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 _____	11/17/2011

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
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to promote a dignified dining experience [cognitive impaired resident] for 2 of 23 dependent and independent residents in the main dining room (Residents #125 and # 15) During an observation on 11/16/11 at 5:00 p.m., 23, residents were being escorted and seated in the main dining room. The main cart for the main dining room arrived at 5:05 p.m. All of the residents were served and fed except residents #125, and #15. These residents were seated at various tables waiting for their meals while the staff served and fed 23 other residents. Resident #125 and # 15 watched the residents in the main dining room as they were being fed. (Resident #125 and #15 were identified by Staff Nurse on 11/15/11 as being the cognitively impaired.) During an interview on 11/16/11 at 5:49 p.m. with the dietary manger, the manager stated that " these residents (residents #125 and #15) are fed by the restorative aides. We never have so many residents in the dining hall for dinner. Most of these people never eat in here for dinner. I have called for help more than 45 minutes ago, but no one responded. "	F 241	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F241 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #15 was assisted with her evening meal on 11/16/11 Resident # 125 was assisted with her evening meal on 11/16/11 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Residents will be served meals in preferred area in a timely manner.	12/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James A. Newman, Jr. | TITLE: Administrator | (X6) DATE: 12/15/11

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 241	Continued From page 1 During an interview on 11/16/11 at 6:35 p.m., NA#1 stated that " Resident # 125 [Name of the resident] was not fed because we had no meal tray for her. " She further stated, " Resident #125 does not normally eat in the dining room. Her tray went somewhere else so I had to wait until it was found. " During an interview on 11/16/11 at 6: 40 p.m. with the Assistant Director for Nursing (ADON), the ADON stated, " I am not normally here for supper; the nursing supervisor was supposed to be here in the dining room for dinner. I did not realize that she was not here. " The ADON added that " Resident# 15 [Name of resident] is cognitively impaired so her feeding varies. Sometimes she feeds herself with assistance, while sometimes she sleeps. " During an interview on 11/16/11 at 6:35 p.m. with the DON she stated, "my expectations are that the residents are fed when their tray is placed in front of them. I was not aware that residents were sitting waiting to be fed for more than 45 minutes. " During an interview with the administrator on 11/17/11 at 10:00 a.m., the administrator stated, " My expectations are that the residents are fed minutes after each other, but yesterday was an exception because the nurse assigned to the dining room had 2 admissions that were expected to arrive at 2:00 p.m. but came later. These were difficult admissions with family issues. "	F 241	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: CNA 's will be re-educated on serving resident meals in the dining room to include serving each resident one table at a time. Licensed staff will be re-educated on proper technique of serving residents in the dining room. In addition the licensed staff will be re-educated on their responsibility of dining room supervision. DON or designee will monitor the evening meal three times a week for four weeks to confirm that residents at each table are served and eating together 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 3 months.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities,	F 242		

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F 242	Continued From page 2 schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family interview and record review, the facility failed to honor 2 of 2 resident likes and dislikes of fluids (Resident #60 and #82). The findings included. 1. Resident #60 was admitted to the facility on 9/14/10, readmitted on 5/27/11. The cummulative diagnoses included cerebral vascular accident, cornoray disease, hypertension, dysphagia, gastroesphogeal reflux and chronic venous insufficiency. The Minimum Data Set(MDS) dated 9/24/11, indicated that Resident #60 had moderate cognition and decision making skills. The MDS also indicated that she was dependent upon staff for all her activities of daily living skills. Review of physician's order dated 9/27/11, revealed Resident #60 was on a mechanical soft diet with pureed meat, no added salt, chocolate high calorie/proetein, 1 can of glucerna two times a day, glytrol tube feeding via pump at 20cc an hour for 4 hours if tolerate. Review of the monthly nurse practitioner note dated 11/8/11, revealed that Resident #60 had chronic health conditions and benefit from tube feeding with water flushes in addition to the supplement of glucerna. Resident#60 overall appetite was poor and had improved with the implementation of the glucerna and Resident #60	F 242	F242 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #60 received chocolate glucerna on 11/15/11. Resident #82 had cranberry and apple juice removed from tray along with likes and dislikes of fluids updated on 11/17/11. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Residents will receive fluids of choice per their likes and dislikes information.	12/15/11

