| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345227 | A. BUILDING _____ B. WING _____ | C 02/08/2017 |

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

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| F 313 SS=D | 483.25(a)(1)(2) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION<br><br>(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-<br><br>(1) In making appointments, and<br><br>(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interviews, the facility failed to provide a vision examination for one of one resident reviewed (Resident #99).<br><br>Findings included:<br><br>Resident #99 was admitted 02/12/14. Diagnoses included cognitive communication deficit, cataracts and age-related macular degeneration.<br><br>A quarterly Minimum Data Set (MDS) dated 12/08/16 recorded a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. No impairment in vision was noted on the MDS.<br><br>The Nurse Practitioner wrote an order on 12/15/16 for an "eye exam due to questionable vision concerns." Resident #99 had not yet completed an eye exam at the time of the survey, 55 days after the order had been placed. | F 313 | F 313<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to Resident #99. The family requested to have resident seen by consulting optometrist at the facility. MD/NP made aware and agrees. Consulting optometrist is scheduled to visit on April 4, 2017.<br><br>Current facility residents have the potential to be affected by the alleged deficient practice. The Social worker completed an audit on 2/27/17, of current facility residents to identify residents with orders for vision consults and validate appointments were scheduled.<br><br>Measures put into place to ensure the alleged deficient practice does not recur | 3/8/17 |

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

Electronically Signed | 03/03/2017

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| F 313 | Continued From page 1<br><br>The care plan dated 12/19/16 revealed no concerns regarding the resident ' s vision.<br><br>In an interview with the Social Worker on 02/08/17 at 4:35 p.m., she described the process for scheduling an eye exam. The unit nurse upon receipt of the order for an eye exam informed the social worker who then arranged an appointment with the consulting optometrist. The nurse would schedule an outside appointment for an exam if the family consented to and preferred an outside appointment. The Social Worker indicated that she recently assumed the task of scheduling in January and could not address why Resident #99 had not yet had her exam.<br><br>In an interview with the Director of Nursing (DON) on 02/08/17 at 5:56 p.m., she shared her expectation that a vision exam ordered by the medical provider should be completed promptly. If an in-house appointment was not able to be scheduled within a reasonable timeframe, she expected that staff would arrange an outside appointment. | F 313 | include: The Director of Nursing (DON) provided in service education beginning on 2/20/17, for licensed nurses and social worker, regarding process for scheduling appointments. The DON and/or unit managers will review telephone orders and communication forms 5 times a week for 4 weeks, then weekly for 3 months to identify orders for consults and validate appointments are scheduled.<br><br>The Director of Nursing will analyze audits/reviews 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. | |
| F 314 SS=D | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition | F 314 | | 3/8/17 |

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| F 314 | Continued From page 2<br>demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff and nurse practitioner interviews the facility failed to provide pressure ulcer dressing changes as ordered by the physician for 1 of 3 sampled residents (Resident #3).<br><br>Findings included:<br><br>Review of the care plan dated 12/22/16 revealed Resident #3 has a stage 4 pressure ulcer Of right ischium and an unstageable deep tissue ulcer to her sacrum. The goal was the wound would not worsen or show s/s of infection thru next review date. The intervention was to change dressing as ordered and prn (as needed).<br><br>Resident #3 was readmitted on 01/19/17 with diagnosis in part, diabetes mellitus, sacral pressure ulcers, cerebrovascular disease. The most recent Minimum Data Set (MDS) dated 1/26/17 revealed two (2) stage four (4) pressure ulcers.<br><br>Review of the wound care physician notes dated 1/25/17, revealed the right ischium measurements were 4.5 cm x 2.0 cm x 2.0cm, heavy serous exudate wound drainage, 35 % necrotic tissue and 65% granulated tissue. The wound progress had deteriorated. The wound was surgically debrided. The dressing change | F 314 | F 314<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to Resident #3. The Licensed nurse notified the physician on 2/7/17, and obtained a treatment order for a normal saline dressing and initiate negative pressure wound vac when available. The wound vac was initiated on 2/08/17. The wound vac remains in place with orders to change every three days. The wound physician visits weekly.<br><br>Current facility residents have the potential to be affected by the alleged deficient practice. The DON and/or unit managers completed and audit on 3/01/17, of current residents with orders for treatments with dressing changes, to validate treatments were completed according to physician orders.<br><br>Measures put into place to ensure the alleged deficient practice does not recur include: The DON and/or RN manger provided in service education for the licensed nurses beginning on 2/20/17, regarding providing treatments according to physician orders. The DON and/or unit | |

