

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

PRINTED: 03/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD RD CONCORD, NC 28025	
(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 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>APR 09 2012</p> <p>Preparation and or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion 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 the federal and state law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Imaballa

Administrator

4/4/12

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 156	<p>Continued From page 1</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This</p>	F 156	<p>F156 483.10(b)(5) – (10) 483.10(b)(1) Notice of Rights, Rules, Services, Charges</p> <p>The current state agency contact information is posted.</p> <p>All alert and oriented residents have been informed of where to find the current state agency and advocacy contact information during Resident Council meeting and/or individually.</p> <p>All new residents will be informed of the location of the current state agency and advocacy contact information during the admission process.</p> <p>A monthly audit of new admissions will be conducted to monitor the information is conveyed about the location of the state agency and advocacy contact information.</p> <p>This process will be reviewed monthly in QA&A meetings for three months for review and further recommendations.</p>	3/23/2012

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F 156	<p>Continued From page 2</p> <p>includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to post current state survey agency contact information.</p> <p>The findings include:</p> <p>On 2/26/12 at 2:20 pm, upon entering the facility, a frame on the main lobby wall, listed the state nursing home regulatory agency as The Division of Facility Services. The address to the state agency was listed incorrectly, as well as the contact number to the regulatory complaints division.</p> <p>On 2/26/12 at 6:50 pm as well as on 2/27/12 at 5:15 pm, the same observations were made about the state contact information.</p> <p>On 2/29/12 at 7:50 am, the Administrator was</p>	F 156	<p>All staff have been informed of the state agency that governs nursing home Regulations by Administration.</p> <p>All new employees will be informed of the state agency that governs nursing home regulations during orientation by Administrator, DON or Social Services Director.</p> <p>The staff were shown where the information is located in the facility and provided a copy of the information regarding which state agency governs nursing home regulations.</p>	4/9/2012	

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F 156	Continued From page 3 informed that the state contact agency did not reflect the changes the agency made in 2007 and should be current, for contact purposes. The Administrator stated that she had been in her position for 8 months, but never noticed that the frame contained outdated information. On 3/1/12 at 2:15 pm, the Resident Council President was interviewed. She attends the council meetings monthly and shared she did not know where she could find contact information for the state agency, in the facility, The Administrative Staff # 3 was interviewed on 3/1/12 at 2:55 pm. She stated that she has been in her role at the facility for four months. She shared that she facilitates the Resident Council Meetings, which are held monthly and attended by residents who are alert and oriented. In these meetings, she reviews resident rights. Thus far, she had not discussed advocacy groups or state contact information with the residents who attend. When asked what state agency governed nursing home regulations, she responded JCAHO, which stands for Joint Commission on Accreditation of Healthcare Organizations.	F 156			
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of	F 159			

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F 159	<p>Continued From page 4</p> <p>the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 159			

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F 159	<p>Continued From page 5</p> <p>Based on record review, resident and staff interviews, the facility failed to uphold acceptable accounting practices, by not separating resident trust funds from the general account funds for 3 of 3 residents (Residents # 112, 109 & 34); failing to deposit the Medicaid \$30 personal allowance into 1 of 3 resident (Resident # 109) trust funds account; failing to close 2 of 2 resident trust funds accounts of deceased residents(Residents # 4 & 69), diverting interests from active trust fund accounts and failing to inform 1 of 3 residents (Resident # 81) with trust funds accounts, the procedure to access petty cash on weekends.</p> <p>The findings include:</p> <p>1a. Resident # 112 was admitted to the facility on 4/21/10. On 2/29/12 at 9:40 am, his financial record was reviewed with Administrative Staff #5. It revealed that a resident trust fund account was opened on his behalf on 1/14/11. He became Medicaid eligible after his admission into the facility.</p> <p>The Administrative Staff #5 stated that Resident #34 became eligible for Medicaid, a few months after he applied and the program allowed retroactive payments up to three months for services rendered. As a result, she explained that the facility had to credit him \$4004 in payments that he made toward his patient medical liability. The Medicaid program has a resource spending limit of \$2000 in order to maintain eligibility for services. She also explained that the facility did not want to jeopardize his Medicaid eligibility, so part of his income has been transferred to their accounts receivable, instead of allowing his</p>	F 159	<p>F159 483.1(c)(2)-(5) Facility Management of Personal Funds</p> <p>Resident trust funds are separated from the general account for Residents #112, 109 & 34.</p> <p>A 100% audit of every resident's general account compared to their resident trust account to assure separate accounts for all residents.</p> <p>Other residents were identified and their accounts have been corrected.</p> <p>Weekly review of General and Trust account Funds to be conducted by Administrator Or Regional Account Manager to ensure Accounts are separate.</p> <p>This process will be reviewed monthly in QA & A for three months for review and recommendations.</p>	<p>3/30/2012</p> <p>4/9/2012</p>