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F 242	Continued From page 3 weight had begun to stablized. During an observation on 11/13/11 at 10:50AM, Resident #60 was lying in bed with vanilla and chocolate glucerna can on the night stand. The chocolate glucerna can was empty. Resident #60 stated that she received the vanilla glucerna daily on her meal tray and she did not like vanilla. She added that she had told the nursing staff and dietary that she did not like the vanilla and the kitchen continued to send the can. She added that her family would bring her the chocolate because they knew what she liked and the facility told her they could not order the chocolate glucerna. During an interview on 11/14/11 at 11:40AM, family member stated that Resident #60 liked chocolate glucerna and was told by facility staff and dietary staff that they could not purchase any other flavor. The family member questioned why only one flavor was being purchased when residents would tolerate other flavors. Family stated that she had to start buying the chocolate so that Resident #60 could have what she liked and maintain appetite. She indicated that she didnt feel that she should have to provide a supplement that was ordered by the physician. During an interview on 11/14/11 at 11:43AM, dietary manager indicated that it was a corporate issue and that she had asked several times about why they can only purchase one flavor. She added that the facility could have purchased other flavors from other vendors. .During an interview on 11/14/11 at 11:50AM, administrator clerk indicated that she was responsible for ordering supplemental supplies for residents. She indicated that the current company only had 1 flavor of glucerna and they were in the process of trying another company.	F 242	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Dietician to update likes and dislikes of fluids for residents. Licensed staff to be re-educated on communication likes and dislikes of fluids to the dietary department. Supervisor or designee to interview 5 residents weekly to confirm if residents are receiving fluids of choice. 4. Indicate how the facility will monitor its performance: Results will be presented to QA&A team for recommendations and follow up for 3 months.	

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F 242	Continued From page 4 She added that she was aware that Resident #60 did not like the vanilla. She added that due to the inability to get the desired glucerna, we did tell the family we could not order that flavor. During an interview on 11/14/11 at 12:27PM, Nurse #3 indicated that Resident #60 had always requested chocolate glucerna and the family has been buying and bringing it for the resident. She added that DM(dietary manager) had also told them(staff and family) that the chocolate glucerna could not be purchased. During an interview on 11/14/11 at 12:41PM, Director of Nursing (DON)and Administrator indicated that the expectation was an alternate vendor should have been explored or a purchase from a local store. The dietary manager should have made other arrangements to obtain the glucerna. During an observation on 11/14/11 at 12:50PM, Resident#60 was in room with family eating her meal and the tray had a vanilla glucerna on tray. 2. Resident #82 was admitted to the facility on 8/28/08. The resident's cummulative diagnoses included diabetes, hypertension, end stage renal disease, anemeia, peripheral vascular disease, bilateral above the knee amputation, gastroesophegal reflux disease, coronary artery disease and congestive heart failure. Review of the care plan dated 11/23/10, Resident #82 was non-compliant with diet and fluid restrictions for dialysis/renal. The goals was Resident #82 would show/demonstrate ompliance of diet and fluid restrictions. The approaches included diet as ordered, labs to be secured as ordered and reviewed, monitor intake educate as needed, document extra food and non compliance. During an interview on 11/16/11 at 5:05PM,	F 242		

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F 242	Continued From page 5 Resident #82 stated that she continued to receive foods and juice on her tray that she did not like. Resident #82 added when it was discussed with dietary and in resident council meetings it never got resovled. During the resident council meetings meal choices, meal alternatives and quality of the food was discussed monthly. She added that when she or the resident council members try to tell the dietary manager of their concerns the DM continues to tell them there was nothing she could do about making changes because it was a coprporate decision or they cant make a specific meal or the item cant be ordered. She added that she continued to receive cranberry juice at every meal. Resident #82 stated that she has told the dietary manager, nursing and the aides that she did not like any of the juices. She added that the nurses knew and they would give her water with her meds, but the DM continued to send cranberry or apple juice. She added that when she brought the issues up in resident council she gets ignored and it really made her upset. Resident#82 also stated that she felt like the meals should meet the residents needs and they should not be told that corporation cannot order the food. She added that the food should be of better quality as well. It has been brought up several times in resident council that residents did not know what was on the menu, even what was posted was not what they receive on their tray. Resident #82 further stated that when you look at the alternate, the alternate was not what was listed on the menu. During an observation and interview on 11/16/11 at 6:00PM, family member was present during the meal. Resident #82 had cranberry juice on the tray . The family member indicated that Resident #82 had never really liked juice and the cranberry	F 242		