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| F 314 | Continued From page 3<br>order was to use Santyl (an enzymatic debriding ointment) and calcium alginate (a dressing that absorbed fluids and promoted healing) and cover with a dry protective dressing once daily. The sacrum wound was 8.0 cm x 4.0 cm x 1.5 cm, with heavy serous exudate wound drainage. The dressing change order was to use Santyl, calcium alginate and betadine cover with a dry protective dressing once daily.<br><br>Review of the wound care physician note dated 2/1/17 revealed the right ischium measurements were 4.5 cm x 2.0 cm x 2.0cm, heavy serous exudate wound drainage, 35 % necrotic tissue and 65% granulated tissue. The wound progress had improved. The tissue was 100% granulation. The dressing change order was to discontinue the previous dressing and begin negative pressure (a machine that provides a negative pressure for wounds with heavy exudate) - every three days. The sacrum wound was 8.0 cm x 4.0 cm x 1.5 cm, with undermining (undermining is caused by erosion under the wound edges, resulting in a large wound with a small opening) at 12 o'clock. Heavy serous exudate wound drainage. The tissue was 100% granulation. The dressing change order was to discontinue the previous dressing and begin negative pressure every three days. Nurse #4 was responsible for implementing the order change was terminated after 02/05/17 and not available by telephone.<br><br>A pressure wound dressing observation was conducted on 02/07/17 at 3:00 PM, Nurse # 3 revealed there was no Santyl to do the dressing change. Nurse # 3 indicated she was unaware of why the negative pressure dressing wasn't carried out. She had called the doctor and obtained an order for a saline dressing. | F 314 | managers will observe 5 treatments for at least 5 residents weekly for 4 weeks and 10 residents monthly for 3 months to validate treatments are completed according to physician orders. The wound physician will meet with DON and/or unit managers weekly after completion of wound rounds to discuss resident wound progress and treatment change recommendations. The DON, unit managers and/or charge nurse will notify the primary care physician regarding treatment change recommendations and implement orders as given.<br><br>The Director of Nursing will analyze audits/reviews 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 314 | Continued From page 4<br>Observation revealed no dressing was on the ischium wound. The dressing on the sacrum was dated 02/05/17 which revealed a missed treatment. The wound dressing was saturated with a heavy exudate and a strong noxious odor. The exudate was dark colored and absorbed through the dressing into the incontinent product. Nurse #3 confirmed the dressing had not been changed the previous day.<br><br>During interview on 02/07/17 at 4:03 PM, Nurse #1 indicated when a negative pressure dressing was ordered by the wound care physician, the nurse practitioner or physician were notified and the equipment was ordered and implemented within 24 hours. If there was a problem initiating the treatment the physician was notified the change of order documented.<br><br>During an interview on 02/08/17 at 9:16 AM, via telephone the nurse practitioner indicated the wound care physician orders were the orders used for wound care, and the nurses were to execute them. Once a negative pressure dressing was ordered the expectation was for it to be implemented. The notification was a courtesy.<br><br>During an interview on 02/08/17 at 02/08/17 at 3:13PM, Director of Nursing indicated she expected the nurses to carry out the physician orders and write a nursing note. | F 314 | | |
| F 315 SS=D | 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>(e) Incontinence.<br>(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain | F 315 | | 3/8/17 |

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| F 315 | Continued From page 5<br>continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br><br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and<br><br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to provide a catheter anchor to secure 1 of 2 sampled residents with an indwelling urine catheter (Resident #3).<br><br>Findings included: | F 315 | F 315<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to Resident #3. The licensed nurse secured the catheter tubing on | |

