administrator on 10/27/16 at 3:42 pm revealed that the current	F 520	F 520 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #2. Resident was referred to OT on 11/2/16 for assessment of contracture of right hand and appropriate interventions and splinting. The MDS coordinator initiated a Contracture management care plan on 11/2/16. Current facility residents have the potential to be affected by the alleged deficient practice. The DON, ADON, MDS coordinator and Rehab Program manager identified current facility residents with contractures and/or decreased ROM on 11/2/16, to validate that a care plan for contracture management was in place and appropriate interventions were included. A care plan for contracture management was initiated for residents identified as	

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F 520	Continued From page 9 Administrator had only been at the facility for 4 weeks and the current Director of Nursing (DON) had only been at the facility for 1 week. The Administrator indicated that he and the DON had just taken over the QAA committee. The Administrator revealed that he and the DON were working to ensure that all employees realize that everyone is a part of the quality assurance process. He indicated that all employees should help to identify QAA issues so they can be looked at and improved upon. The Administrator further revealed that he and the DON have recently implemented a quality of life program in which a sample of resident charts are reviewed on a regular basis. He indicated the intent of this review is to ensure that physician orders are being followed and that residents are getting everything they need. The Administrator indicated that this process should have been done in the past but it was not being done consistently. He further indicated if inconsistencies were found during this process, the plan would be to track and trend the information in an effort to determine the root cause to resolve the issue.	F 520	necessary. Measures put into place to ensure the alleged deficient practice does not recur include: The Region Nurse provided in service education on 11/10/16, regarding restorative services, to include the types of restorative programs, identifying residents for the program, monitoring and documentation requirements for residents that are on a restorative program. The DON and/or Rehab program manager provided in service education for nursing staff beginning on 11/16/16 regarding notification of licensed nurse and/or therapy staff if decreased ROM is identified or if resident is non-compliant with contracture management interventions such as splinting. The DON, ADON, MDS coordinator and Rehab program manager will observe/assess new admissions and readmission residents for contractures and/or decreased ROM and will implement appropriate interventions for contracture management. The DON, MDS coordinator and Rehab Program manager will observe/assess residents with contractures and/or decreased ROM monthly to validate continued splint and/or contracture management and will update care plan as necessary to reflect resident's current status.	

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F 520	Continued From page 10	F 520	The Administrator and/or Region nurse provided in-service education for Interdisciplinary team beginning on 11/16/16, regarding an effective QA process which includes identification of a concern, interventions and ongoing monitoring of situation/concern to assure continued compliance. The Administrator and/or the Director of Nursing will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. "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."	