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juice was on her tray everyday at all meals. In addition, there were several other foods that were on the tray that Resident #82 did not like, but she would just push it to the side. The family brought alternate fluids of choice because Resident #82 would not drink the juice. The family futher stated that dietary manager and nursing was aware of Resident #82 dislike for any juice.
During an interview on 11/16/11 at 6:15PM, dietary manager indicated that Resident #82 meal preference sheet was updated on 8/22/11, and she was unaware that Resident #82 did not like juice(cranberry/apple juice). DM added that the only fluid dislike that she was aware of was tea. She further stated the preference list was updated every 30-60 days and Resident #82 had discussed many food concerns in the resident council meetings, but fluid dislikes was not a concern. DM further stated that the concerns from resident council regarding food, likes/dislikes was resolved on an individual basis.
During an interview on 11/16/11 at 6:55PM, Nurse #4 indicated that she was aware that Resident #82 did not like juice of any kind. She added that she gave Resident #82 water instead. She indicated that she was uncertain whether dietary was aware of the resident's dislike for juice.
During an interview on 11/17/11 at 8:15AM, Nurse#5 indicated that she was aware that the Resident #82 did not like juices and she gave Resident #82 water in place of the juice. Nurse #5 indicated that she was unaware of whether the dietary manager was aware that Resident #82 did not like juice, but she did get cranberry juice everyday on the tray and she never saw the resident drink the juice. She only saw Resident #82 drink water or diet soda that family would

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F 242	Continued From page 7 bring in. During an interview on 11/17/11 at 8:45AM, the Administrator indicated that the expectation was that DM should be reviewing with the resident their likes and dislikes and update records on a consistent basis. In addition,alternate options should be offered to the residents for their likes and dislikes that were within reason of the organization. Residents should not be told they cannot receive something because corporation would not allow unless other options have been explored. During an interview on 11/17/11 at 9:30AM, the activity assistant indicated that Resident #82 did attend the resident council meetings monthly and did bring up several concerns regarding food, meal choices, dislikes being received and alternatives. She added that since the dietary manager was generally present during the meeting it was assume that she would handle the concerns since she heard them first hand from the residents. She added that she did not follow-up with the concerns since the DM was aware.	F 242		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident	F 244	F244 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #41,109, and 45 were addressed by the dietary manager and likes and dislikes were updated. The dietary manger also informed these three residents that if menus change the changes would be posted.	12/15/11

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F 244	Continued From page 8 interviews and review of the resident council minutes, the facility failed to resolve resident dietary choices discussed in resident council meetings. (Residents #41, #109 and #45). Findings included: Review of the facility policy titled, "Resident Grievance" dated 12/3/08, read in part: The Resident Grievance may be given verbally or in writing but in either case must contain the following information: section A included there must be notice that a Resident Grievance was being filed. Additional, information revealed that if a Resident Grievance was given verbally, it must be transcribed into writing before the person receiving the Grievance lease the facility. Every employee, supervisor and agent of the facility must assist any originator in filing a Resident Grievance upon request. No employee, supervisor or agent of the facility shall hinder the Resident Grievance process, nor shall they retaliate against the originator of a Resident Grievance or the resident who is the subject of a Resident Grievance. A resident Grievance should be filed on a Resident Grievance form. 7. Resident Grievance forms should be accepted by any Avante Department head that will give the form to the Facility Risk Manger for appropriate action. The investigation must be completed with three (3) working days. The Facility Risk Manager must meet with the facility administrator or the DON to review the finding of the investigation, and determine what corrective action, if any is needed, the corrective action must be record on a Grievance Response form, and The Grievance Response must be available to the originator of the Grievance with five (5) working days.	F 244	2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: An audit was completed by RD/CDM to insure that current residents' likes and dislikes are current and updated. Dietary concerns voiced in resident council will be documented on a concern form and routed to the appropriate department head to address in writing. Follow up from the concerns will be presented in resident council by the activity coordinator and this too will be documented in the minutes. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Dietary manger will be re-educated on how to respond to concerns in writing. Activity coordinator will be re-educated on how to document concerns and there resolution from resident council RD/CDM will complete 5 random audits of residents' likes and dislikes to insure they are current and updated. In addition, Administrator or designee will monitor resident council minutes monthly times three months to confirm concerns are being addressed with follow up documentation reflected in the minutes. 4. Indicate how the facility will monitor its performance: Results will be presented to the QA&A team for recommendations and follow up for 3 months.	

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F 244	Continued From page 9 1. During an interview on 11/14/11 at 10:31AM, Resident #41 indicated the she requested on Saturday, the alternate meal of polish sausage and sauerkraut and the kitchen sent a bologna sandwich. She indicated they did not send the alternate meal. She indicated she complained to the nurse and was told it was not available. 2. During an interview on 11/16/11 at 10:48AM, Resident #109 revealed the facility activities director or the assistant activity director would facilitate the resident council meeting. The dietary manager attended the meetings and was not responsive to grievances. The most recent ongoing concern was a request for rice pudding on the menu and to stop serving rice at so many meals. The resident council had requested for more dry beans and the choice of salad dressings and condiments offered with the meal tray. He indicated alternate meals were not served as posted, no choices of sandwiches were offered. Resident #109 had requested a banana sandwich; the staff finally brought him a banana and two slices of bread. During an interview on 11/16/11 at 11:10AM, the activity director indicated food complaints were the biggest concern during the resident council meeting. The dietary manager was usually always present to hear the residents concerns. She indicated grievances for the dietary department were not documented on a grievance form or the minutes because the dietary manager attended the meetings and assumed she would take care of it. She indicated no copies of the actual grievances were kept. All other grievances for the other departments were written and given to the social worker. The social worker was responsible	F 244		

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for giving the grievances to the department heads. The activity director indicated she had not followed up on any grievances from the resident council meeting; the assumption was the department head would follow through.