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| F 315 | Continued From page 6<br><br>Resident #3 was readmitted on 01/19/17 with diagnosis in part, diabetes mellitus, sacral pressure ulcers, and cerebrovascular disease. The most recent Minimum Data Set (MDS) dated 1/26/17 revealed she was incontinent at all times of bladder.<br><br>Review of the care plan dated 1/9/17, revealed Resident #3 had an indwelling catheter due to a pressure ulcer stage 4 of right ischium and an unstageable deep tissue injury to the sacrum. The goal of the care plan was the resident will be/remain free from catheter-related trauma through next review date. The intervention was to check tubing for kinks PRN (as needed).<br><br>During a wound observation conducted on 02/07/17 at 3:06 PM, the indwelling catheter tubing was fully exposed. A device to secure the catheter tubing was absent. Nurse # 3 revealed the tubing needed an anchor to secure the tubing. Aide #1 indicated the facility had anchors for the catheters. During an interview on 02/07/16 at 4:40 PM Nurse # 1 indicated catheter anchors on indwelling urinary catheters were required at all times.<br>During an interview on 02/08/17 at 4:48 PM, the Director of Nursing indicated her expectation was to secure the catheter tubing at all times. | F 315 | 2/08/17 and remains secured.<br><br>Current facility residents have the potential to be affected by the alleged deficient practice. The DON and/or unit managers identified residents with indwelling foley catheters on 2/28/17, and validated that catheters were secured to residents legs to prevent pulling of tubing.<br><br>Measures put into place to ensure the alleged deficient practice does not recur include: The DON and/or unit managers provided inservice education for the licensed nurses and certified nursing assistants beginning on 2/20/17, regarding properly securing catheter tubing to prevent pulling of tubing. The DON and /or unit managers will observe at least 2 residents weekly for 4 weeks and 4 residents monthly for 3 months to validate indwelling catheter tubing is properly secured to prevent pulling of tubing.<br><br>The Director of Nursing will analyze audits/reviews 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. | |
| F 353 SS=D | 483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>483.35 Nursing Services | F 353 | | 3/8/17 |

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| F 353 | Continued From page 7 | F 353 | | |

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]

(a) Sufficient Staff.
(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and

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| F 353 | Continued From page 8<br>described in the plan of care.<br><br>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, nurse practitioner and staff interview, the facility failed to have adequate nursing staff to provide treatments to pressure ulcers as ordered by the physician for 1 of 3 sampled residents reviewed for pressure ulcers. The facility failed to provide registered nurse (RN) coverage of 8 consecutive hours per day for 8 of 9 weekends reviewed.<br><br>The findings included:<br><br>1. This tag cross referenced to F 314. Based on observation, record review and staff and nurse practitioner interviews the facility failed to provide pressure ulcer dressing changes as ordered by the physician for 1 of 3 sampled residents (Resident #3).<br><br>2. This tag was cross referenced to F354. Based on record review and staff interviews, the facility failed to provide registered nurse (RN) coverage of eight consecutive hours per day for eight of the nine weekends reviewed.<br><br>During an observation 2/04/17 at 11:00 AM, there were 3 licensed practical nurses on duty. The staff posting was dated 2/3/17. The designated nurse supervisor, who was the assigned registered nurse, called out for the day and the staff was not replaced. | F 353 | F 353<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to Resident #3. The Licensed nurse notified the physician on 2/7/17, and obtained a treatment order for a normal saline dressing and initiate negative pressure wound vac when available. The wound vac was initiated on 2/08/17. The wound vac remains in place with orders to change every three days. The wound physician visits weekly.<br>The facility hired a Registered Nurse beginning on 3/08/17, to provide assistance and oversight of wounds and assure treatments are provided as ordered by physician.<br><br>Current facility residents have the potential to be affected by the alleged deficient practice. The DON and/or unit managers completed and audit on 3/01/17, of current residents with orders for treatments with dressing changes, to validate treatments were completed according to physician orders.<br><br>Measures put into place to ensure the | |

