STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	1804 FOREST HILLS ROAD WILSON, NC 27893

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166	Avante at Wilson POC (Annual visit 7/31/17 – 8/3/17) **"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 both federal and state law".** **F-166 Resolve Grievances:** Corrective action has been accomplished for the alleged deficient practice regarding grievances. 1. The facility maintenance staff modified HVAC supplies and flows in the rooms of residents #56 and #5 per their requests to resolve their grievance on room temperature. This was done in February 2017 at the time the grievance was raised in the Resident Council meeting. 2. All current facility residents have the potential to be affected by the alleged deficient practice. The process whereby resident grievances (concerns) are communicated and responded to during Resident Council meetings has been modified. Any resident council grievances (concerns) verbalized during a meeting are now being processed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Interim Administrator	8/21/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement	F 166	through the existing facility grievance process rather than the process that the Resident Council was using formerly. That being, such grievances will be documented on a facility grievance form and processed through existing facility grievance process where a response is made to the resident within the time frame outlined in the facility grievance policy. Further, for any grievances raised at a Resident Council Meeting, the grievance outcome will be presented at the next following Resident Council meeting. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: • Any resident council grievances (concerns) verbalized during a meeting are now being processed through the existing facility grievance process rather than the process that the Resident Council was using formerly. • Further, for any grievances raised at a Resident Council Meeting, the grievance outcome will be presented at the next following Resident Council meeting. • The designated facility grievance officer, the social worker, has in-serviced the Activities Staff and the management team on this	

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to resolve grievances for two of three residents reviewed (Resident #56 and Resident #5). Findings included: A review of the medical record revealed Resident # 56 was admitted in 2015 with diagnoses of atrial fibrillation and Peripheral Vascular Disease (PVD). The Annual Minimum Data Set dated 11/9/2016 noted Resident #56 to be cognitively intact. In an interview on 8/1/2017 at 1:40 PM, Resident #56 stated she was cold at night and sometimes, had to have three blankets for her bed. Resident #56 stated she had told the nurse more than one time. A review of the medical record revealed Resident #5 was admitted in 2010 with diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes and PVD. The Annual MDS dated 5/17/2017 noted Resident #5 to be cognitively intact. In an interview on 8/2/2017 at 3:00 PM, Resident #5 stated it was always cold at night in her room and there was no way to turn the air up or down because there were no individual units in the rooms. Resident #5 stated she had told the	F 166	grievance process modification as well as the Resident Council. • The Grievance Officer will track all Resident Council grievances in the facility grievance log and will facilitate timely response compliance per policy. • Weekly, the Grievance Compliance Officer, will audit submitted grievances and the grievance logs to assure for timely grievance follow-up and outcome communication per facility grievance policy. This will be on an ongoing basis. 4. The Administrator will analyze Grievance Officer audits/reviews for patterns/trends and report in the Quality Assurance Committee Meeting monthly for three (3) months to evaluate the effectiveness of the plan and will make any needed adjustment based on outcomes/trends identified. 5. The Administrator is responsible for implementing the Plan of Correction. 6. Corrective action will be completed on 8/25/2017.	

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F 166	Continued From page 3 nurse, but nothing had been done. A review of the Resident Council Meeting Minutes revealed at the February 1, 2017 meeting, there was a complaint of temperatures in rooms being low at night, and a note that room numbers were given to the Director. Further review of Resident Council Meeting Minutes revealed residents asked for vent covers (to divert the air flow) in the March and April meetings. A review of the May, June and July meetings revealed no mention of the complaints about cold temperatures in rooms, nor any mention of the resolution to these complaints. In an interview on 8/3/2017 at 11:15 AM, the Activity Director stated when concerns are voiced in the Resident Council meetings, the concerns are given to the head of the department that is in charge of that area. The Activity Director stated the concern about cold temperatures in the rooms was given to the Maintenance Director, with the list of rooms. The Activity Director stated she just assumed the department heads took care of the problems. On 8/3/2017 at 11:30 AM the Maintenance Director was interviewed and stated he did get the concern from the Resident Council and put deflectors in the rooms. The Maintenance Director stated if that was not sufficient, the vent could be closed. The Maintenance Director produced the list of rooms that was given to him by the Activity Director from the meeting, but stated he did not have any documentation to show what he had done to address the problem or when the concerns were dealt with. Resident #56 was interviewed on 8/3/2017 at	F 166		