During an interview on 11/16/11 at 11:20AM, dietary manager indicated a meal of the week was offered. Residents had beans every Wednesday at lunch. The resident council had asked for rice pudding for about three months, she indicated she did not know how to make it. She presented an recipe from a family member and stated it could be done as an activity because a small group wanted it. She reviewed the list from the June meeting and indicated condiments was offered as well and a variety of salad dressing. She indicated she was not aware of the request for the onions on the pintos, and only one resident had requested the polish sausage with kraut as the alternate, it was not offered. The dietary manager indicated bananas and yogurt when available were on the snack cart that was taken out at 10:00am and 2:00pm. The dietary manager indicated residents had choices of sandwiches and was not aware of anyone who requested a banana sandwich.

During an interview on 11/16/11 at 11:49AM, NA#1 and #2 indicated if banana or yogurt were offered it would be on the snack cart at 10am or 2 pm. The items varied; from day to day residents were offered jello, ice cream, pudding, crackers, bananas, and yogurt.

During an observation of lunch on 11/16/11 at12:30PM , revealed the posted " Resident Meal of the Week " was meat loaf, navy beans, June

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F 244	Continued From page 11 peas and rolls, red velvet cake. Alternate was hot dog. Dinner observation at 6:00PM included, chicken and dumplings, tossed salad and sherbet and the alternate was cottage cheese plate, carrot raisin salad. During an interview on 11/17/11 at 8:05AM, nurse #1 indicated resident #109 had requested food and the kitchen would deny the request. The kitchen gave only items that were on the menu for the day and nothing else. An example was made when Resident #109 asked for a banana sandwich and peanut butter was on the menu. The resident received peanut butter sandwich. During an interview on 11/17/11 at 8:10AM, nurse #2 indicated residents were denied the food they requested. The menu repeated rice, fish and pork. The aid was sent to the kitchen for a substituted item and the nurse had to come and sign for the item.Nurse#2 added she had to stop what she was doing to sign for a banana. During an interview on 11/17/11 at 8:20AM, nurse #3 indicated she indicated she had discussed with the dietary manager about the lack of response to the resident requests and was told there was no room in the budget for changes. She continued by saying residents was not given a choice of salad dressing or condiments. What was on the tray was what they got. The menu would repeat pork, fish and rice. The menu did not reflect the resident's choices. They had asked for meat, potatoes and dry beans. The kitchen sent out a lot of soup and sandwiches residents did not eat. The administrator and the director of nursing were aware of the dietary grievances. No snacks were available for residents in the	F 244		

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F 244	Continued From page 12	F 244		

nourishment room, except on the cart sent out by the kitchen at 10:00am and 2:00pm. The nurses do not have access to any food items unless they go to the kitchen. The kitchen was locked at night. She indicated she had complained to the administrator and the dietary manager, at the lack of availability of ginger ale and snacks for residents. The dietary manager indicted to her it was not in the budget and the administrator took no action.

During a follow-up interview on 11/17/11 at 9:10AM, dietary manager produced the copy of recipe #209, which was raisin rice pudding. The dietary manager indicated the recipe for the rice pudding was actually purchased in a can, there was no recipe. The dietary manager also indicted all the menus had the words "choice of "marked through because the facility preferred not to use that wording.

During an interview on 11/17/11 at 10:28AM, the social worker indicated she was responsible for ensuring the department heads received grievances forms and admitted she did not follow up the dietary grievances.