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| F 353 | Continued From page 9<br><br>During an interview on 02/05/17 at 11:03 AM, Nurse #5 indicated that there were no registered nurses scheduled on weekends since November. The licensed practical nurses provided coverage for all three shifts and were expected to divide the unit responsibilities with three or less nursing staff.<br><br>During an interview on 2/05/17 at 3:46 PM, Nurse #4, indicated she had worked here for two years as night supervisor, who was a registered nurse. She stated there were only two additional registered nurses in the facility. The additional registered nurse was the MDS coordinator and the Director of Nursing. Nurse #4 added that she only worked during the week and was off on the weekends.<br><br>During an interview on 2/04/17 at 11:55 AM, Nurse #6 indicated that they were down a nurse on the upper A hall and it was impossible to be in two places at one time. Nurse #6 stated "We" had been talking with "our" DON since this morning about getting someone in here to help. Nurse #6 indicated a patient fell this morning and that she had to send out to the hospital which took more time from other responsibilities.<br><br>During an interview on 2/7/17 at 4:59 PM, the Nurse Practitioner (NP) stated facility had several staff changes and the new administration felt the resident care could be done with less than four nurses. The wound care and dressing changes were not getting done as ordered because there were not enough nurses to do wound care. | F 353 | alleged deficient practice does not recur include: : The DON and/or RN manger provided in service education for the licensed nurses beginning on 2/20/17, regarding providing treatments according to physician orders. The DON and/or unit managers, RN wound nurse will observe 5 treatments for at least 5 residents weekly for 4 weeks and 10 residents monthly for 3 months to validate treatments are completed according to physician orders. The wound physician will meet with DON and/or unit managers weekly after completion of wound rounds to discuss resident wound progress and treatment change recommendations. The DON, unit managers, RN wound nurse and/or charge nurse will notify the primary care physician regarding treatment change recommendations and implement orders as given. The facility hired a Registered Nurse beginning on 3/08/17, to provide assistance and oversight of wounds and assure treatments are provided as ordered by physician.<br><br>The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly x 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. | |

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| F 353 | Continued From page 10<br>During an interview on 2/8/17 at 9:40AM, Nursing assistant (NA) #6/scheduler indicated that she was responsible for doing staff schedule. She added that Nurse #7 was scheduled as the RN to work the weekend. The expectation was for staff to contact her and the DON to find coverage for the building. She stated Nurse#7 did not contact her and it was assumed someone had contacted the Director of Nursing. She added that there had been several staff changes since new management transition. She indicated that there were only 3 hired RNs in building which included the director of nursing. She reported there had not been RNs scheduled on the weekends for several months. The expectation was for the charge nurse to contact the DON and go through the on-call list to find coverage for the weekends.<br><br>During an interview on 2/8/17 at 11:40AM, Nurse #7 indicated that there were no registered nurses (RN) scheduled on any shift on the weekends. The RNs were assigned on day shift. The licensed practical nurses worked the weekend on all three shifts. | F 353 | | |
| F 354 SS=E | 483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON<br><br>(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>(3) The director of nursing may serve as a charge | F 354 | | 3/8/17 |

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| F 354 | Continued From page 11<br>nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to provide registered nurse (RN) coverage of eight consecutive hours per day for eight of the nine weekends reviewed.<br><br>Findings included:<br><br>In an interview with the Manager of Human Resources on 02/07/17 at 11:37 p.m., she indicated that the facility employed three RNs who worked full-time and one who worked on an as-needed basis. Of the three full-time nurses, one served as the Director of Nursing (DON) and one as the Minimum Data Set (MDS) Coordinator.<br><br>A review was conducted of printouts of time worked for each of the four RNs. No RNs worked any hours on the following eight weekends: 12/03-04/16, 12/17 -18/16, 12/24-25/16, 12/31/16 - 01/01/17, 01/07-08/17, 01/14-15/17, 01/21-22/17, and 01/28-29/17.<br><br>In an interview with the DON on 02/08/17 at 5:56 p.m., she acknowledged the need for RN coverage on the weekends and indicated she was in the process of hiring more RNs. | F 354 | F 354<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to the provision of a Registered Nurse (RN) 8 hours a day 7 days a week. The facility has had continuous RN coverage for at least 8 hours a day 7 days a week beginning on 3/8/17. The facility has hired a RN that starts working on 3/08/17, and has other RN candidates in the hiring process, that will accommodate the needs of the facility and full fill the requirement for RN coverage at least 8 hours a day 7 days a week.<br><br>Current facility residents have the potential to be affected by the alleged deficient practice. Facility RN coverage will be available to assure that RNs will work at least 8 hours a day 7 days a week to assist , monitor and assure for the daily provision of quality care and needed operational functioning of the facility which includes provision of appropriate level of care and services to the residents. Further, the facility has secured an agency nursing staffing contract for nurses to assist with covering open positions until positions are filled appropriately.<br><br>Measures put into place to ensure the alleged deficient practice does not recur | |