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F 159	<p>Continued From page 6</p> <p>money to accumulate in the resident trust fund account.</p> <p>The Administrative Staff #5 stated that their intent was to issue a portion of the \$4004 that they need to reimburse to him, a little at a time, and recently they deposited \$200 into his Resident Trust Fund account from their accounts receivable, on 2/27/12.</p> <p>1b. Resident # 109 was admitted to the facility on 7/16/09. On 2/29/12 at 9:40 am, his financial record was reviewed with Administrative Staff #5. It revealed that a resident trust fund account was opened on his behalf on 1/14/11. He applied for Medicaid at the time of his admission. Administrative Staff #5 stated that Resident #109 became eligible for Medicaid, a few months after he applied and the program allows retroactive payments up to three months for services rendered. As a result, she explained that the facility had to repay him \$2904 that he made toward his patient medical liability. The Medicaid program has a resource spending limit of \$2000 in order to maintain eligibility for services. She also explained that the facility did not want to jeopardize his Medicaid eligibility, so part of his income had been transferred to their Accounts Receivable, instead of allowing his money to accumulate in the Resident Trust Fund account.</p> <p>The Administrative Staff #5 stated that their intent was to issue a portion of the credit a little at a time; however, they have not issued a payment yet to his resident trust fund account. A copy of Resident #109 's account statement was examined. It documented that during December, 2011, Resident #109 's personal medical liability</p>	F 159	<p>The personal allowance deposit for resident #109 was deposited into their trust fund.</p> <p>A 100% audit of personal allowance transfers for all residents with trust accounts conducted.</p> <p>This process will be reviewed monthly in QA & A meeting for three months for review and recommendations.</p> <p>Resident #4 & 69 trust funds were closed With interest.</p> <p>A 100% audit conducted of deceased residents with trust accounts.</p> <p>Credits will be Refunded with interest within thirty days of resident expiration.</p> <p>This process will be reviewed monthly in QA & A meeting for three months for Review and recommendations.</p>	<p>3/1/2012</p> <p>4/9/2012</p> <p>3/30/2012</p> <p>4/9/2012</p>	