During an interview on 11/17/11 at 11:30AM, the administrator indicated he was unaware of any grievances regarding food choices or preferences. He was unaware there were no snacks available in the nutrition rooms and ginger ale was available if a resident was nauseated. He indicated the expectation was grievances made during the resident council meeting were written on a grievance form. The department head was to follow up within 3-5 days. The resident council

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F 244	Continued From page 13 minutes were expected to reflect all of the grievances. Review of the Resident Council Minutes revealed April meeting note for dietary indicated, "the dietary manager was present to discuss any dietary manner (sic) with the resident ' s, the dietary manager also discussed the resident meal of the month also the resident meal for National Nursing Home Week. " No documentation was written for the month of May. A hand written copy of suggestion from the resident council was given to the dietary manager for the month of June. Which read in part, "Give choices of salad dressing, pinto beans and onions, rice pudding. Requested dry beans each Wednesday. Meal choice of the month not being served." No specific concerns were documented in the minutes for the months of August, September and October the statement, "Dietary manager was present to speak with the resident about any concerns that they may have about the meals." Review of the menu dated 11/15/11, revealed dessert for lunch pudding (Raisin Rice marked thru) words "choice of " was crossed out for juice and salad dressing. On Wednesday 11/16/11, Breakfast: Cold cereal "Hot" was crossed out, French toast, links "turkey" was crossed out, syrup, margarine, and juice "choice of " was crossed out. Lunch: Balsamic Mediterranean was crossed out, leaving Tilapia, Rice Pilaf , Squash " zucchini " was crossed out, Bread "wheat ' was crossed out, red velvet cake the alternate was soft shell beef tacos refried beans (a question mark next to entry) , Dinner: "Chicken and Dumplings, Carrots Tossed salad Peaches, Sherbet cup, dressing "choice of "	F 244		

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F 244	Continued From page 14 crossed out the alternate was "cottage cheese plate, carrot raisin salad." Evening snack: assorted snacks & assorted beverages." 3. Resident #45 was admitted to facility 10/8/2010. The resident cummulative diagnoses included chronic airway obstructive, congestive heart failure, renal failure, anemia. The Minimum Data Set(MDS) dated 10/11/11, indicated that Resident #45 had moderate cognitive and decision making skills. The MDS indicated that two person assistance was required with activities of daily. Review of the care plan dated 8/24/11, Resident #45 had dehydration or potential fluid deficit related to poor intake of some meals and non compliance with diet restrictions. The goals included resident would drink a minimum of 1500-2000cc each 24 hr period through next review. The approaches included monitoring and document intake and output as per facility policy. During an interview on 11/16/11 at 5:00PM, Resident #45 stated that she attended the resident council group meeting every month and the concerns that she brought up about the food never was addressed. She added that she had complained to DM and floor staff about the quality of the food and the DM tells the group that there was noting that could be done because the corporation determines what the residents were going to eat and how they was going to fix the food. The food was not fit to eat. She added that half the time you never know what you were going to eat because what they post on the menu board was not what was being served or what	F 244		

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F 244	Continued From page 15 was on the alternate maybe something you dont like and then you have nothing to eat but a sandwich or soup. During an interview on 11/16/11 at 6:10PM, Nurse #4 indicated that Resident #45 had several concerns with the food and has shared with dietary manager,but she was unaware of the results of the food. The resident was alert and able to vocie her concerns without difficult. During an interview on 11/17/11 at 8:45AM, the Administrator indicated that the expectation was that DM should be reviewing with the resident their likes and dislikes and update records on a consistent basis. He added that in addition,alternate opitions should be offered to the residents for their likes and dislikes that were within reason of the organization. Residents should not be told they cannot receive something because corporation would not allow unless other options have been explored. He added that each department head was responsible for following up on group concerns. DM(dietary manager) should be communicating with the group regarding alternate ways to resolve the group concerns. During an interview on 11/17/11 at 9:30AM, the activity assistant indicated that Resident #45 attended the resident council meeting monthly and she indicated that Resident #45 did bring up several cocnerns regarding food, meal choices, dislikes and alternates. She added that since the dietary manager was generally present during the meeting it was assume that she would handle the concerns since she heard them first hand from the residents. She added that she did not follow-up with the concerns since the DM was aware.	F 244		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=D	Continued From page 16 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interview, the facility failed to maintain an odor free environment for 2 of 5 halls. (Resident #82). The findings include Duing tour on 11/13/11 at 9:45AM, there was offensive fecal and urine odors present on A hall when you enter the facility. During an observation on11/14/11 at 8:00AM, there was stale and fecal odor present on hall A. there was housekeeping present. The odor was severly present upon entry of side door of facility. On 11/14/11 at 8:19AM, B Hall 1-11, the offensive odors of fecal and urine was present and at 8:21AM, on BHall 13-29 additioanl offensive fecal and urine odor was present. During an observation on 11/14/11 at 10:52AM, strong offensive fecal/stale odor between B1-11 hall.. During an interview on 11/14/11 at 10:55AM, there was a lingering offensive odor present on lower end of A hall that had been lingering until 11:20AM, the odor was very strong in that it was present in the hall way from the nurse's station located in the center of the building. During an interview on 11/14/11 at 11:58AM, housekeeper(HK#1) indicated that she was responsbile for the general cleaning of resident rooms and supplying the rooms with cleaning	F 253	F253 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Offensive odors of urine and feces were eliminated from A and B hall on 11/16/11 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Maintenance director will conduct a hall to hall inspection to determine if any other halls have offensive odors of urine and feces.	12/15/11