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| F 354 | Continued From page 12 | F 354 | include: The Administrator and/or the DON provided education to the HR director and the Scheduler on 2/05/17, regarding the requirement for RN coverage 8 hours a day 7 days a week. The Administrator and/or the DON will review the schedule daily to assure RN coverage is provided. The HR director will monitor applications and communicate viable candidates for hire with the DON on a timely basis.<br><br>The Director of Nursing and/or the Administrator will analyze audits/reviews 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. | |
| F 356 SS=C | 483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION<br><br>483.35<br>(g) Nurse Staffing Information<br>(1) Data requirements. The facility must post the following information on a daily basis:<br><br>(i) Facility name.<br><br>(ii) The current date.<br><br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: | F 356 | | 3/8/17 |

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| F 356 | Continued From page 13<br>(A) Registered nurses.<br><br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)<br><br>(C) Certified nurse aides.<br><br>(iv) Resident census.<br><br>(2) Posting requirements.<br><br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br><br>(ii) Data must be posted as follows:<br><br>(A) Clear and readable format.<br><br>(B) In a prominent place readily accessible to residents and visitors.<br><br>(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to post accurate daily staffing information for one of five survey days.<br><br>On the initial tour of the facility conducted on | F 356 | F 356<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to posting of the nurse staffing | |

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| F 356 | Continued From page 14<br>Saturday 02/04/17 at 11:00 a.m., staffing information for the facility with the date of 02/03/17 was posted. The staffing sheet listed the Director of Nursing (DON) as the Designated Supervisor.<br><br>In an interview with the Administrator on 02/04/17 at 2:55 p.m., he acknowledged that the facility staffing sheet posted applied to the previous day. He indicated that the task of posting the current day ' s staffing information on the weekends was the responsibility of the Manager on Duty. The role of Manager on Duty on the weekends was rotated among the department head members of the Quality Assurance Committee. The individual assigned to be Manager on Duty did not come to work that day and the new staffing information was not posted.<br><br>In an interview with the DON on 02/08/17 at 5:56 p.m., she confirmed that the Manager on Duty is tasked with posting the daily staffing sheet. She indicated that at the present time there was no alternate plan for posting if the Manager does not come in. | F 356 | information daily. The information was posted on 2/4/17 and has been posted daily thereafter.<br><br>Current facility residents have the potential to be affected by the alleged deficient practice.<br><br>Measures put into place to ensure the alleged deficient practice does not recur include:<br>The Director of Nursing (DON) educated the staffing coordinator and receptionist beginning on 2/04/17, regarding the requirement for posting staffing information daily. The staffing coordinator or designated staff member, the receptionist on the weekend, will post the information daily in the prominent location readily accessible to resident and visitors. The DON and/or the Administrator will validate the posting of information at least 5 times a week for 4 weeks, then weekly for 3 months including weekends.<br><br>The Director of Nursing will analyze audits/reviews 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. | |
| F 371 SS=E | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. | F 371 | | 3/8/17 |

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| F 371 | Continued From page 15<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and facility staff interviews, the facility failed to label opened foods, maintain proper dishwasher temperatures and use dish sanitizer at manufacture recommended levels.<br><br>Findings include:<br><br>1a. An observation of the walk-in refrigerator on 2/4/17 at 11:25 AM revealed four (4) trays covered with aluminum foil that was not labeled, two (2) baking sheets that had baked product that looked like a cake covered in plastic wrap that was not labeled, opened bag containing sliced cheese that was not labeled and one (1) half gallon carton of buttermilk that was labeled as "Opened on 1/26/16 and Discard by 2/2/17." | F 371 | F 371<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to:<br>1)<br>a) 4 trays and 2 baking sheets observed in the walk-in refrigerator were discarded on 2/4/17. The half-gallon carton of buttermilk was discarded on 2/4/17.<br>b) The bag of frozen diced brown colored meat observed in the walk-in freezer was discarded on 2/4/17.<br>c) The 20 covered cups of brown fluid, 3 cups of milky white fluid, 10 cups of red colored fluid and 4 cups of coleslaw were | |