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F 166	Continued From page 4 2:00 PM and stated she wanted the vent closed to her room. Resident # 5 stated she wanted the air vent closed in her room also. On 8/3/2017 at 2:11 PM, the Administrator stated his expectation was the concerns from the Resident council meetings would be followed up on and resolved.	F 166		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to provide a dignified dining experience when it allowed 1 of 3 residents (Resident #33) seated at the same table to wait for 35 minutes while others ate before being fed. Findings included: Record review revealed Resident #33 was admitted to the facility on 1/9/2012 with diagnoses which included Hypertension, Abnormal Posture and Muscle Weakness. The most recent comprehensive Minimum Data Set (MDS) dated 5/10/2017 indicated Resident #33 was severely cognitively impaired and required total assistance for all Activities of Daily Living. The MDS indicated the resident was totally dependent on 1 person for assistance with eating. Record review revealed the resident's Care Plan was updated on 5/16/2017 and indicated the resident required total assistance with eating. The	F 241	**F-241 Dignity and Respect of Individuality:** Corrective action has been accomplished for the alleged deficient practice regarding Dignity and Respect. 1. Corrective action for resident #33 was achieved on 7/31/17 by implementation of the corrective action listed below on 8/1/2017. This was when the next group feeding for resident #33's participation took place. 2. All current facility residents have the potential to be affected by the alleged deficient practice. On 7/31/2017 after learning of this dignity issue, the Director of Nursing conducted a nursing restorative aide staff teachable in-service on the correct facility protocols for restorative feeding. This included resident dignity compliance protocols when group feeding activities were required. 3. Measures put into place to ensure that the alleged deficient practice does not	

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F 241	Continued From page 5 Care Plan interventions included Resident #33 would eat in the Assisted Dining room to promote communication with others. A continuous dining observation was conducted on 7/31/2017 from 12:00 PM until 12:58 PM. Resident #33 was brought to the dining room at 12:05 PM and was seated at a table with 2 other residents. At 12:10 PM, a tray was delivered and set up by Nursing Assistant (NA) #5 to one of the residents seated at the table, and the resident began eating. Immediately after the tray set up, NA #5 retrieved a tray from the cart and began to feed the other resident seated at the table. Resident #33 watched both of the residents seated at the table and occasionally reached out for one of the trays at the table, and NA #5 moved the other residents' trays out of reach. The NA attempted to redirect the resident. At 12:45 PM, the resident was observed fidgeting with the tablecloth and attempting to pull her clothing protector off. NA #5 completed feeding the other resident at the table and retrieved Resident #33's tray at 12:47 PM. NA #5 began feeding the resident at 12:50 PM. An interview was attempted with Resident #33 on 7/31/2017 at 1:20 PM. The resident was alert but unable to answer any questions. An interview was conducted with NA #5 on 8/1/2017 at 11:01 AM. NA #5 stated all the residents seated at a table needed to eat at the same time. NA #5 indicated when the lunch trays were delivered to the Assisted Dining Room on 7/31/2017, she was informed NAs could feed only 1 resident at a time. NA #5 reported she could not remember who gave her that information. NA #5 indicated normally she positioned herself between the 2 residents at the table so both could be assisted. NA #5 stated she felt really bad because it didn't seem right for Resident #33 to	F 241	recur include: • On 7/31/2017 the Director of Nursing conducted a nursing staff teachable in-service on the correct facility protocols for restorative feeding to all other members of the licensed and certified nursing staff. This included resident dignity compliance protocols when group feeding activities were required. • The Director of Nursing or other nursing supervisor, will perform observation audits by observing 5 times a week for 30 days than 2 times a week for 30 days, then monthly for 3 months, the restorative dining/feeding program to assure for compliance with facility protocols on dinning dignity compliance. 4. The Director of Nursing will analyze the audits/reviews for patterns/trends and report in the Quality Assurance Committee Meeting monthly for three (3) months to evaluate the effectiveness of the plan and will make any needed adjustment based on outcomes/trends identified. 5. The Administrator is responsible for implementing the Plan of Correction. 6. Corrective action will be completed on 8/25/2017.	