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F 253	Continued From page 17 supplies.emptying trash, cleaning residents beds after a bowel movemnt. The HK #1indicated that the day hours were from 7-3 and floor techs works 3-11(1 to 2) responsible for cleaning carpet, empty soil linen barrels from soiled linen room, During an interview on 11/14/11 at 11:15AM, HK #2, indicated that she was responsible for cleaning floors, sinks, trash cans, sweeping, mopping, checking supplies,. The routine consist of basic cleaning. Detail cleaning assisignments included windows, blinds, sweep behind dresser, pull curtains. She added that when there were complaints of odors the expectation was to eliminate them as soon as possible. During an interview on 11/14/11 at 11:24AM, family member on A hall indicated that there had been several reports of odors throughout the building. The family member reported that it had been reported to nursing and housekeeping supervisor. During an observation on 11/15/11 at 3:30PM-4:00PM, strong offensive fecal and urine odor on front end of A hall and near side entrance as well as back end of B hall. During an interview on 11/16/11 at 9:17AM, HK#3 indicated the responsible for cleqning the basis of a residents room such as trash, toilets, outside of heaters, window seals,wipe down beds, sweep/mop. Deep cleaning done when assisnged includes cleaning curtains, wipe down doors walls, clean behind doors etc. she indicated that they used ocean wave air fresherner that she recieved the other day. The expectation was to eliminate the odors right away when the residents or family complained. During an interview on 11/16/11 at 9:21AM, the	F 253	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Maintenance director or his designee and Administrator will conduct daily rounds for 12 weeks of each hall to determine if any offensive odors of urine and feces are present. House keeping staff were re-educated on how to maintain a clean and sanitary rooms free from odors. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 3 months.	

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F 253	Continued From page 18 environmental service director indicated that 4 HK during the wk and 1 floor tech, responsible for housekeeping and floor cleaning. There was 2 HK first shift and 1 flr tech. Residents rooms was deep cleaned on a weekly basis, which included stripping beds, extensive floor cleaning, cleaning curtains, windows and on the weekends as well. He indicated that he did not have any recent cocnerns with odors. The ocean wave deoradaizer was used to refresh the area. During an interview on 11/16/11 at 5:05PM, Resident #82 stated that she added that she has told the nursing staff about the odors in the building and she never got a response so she asked her son to bring her a hide away stash of air fresherner. I rather smell flowers that that funky stuff all day. She indicated the smell of old socks and body all throughout the building. During an interview on 11/16/11 at 6:10PM, Nurse #4 indicated that she was aware that Resident #82 did complain of the odors in the building and the resident told her that she had a can of air freshener because she did not want to smell other residents BM or urine. She added that the expectation was that housekeeping clean the rooms daily and eliminate the odors with whatever they clean with. During an interview on 11/17/11 at 8:25AM, HK#4 indicated that she on occassion would receive complaints from residents or family about the odors in the building. She added that the expectation was to clean the area where the odors were as soon as they were reported. She added that HK should be checking resident rooms and cleaning and empty trash etc. She added that she worked the A hall and she had to go in several resident rooms several times of the day due to offensive fecal and urine odors.	F 253		

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F 253	Continued From page 19 During an interview on 11/17/11 at 8:45AM, the Administrator indicated that the he was unaware of any concerns with the odors being reported by residents or family. The expectation is that when there is any odors, HK should attempt to eliminate the odor immediately. He added that no concerns were brought to his attention regarding this.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, observation and record review, the facility failed to follow the physician order to perform a speech therapy evaluation in one of five residents (Resident # 47). The findings include: Resident #47 was admitted 12/08/10 with diagnoses, in part, Alzheimer type dementia and dysphagia. The Minimum Data Set (MDS) dated 09/16/11 indicated the resident had moderately impaired cognitive skills. The MDS indicated the resident was independent with eating after set-up and had no swallowing disorder. The MDS nutritional approach indicated the resident was on a mechanically altered diet which required a change in food texture. The Care Plans since 12/19/10 for the resident did not include a focus for diet or dysphagia.	F 281	F281 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Speech therapy evaluation completed on 11/17/11 for resident # 47 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: An audit was completed on current residents to determine if any other speech evaluations failed to be addressed. No other residents were found to be affected.	12/15/11