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| F 371 | Continued From page 16<br><br>b. An observation of the walk-in freezer revealed a bag of frozen diced brown colored meat that had no label or date on it.<br><br>c. An observation of the reach in refrigerator revealed twenty (20) covered cups of brown colored thicker consistency looking fluids, three (3) covered cups of milky white fluids, ten (10) covered cups of red colored fluids , four (4) cups of coleslaw that were not labeled .<br><br>d. An observation of the reach in freezer revealed a piping bag half filled with food that looked like cream inside a Ziploc bag that was not labeled.<br><br>During an interview with the facility's Cook #1 on 2/04/2016 at 11:35 AM, she stated that that the food should be covered and opened bags of food should have been labeled.<br><br>During an interview with the District Dietary Manager on 2/6/17 at 1: 40 PM, he stated that it was his expectation that staff should follow the correct labeling procedure and that all equipment cleaned immediately after each use.<br>During an interview with Administrator on 02/08/2017 at 3:40 PM, he stated that it was his expectation that staff label and date foods and check them daily. He further stated that dietary managers should be checking for food labeling and sanitation daily.<br><br>2. An observation of the three compartment sink that was used to wash pots and pan on 02/05/2017 at 12:05 PM, revealed sanitize compartment contained Quats sanitizer used for sanitizing dishes. Test strip indicated 100 ppm concentration. | F 371 | discarded on 2/04/17.<br>d) The piping bag with cream observed in freezer was discarded on 2/4/17.<br>2) Dietary staff was educated by the Dietary manager beginning on 2/6/17, regarding proper testing of sanitizer levels in the 3 compartment sink and process to maintain sanitizer levels between 200-400ppm, per manufacturer recommendations.<br>3) The Dietary manager notified Ecolab on 2/6/17, to correct wash and rinse temperatures on the dish machine to meet manufacturer recommendations of 140-150 degrees F for wash cycle and 180 degrees F for rinse cycle. The temperatures were corrected on 2/7/17.<br>The Dietary manager provided in service education for the dietary staff beginning on 2/6/17, regarding completing and signing off on daily temp and sanitation logs and appropriate process when temperatures do not meet specified recommendations.<br><br>Current facility residents have the potential to be affected by the alleged deficient practice.<br><br>Dietary manager provided in service education for dietary staff beginning on 2/6/17, regarding proper food handling and storage including dating and labeling of food items, proper testing of dish machine and sanitizer in 3 sink compartments, and process when temperatures or sanitizer does not meet manufacturer recommendations. | |

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| F 371 | Continued From page 17<br><br>During an observation of the three (3) compartment sink that was used to wash pots and pan on 2/6/17 at 1:15 PM, revealed sanitize compartment contained Quats sanitizer that indicated 100 ppm concentration.<br><br>During an interview with the Dietary District Manager on 2/6/17 at 1: 40 PM, he stated that staff should use the test strip, to test and make sure that the sanitize compartment of the three (3) compartment sink contained Quats sanitizer that met manufacture recommendations of 200 - 400 ppm.<br><br>3. An observation of the dishwasher temperatures on 02/05/2017 at 12:05 PM, revealed wash temperature at 120 degrees Fahrenheit (F) and rinse temperature at 140 degrees F.<br><br>Review of the dishwashing temperature log revealed no temperatures were logged on 2/6/17 when dishwasher was used for breakfast and lunch.<br><br>During an interview with the Dietary Aide # 1 on 2/6/17 at 1: 25 PM, she indicated that the dishwashing temperatures are usually logged prior to the start of each washing. She stated that staff needs to report to the dietary manager when temperatures do not meet the manufacture recommendations.<br><br>During an interview with the Dietary Manager on 2/6/17 at 1:30 PM, he indicated that it was his first day at work and was not aware that the dishwasher temperatures had not met the manufacture's recommendations. He stated that | F 371 | Measures put into place to ensure the alleged deficient practice does not recur include:<br>Dietary manger will complete rounds to inspect and ensure food are stored and dated/labeled properly, and will observe dishwasher temperature logs and sanitizer logs at least 5 times a week for 4 weeks then weekly for 3 months to validate appropriate food storage including dating/labeling and water temperatures and sanitizer logs are completed and maintained within manufacturer recommendations.<br><br>The Dietary manager and/or the Administrator will analyze audits/reviews 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 371 | Continued From page 18<br>was his expectation that staff inform him immediately so that appropriate action can be taken. He further stated that he would contact Ecolab immediately service.<br><br>During an interview with the Dietary District Manager on 2/6/17 at 1: 40 PM, he stated that it was his expectation that staff logs the dish washer temperatures for all meals. He further stated that it was his expectation that the dishwasher temperature for wash cycle be between 140 -150 degrees F and rinse cycle at 180 degrees F per manufacture recommendations.<br><br>During an interview with Administrator on 02/08/2017 at 3:40 PM, he stated that it was his expectation that staff follow sanitary procedures. He further stated that managers should check these procedures daily. | F 371 | | |
| F 431 SS=D | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must | F 431 | | 3/8/17 |