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F 241	Continued From page 6 be watching the other residents at the table eat. NA #5 reported the situation should not have happened, and administration informed the NAs in the Assisted Dining Room 2 residents could be fed at the same time. An interview was conducted with the Administrator (ADM) on 8/3/2017 at 10:21 AM. The ADM revealed awareness of Resident #33 not being assisted to eat while the other residents at the table were eating. The ADM indicated that was not the normal practice for the facility. The ADM stated the expectation was for all residents seated at a table to be fed concurrently.	F 241		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431	**F-431 Drug Record, Label/Store Drugs and Biologicals** Corrective action has been accomplished for the alleged deficient practice regarding drug labeling and storage. 1. Corrective action was achieved on 8/3/2017 by the removal of the of the outdated hydrogen peroxide that was found on A-Hall Medication Cart and the removal of the two expired bottles of Magic Mouthwash that were in B-Hall medication storage room. 2. All current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and other nursing supervisor team members completed a 100% audit of medication storage rooms, the medication carts and the treatment	

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F 431	Continued From page 7 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (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. (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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove expired medications from 1 of 4 medication carts and 1 of 2 medication storage rooms. Findings included: An observation of the A Hall medication cart on 8/3/2017 at 11:35 AM revealed an opened bottle of Hydrogen Peroxide 3% in the lower right	F 431	carts for any expired medications. This was completed on 8/3/2017. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: • The Director of Nursing provided in-service education/training beginning on 8/3/2017 on the proper storage of medications to licensed nursing staff members. • The Director of Nursing or nursing supervisory team members will audit medication rooms, medication carts and treatment carts for expired medications 5 times a week for 30 days than 3 times a week for 30 days than monthly monitoring for three months. 4. The Director of Nursing will analyze the audits/reviews for patterns/trends and report in the Quality Assurance Committee Meeting monthly for three (3) months to evaluate the effectiveness of the plan and will make any needed adjustment based on outcomes/trends identified. 5. The Administrator is responsible for implementing the Plan of Correction. 6. Corrective action will be completed on 8/25/2017.	

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F 431	Continued From page 8 drawer of the cart. The expiration date was 04/2017. The Director of Nursing (DON) was at the nursing station where the med cart was located and observed the Hydrogen Peroxide and the expiration date. The DON indicated the nurses are responsible for the disposition of expired medications on the medication carts and was unsure why the Peroxide was not discarded. An observation of the B Hall medication storage room on 8/3/2017 at 12:10 PM revealed a 140 milliliter (ml) bottle of Magic Mouthwash with the expiration date of 7/11/2017 and an opened bottle of Dukes Magic Mouthwash with the expiration date of 7/6/2017. The nurse in the medication room during the observation reported the medications were discontinued for both of the residents who were ordered the medication. The nurse stated normally the medications were sent back to the pharmacy when they were discontinued. An interview was conducted with the DON on 8/3/2017 at 2:13 PM. The DON indicated there was a pharmacy bin in the medication rooms for expired and discontinued medications. The DON reported when the medications were placed in the bins, the nurses were supposed to document the medications which were to be returned so the facility would have a record of the returned medications. The DON also indicated the pharmacy picked up the medications from the bins when they made the daily deliveries. The DON stated the pharmacists checked the medication carts and the medication rooms at least every 60 days for expired medications or any other issues. The DON stated the expectation was for all expired and discontinued	F 431		

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F 431	Continued From page 9 medications to be removed from the medication carts and medication rooms and returned to the pharmacy.	F 431		