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F 281	Continued From page 20 The dietary evaluation dated 10/21/11 indicated Resident #47 was on a therapeutic and mechanical soft diet. The dietary evaluation did not indicate the resident had chewing or swallowing problems. The physician ' s order dated 11/07/11 was written for ST (speech therapist) to evaluate for an upgrade in the diet for the resident. On 11/13/11 at 3:16 PM, Resident #47 was evaluated to be interviewable and an interview was obtained to include dietary. The resident stated his food didn't look good because the meat was all cut up. The resident stated he wanted solid meat. On 11/16/11 at 9:17 AM, Nurse #1 stated she didn't know if the evaluation for a diet upgrade was done yet for Resident #47. Nurse #1 stated the evaluation was to be done by the ST. On 11/16/11 at 9:23 AM, the ST stated she did not know there was an order for a diet upgrade evaluation for Resident #47. The ST stated the resident was on a mechanical soft diet and his meat was ground. The ST stated an evaluation would determine if the resident could tolerate solid meat. On 11/17/11 at 7:26 AM, the dietary manager stated with a mechanical soft diet, the meat was ground. On 11/17/11 at 7:44 AM, the nursing supervisor (NS) stated new physician orders were communicated in the daily morning stand-up meeting. The NS stated all department heads	F 281	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Licensed nurses will be re-educated on the use of nursing to therapy communication forms. The nursing to the therapy communication form will be the communication used to notify therapy of a screen and therapy will use the same form to communicate the need for evaluation. The rehab manager will provide a copy of the written order for evaluation to speech therapy and will follow up to insure evaluations are completed timely. The rehab manager or designee will audit 5 random charts a week for 12 weeks to insure speech evaluations are completed in a timely manner. 4. Indicate how the facility will monitor its performance: Results will be presented to QA&A team for recommendations and follow up for 3 months.	

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F 281	Continued From page 21 attended the morning stand-up meeting. The NS stated the medical records manager made copies of new physician orders and distributed the copies to department heads. The NS stated the physician order for Resident #47 for a diet upgrade evaluation was generated by the resident ' s preference to not have ground meat. On 11/17/11 at 7:45 AM, the NS provided a 24 hour follow-up report for the clinical stand-up morning meeting. The report dated 11/07/11 indicated Resident #47 ' s follow-up communication need " speech eval (evaluation) for upgrade in diet " was " done " . The NS stated " done " meant the communication had been done in the stand-up meeting. On 11/17/11 at 7:46 AM, the Director of Nursing (DON) stated each morning in the stand-up meeting, in which the rehabilitation manager (RM) was present, the previous 24 hours of physician orders were reviewed. The DON stated copies were made by the medical records manager and provided to department heads/managers. On 11/17/11 at 7:51 AM, the medical records manager stated he made copies of new physician orders for the daily stand-up meeting for all department heads. On 11/17/11 at 7:57 AM, the RM stated she was the manager for speech therapy. The RM stated an evaluation was different from a screen and an evaluation needed a physician order. The RM stated she went to stand-up meetings every day. The RM stated she attended the morning stand-up meeting on 11/07/11, 11/08/11 and 11/09/11. The RM stated the medical records	F 281		

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F 281	Continued From page 22 manager made copies of new physician orders and distributed a copy of the orders to department heads. The RM stated she was included in a copy of new physician orders. The RM stated after she read the copy of new orders she shredded the copy. The RM stated the evaluation for Resident #47 should have been done on the same day as the order.	F 281		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. The facility must maintain the posted daily nurse	F 356	F356 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Nurse staff posting to include RN hours was posted on 11/17/11 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Nurse staff posting information was re-vamped to include the number of hours worked by RN per shift.	12/15/11

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F 356	Continued From page 23 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: Based on observations, staff interviews, facility posted nursing staff information form and facility nursing staff information form records; the facility failed to post numbers and actual hours worked for licensed staff by category/discipline for all three shifts for 4 of 4 days of survey. Findings include: During observations on 11/13/11 at 10:20AM, review of the staff posting located on the wall in front of the business office included the facility name, date, resident census, licensed and unlicensed staff by shift and hours. However, the licensed staff on duty was not clearly identified by role between register nurse and the licensed practical nurse. Review of the posted information did not indicate whether an RN was on duty. During a follow-up observations on 11/14/11 at 12:45PM, 11/15/11 at 10:40AM and 11/16/11 at 2:20PM, the staff information that was posted did not include the registered nurse hours on duty During an interview on 11/17/11 at 10:50AM, Nurse supervisor, DON(director of nursing) and ADON(assistant director of nursing) indicated that the scheduler for the facility completed the posting daily and that a register nurse worked 12 hours a day. Review of the posted hours revealed that it could not be distinguished between the register nurse hours from the licensed practical nurse.	F 356	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Re-educate staffing coordinator and supervisors as to what the nurse staff posting must contain. DON or designee will monitor nurse staff posting three times a week for four weeks to confirm it contains the RN hours worked per shift. 4. Indicate how the facility will monitor its performance: Results will be presented to the QA&A team for recommendations and follow up for 3 months.	