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| F 431 | Continued From page 19<br>employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>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.<br><br>(h) Storage of Drugs and Biologicals.<br>(1) 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.<br><br>(2) 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to store multiple medications in | F 431 | F 431 | |

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| F 431 | Continued From page 20<br>labeled packaging to identify the medication name, strength and expiration date in three of four mobile medication carts inspected.<br><br>Findings included:<br><br>1. During an inspection of the medication cart on the Upper B Hall on 02/07/17 at 4:50 p.m., the following was found: one loose orange tablet at the bottom of one drawer on the right-hand side of the cart, 22 loose tablets and capsules of different colors and sizes at the bottom of one drawer on the left-hand side of the cart, and 30 loose tablets and capsules of different colors and sizes at the bottom of a different drawer on the left-hand side of the cart. When the loose pills were shown to Nurse #1 who was giving medications, she disposed of them in the sharps container. She indicated in an interview that had she seen them underneath the bulk medications in the drawers she would have disposed of them on discovery.<br><br>2. During an inspection of the medication cart on the Lower A Hall on 02/06/17 at 8:57 a.m., 10 round white tablets were found in an uncovered 30 cubic centimeter medicine cup in an upper drawer on the left-hand side of the cart. The medicine cup was not labeled or covered. The nurse giving medications, Nurse #3, was unable to identify the medication and she disposed of the tablets in the sharps container.<br><br>3. During an inspection of the medication cart on the Upper A Hall on 02/06/17 at 8:40 a.m., one loose white tablet was found at the bottom of one drawer. The nurse giving medications, Nurse #2, was unable to identify the medication and she disposed of it in the sharps container. | F 431 | Corrective action has been accomplished for the alleged deficient practice in regards to medications found in medication carts that were not packaged and/or labeled. The medications were disposed by the licensed nurses when found on 2/6/17 and 2/07/17.<br><br>Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) and/or licensed nurses observed facility medication carts beginning on 2/27/17 and removed and discarded any loose medications that were noted not labeled appropriately.<br><br>Measures put into place to ensure the alleged deficient practice does not recur include: The DON provided in service education for the licensed nurses beginning on 2/20/17, regarding proper labeling and storage of medications. The DON and/or the unit managers will observe medication carts weekly for 4 weeks then monthly for 3 months to validate proper labeling and storage of medications.<br><br>The Director of Nursing will analyze audits/reviews 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 431 | Continued From page 21<br><br>In an interview with the Director of Nursing (DON) on 02/08/17 at 5:56 p.m., she shared her expectation that any nurse who drops a pill into a drawer on the medication cart or who sees a loose pill in the cart will remove and waste it. She acknowledged that medications should not be removed from their original packaging and/or stored in an unlabeled medicine cup in a drawer. | F 431 | | |
| F 490 SS=D | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, nurse practitioner interview, and record review, the facility's administration failed to maintain adequate staff to provide wound care as ordered by physician for 1 of 3 sampled residents (Resident #3). The facility failed to monitor the staffing pattern for registered nurses (RN) to ensure a coverage of 8 consecutive hours per day for 8 of 9 weekends reviewed. Findings include:<br><br>1. This tag was cross referenced to F314.<br>Based on observation, record review and staff and nurse practitioner interviews the facility failed to provide pressure ulcer dressing changes as ordered by the physician for 1 of 3 sampled residents (Resident #3). | F 490 | F 490<br><br>Corrective action has been accomplished for the alleged deficient practice in regards to Resident #3. The Licensed nurse notified the physician on 2/7/17, and obtained a treatment order for a normal saline dressing and initiate negative pressure wound vac when available. The wound vac was initiated on 2/08/17. The wound vac remains in place with orders to change every three days. The wound physician visits weekly.<br>The facility hired a Registered Nurse to provide assistance and oversight of wounds and assure treatments are provided as ordered by physician. | 3/8/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345227 | A. BUILDING _____ B. WING _____ | C 02/08/2017 |