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F 159	<p>Continued From page 7</p> <p>was \$780 based on a monthly income of \$ 975. On 1/3/12, his income was increased to \$1010.00 and his personal medical liability was adjusted to \$1000.00. On 1/5/12 & 2/3/12, Resident #109 only received \$10 of his \$30 Medicaid personal allowance, because the Administrative Staff #5 stated that they placed \$20 in their accounts receivable, so that his balance wouldn ' t rise above his resource spending limit. On 2/27/12 his resident trust fund account balance was \$1948.48.</p> <p>1c. Resident # 34 was admitted to the facility on 9/1/08. On 2/29/12 at 9:40 am, her financial record was reviewed. It revealed that a resident trust fund account was opened on her behalf on 1/14/11. Resident #34 was a Medicaid recipient. On 10/3/11, her resident trust fund account balance was \$2212.01. Her monthly income was \$816.00 and her patient medical liability was set at \$786.00. On 10/3/11, the facility withdrew \$786.00 for care cost and an additional \$400.00 for care cost on 10/20/11, leaving her with a balance of \$1812.10. On 2/3/12, a deposit was made into her resident trust fund account for \$846.00 based on her monthly income. On 2/3/12, \$816.00 was deducted for her patient medical liability and \$300.00 on 2/27/12 for a care cost payment, leaving a balance of \$1795.55.</p> <p>During the review, the Administrative Staff #5 stated that corporation has to repay Resident #34, \$306. She shared that they recently took \$300 out of her account on 2/27/12 trying to keep her resource spending limit under \$1800 and placed the money in accounts receivable. She shared that once everything was settled with their audit, they will have to owe Resident #34, a total</p>	F 159	<p>The Business Office Manager in-serviced on Upholding acceptable accounting practices by Keeping resident trust funds separate from general account funds; depositing correct Personal allowances into resident trust accounts; Following regulations and guidelines for deceased residents with trust fund accounts by the Administrator.</p> <p>All alert residents informed of banking hours and how to access monies on the weekends during Resident council meeting and/or individually. A poster of the banking hours is posted at the receptionist desk.</p> <p>All new residents will be informed of banking Hours and how to access monies on the weekends during the admission process.</p>	<p>4/9/2012</p> <p>3/23/2012</p>	

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F 159	<p>Continued From page 8 of \$606.</p> <p>2. Resident # 109 was admitted to the facility on 7/16/09. On 2/29/12 at 9:40 am, his financial record was reviewed with Administrative Staff #5. It revealed that a resident trust fund account was opened on his behalf on 1/14/11. He was enrolled with Medicaid and was granted \$30.00 for personal allowance.</p> <p>The Administrative Staff #5 stated that after Resident #109 became eligible for Medicaid, he was entitled to reimbursement for monies he paid toward his bill while his Medicaid application was being reviewed. She stated that the facility has to repay him \$2904, which would create a large amount of cash in his resident trust fund account and would place him above the Medicaid resource spending limit of \$2000. Therefore, the Administrative Staff #5 said that their intent was to transfer some of his income to their accounts receivable, so that his Medicaid would remain intact.</p> <p>A copy of Resident #109 account statement was examined. It documented that on 1/3/12, his income was increased to \$1010 and his personal medical liability was adjusted to \$1000. She provided documentation on her computer screen, that his account was set up to be issued the \$30 allowance, however, they are diverting \$20.00 to accounts receivable in order to keep his balance under the resource limit. On 1/5/12 & 2/3/12, Resident #109 only received \$10 of his \$30 Medicaid personal allowance, because the Administrative Staff #5 stated that placed \$20 in their accounts receivable, so that his balance wouldn't rise above his resource spending limit.</p>	F 159			

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F 159	<p>Continued From page 9</p> <p>On 2/27/12 his resident trust fund account balance was \$1948.48.</p> <p>3a. On 2/29/12 at 9:40 am, the resident trust fund account was examined with Administrative Staff #5. On the Trial Balance summary (monthly bank summary), dated 2/28/12, contained status notes, reflecting that some of the accounts were still opened to residents who were expired.</p> <p>The Administrative Staff #5 indicated when a resident with a trust fund account expires; she has thirty days to convey the funds after the date of their death. Then she would proceed to close the account within thirty days of their discharge. However, she stated that she noticed that some of the expired residents still had accounts opened so she contacted her financial management service on 2/23/12 for further direction. She shared that her call has not be returned yet.</p> <p>Resident #4 expired on 1/1/12, yet received interest of \$0.03 after his funds were conveyed.</p> <p>3b. On 2/29/12 at 9:40 am, the resident trust fund account was examined with Administrative Staff #5. On the Trial Balance summary, dated 2/28/12, contained status notes, reflecting that some of the accounts were still opened to residents who were expired.</p> <p>The Administrative Staff #5 indicated when a resident with a trust fund account expires; she has thirty days to convey the funds after the date of their death. Then she would proceed to close the account within thirty days of their discharge. However, she stated that she noticed that some of the expired residents still had accounts opened</p>	F 159			