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 _____	11/17/2011

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

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F 356	Continued From page 24 Review of the daily nursing scheduled posted on 11/17/11 at 11:15AM, with DON who confirmed that the current format of the posted information did not identify the registered nursing staff on any of the schedules from August 2011 through November 20ll.	F 356		

PF

PRINTED: 12/11/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/08/2011

RECEIVED
DEC 28 2011
CONSTRUCTION SECTION

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

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 12/08/2011 the door to the dry storage room in the kitchen failed to latch when shut. 42 CFR 483.70 (a)	K 029	K029 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: The door to the dry storage room in the kitchen was repaired on 12/13/11 to latch properly. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will complete an audit of all facility doors to ensure they latch properly and repair as indicated. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will complete a weekly inspection of 25% of facility doors to inspect for proper latching and repair as indicated. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 3 months.	1/22/12
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation and staff interview on 12/08/2011 the staff did not know about the master door release switch located at the nurses station. 42 CFR 483.70 (a)	K 038	K038 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: All staff re-educated as to the location of the master door release. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will conduct monthly drills with employees in regards to the location of the master door release. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will complete monthly re-education of employees as to the location of the master door release. Education of location of the master door release will be included in orientation of all new employees. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 3 months.	1/22/12
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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

James A. Newman Jr. — Administrator — 12/22/11

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.

CD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345227	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/08/2011

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AVANTE AT REIDSVILLE	543 MAPLE AVENUE REIDSVILLE, NC 27320

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K 050 SS=D	Continued From page 1 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A. Based on observation and staff interview on 12/08/2011 the staff did not know the fire drill procedure. 42 CFR 483.70 (a)	K 050	K050 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: All staff re-educated as to the proper fire drill procedures. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will conduct monthly fire drills with employees demonstrating proper fire drill procedures. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will complete monthly re-education of employees as to proper fire drill procedures. Review of proper fire drill procedures will be in included in orientation of all new employees. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 3 months.	1/22/12
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: A. Based on observation on 12/08/2011 there were bug lights mounted on egress corridor walls that were to wide and to low . They were reducing the width of the corridors. 42 CFR 483.70 (a)	K 072	K072 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Bug lights in egress corridors moved up on wall to ensure they are not reducing the width of the corridors on 12/20/11. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will conduct an audit of all egress corridor walls to ensure no objects are to wide or low and protruding into the corridor. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will conduct daily rounds of egress corridors and remove /relocate any objects not providing proper clearance. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 3 months.	1/22/12
K 076	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 076 SS=D	Continued From page 2 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 12/08/2011 there was an unsecured 02 cylinder in the Rehab. Room. B. There was 02 in room B-15 with no " No Smoking " sign. 42 CFR 483.70 (a)	K 076	K076 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: All oxygen cylinders in rehab room were properly secured and oxygen located in room B-15 was removed on 12/8/11. All staff re-educated as to proper storage of oxygen cylinders and proper signage for areas with oxygen cylinders. Rehab staff re-educated as to proper storage of oxygen cylinders. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will conduct an audit of all rooms where oxygen cylinders are stored or in use to ensure cylinders are properly secured and proper signage is in place. Rehab manager will review rehab area weekly to ensure oxygen cylinders are properly stored. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will complete monthly review to ensure that oxygen cylinders are properly secured and proper signage is in place. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 3 months.	1/22/12
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K144 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Generator inspected and repaired to ensure proper cranking and transfer on 12/16/11. Awning to be placed over generator to provide protection from inclement weather. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will inspect generator weekly and exercise generator under load for 30 minutes per month. Any issues with proper cranking or transferring will be corrected.	1/22/12

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: A. Based on observation on 12/08/2011 the generator failed to crank and transfer. 42 CFR 483.70 (a)	K 144	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will review weekly generator tests for proper functioning. Repairs to generator and protection from inclement weather completed to ensure proper cranking and transferring. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 3 months.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 12/08/2011 there were exposed incandescent light bulbs in the boiler room near the A Hall nurses station. 42 CFR 483.70 (a)	K 147	K147 Deficiency has been corrected. 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Protective covers placed over exposed incandescent light bulbs in boiler room on 12/12/11. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will audit all light fixtures in facility to ensure proper covers are in place. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will include a review of facility light fixtures to weekly Preventative Maintenance rounds to ensure proper functioning of lights and that proper covers are in place. 4. Indicate how the facility will monitor its performance: Results will be presented to QAA team for recommendations and follow up for 3 months.	1/22/12