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

| (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 |
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| F 490 | Continued From page 22<br>2. This tag was cross referenced to F353. Based on record review, observation, nurse practitioner and staff interview, the facility failed to have adequate nursing staff to provide treatments to pressure ulcers as ordered by the physician for 1 of 3 sampled residents reviewed for pressure ulcers. The facility failed to provide registered nurse (RN) coverage of 8 consecutive hours per day for 8 of 9 weekends reviewed.<br><br>3. This tag was cross referenced to F354. Based on record review and staff interviews, the facility failed to provide registered nurse (RN) coverage of eight consecutive hours per day for eight of the nine weekends reviewed.<br><br>During interview on 2/8/17 at 5:17PM, the Administrator stated the expectation was for the nursing staff to follow physician orders for wound dressing changes. The administrator added that nursing schedule was reviewed daily by the Director of Nursing and schedule coordinator. The scheduler was responsible for ensuring coverage was provided during the week and on weekends. | F 490 | In regards to the provision of a Registered Nurse (RN) a minimum of 8 hours a day 7 days a week the facility has hired additional Registered Nurses that will full fill the requirement for RN coverage at least 8 hours a day 7 days a week.<br><br>Current facility residents have the potential to be affected by the alleged deficient practice. The DON and/or unit managers completed and audit on 3/01/17, of current residents with orders for treatments with dressing changes, to validate treatments were completed according to physician orders.<br><br>Facility RN coverage will be available to assure that RNs will work at least 8 hours a day 7 days a week to assist , monitor and assure for the daily provision of quality care and needed operational functioning of the facility which includes provision of appropriate level of care and services to the residents. Further, the facility has secured an agency nursing staffing contract for nurses to assist with covering open positions until positions are filled appropriately.<br><br>Measures put into place to ensure the alleged deficient practice does not recur include: : The DON and/or RN manger provided in service education for the licensed nurses beginning on 2/20/17, regarding providing treatments according to physician orders. The DON and/or unit | |

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| F 490 | Continued From page 23 | F 490 | managers will observe 5 treatments for at least 5 residents weekly for 4 weeks and 10 residents monthly for 3 months to validate treatments are completed according to physician orders. The wound physician will meet with DON and/or unit managers weekly after completion of wound rounds to discuss resident wound progress and treatment change recommendations. The DON, unit managers and/or charge nurse will notify the primary care physician regarding treatment change recommendations and implement orders as given.<br><br>The facility hired a Registered Nurse beginning on 3/08/17, to provide assistance and oversight of wounds and assure treatments are provided as ordered by physician.<br><br>The Administrator and/or the DON provided education to the HR director and the Scheduler beginning on 2/05/17, regarding the requirement for RN coverage 8 hours a day 7 days a week. The Administrator and/or the DON will review the schedule daily to assure RN coverage is provided. The HR director will monitor applications and communicate viable candidates for hire with the DON.<br><br>The Director of Nursing and/or the Administrator will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the | |

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| **AVANTE AT REIDSVILLE** | **543 MAPLE AVENUE REIDSVILLE, NC 27320** |

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| F 490 | Continued From page 24 | F 490 | effectiveness of the plan and will adjust the plan based on outcomes/trends identified. | |