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F 159	Continued From page 10 so she contacted her financial management service on 2/23/12 for further direction. She shared that her call has not be returned yet. Resident # 69 expired on 10/27/11, yet received interest of \$0.02 after her funds were conveyed. 4. On 2/27/12 at 9:53 am, Resident #81 stated that she had a resident trust account and that there was no way to get her money on the weekends, because the facility kept the money locked up. She stated that she has heard them tell people that they cannot get their money on the weekend. On 2/29/12 at 9:40 am, the Administrative Staff #5 was interviewed. She stated that the business office was opened Monday through Friday from 8:00 am to 5:00pm. However, she added that she has one full-time and two part-time evening receptionists, who have the ability to handle transactions with the resident trust funds account. She shared that the weekday receptionist was on duty until 8pm and on the weekends, the receptionist was present from 8:00 am to 8:00 pm. She commented that she places petty cash in a lock box which the receptionist can access whenever she was not there. However, she stated that she didn ' t think that anyone was aware that her staff was equipped to dispense funds during non-business hours, because when she examined the lock box on Monday, she always found the same amount of cash in it, that she left on Friday.	F 159			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	<p>Continued From page 11</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff and physician interviews, the facility failed to intervene on the behalf of 1 of 1 resident (Resident #23) with a reported sleep disturbance and a history of untreated sleep apnea.</p> <p>The findings include:</p> <p>Resident #23 was admitted to the facility on 3/17/10, and re-admitted on 6/17/11 with the following cumulative diagnoses: end stage renal disease, hypertension, gastro esophageal reflux disease, pulmonary edema and sleep apnea.</p> <p>On the most current quarterly Minimum Data Set (MDS) dated 1/9/12, it assessed him as having a moderate cognitive impairment.</p> <p>A review of his chart, documented a physician 's progress note, on 9/27/11, where the Physician recorded, " This man (Resident #23) snores a lot. He has obstructive sleep apnea. "</p> <p>A review of the nurse 's notes revealed that on 1/17/12 at 10:00 pm, Nurse #3 recorded a concern in a Triage Note to the physician, that when Resident #23 fell asleep in bed, his</p>	F 309	<p>F309 483.25 Provide Care/Services for Highest Well Being</p> <p>Resident #23 was ordered another sleep study by the Physician.</p> <p>All orders are to be written on a physician telephone order slip instead of the triage forms.</p> <p>All orders will be audited by the supervisors daily and will be checked by the Director of Nurses in morning meeting.</p> <p>This process will be reviewed monthly in QA &A meeting for three months for review and recommendations.</p>	3/30/2012	

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F 309	<p>Continued From page 12</p> <p>breathing sounded abnormal. She stated that it sounded like he was trying to catch his breath constantly. She wrote, " I did a triage sometime last year for him to be evaluated at a sleep clinic but nothing was done. Please, I am concerned that he will have respiratory problems one day, if something is not done. "</p> <p>The physician progress note from 1/17/12, mentions that Resident #23 has sleep apnea and was examined, but that he denied any new symptoms. A continuation of his current regimen was recommended by the physician.</p> <p>On 2/24/12, the physician jotted a response on the 1/17/12 Triage Note, that he wanted Medical Records to find the sleep study. The date was unknown, however, Nurse #4 ' s signature was contained on the 1/17/12 Triage Note as well, and she recorded an additional note for Medical Records to find the old sleep study.</p> <p>Resident #162 was interviewed on 2/27/12 at 2:50 pm. He shared that Resident #23 was his roommate and that he snored very loudly. Resident #162 stated that if he didn ' t take a sleep aide at night, he wouldn ' t be able to get to sleep due to his roommate ' s snoring.</p> <p>On 2/29/12 at 4:40 pm, nurse aide #1 was interviewed. She stated that she works with Resident #23 sometimes she has heard him snoring when he slept.</p> <p>On 2/29/12 and 3/1/12, the Administrative Manager #6, provided the thinned chart for Resident #23. It was reviewed thoroughly, however, it did not contain a copy of the sleep</p>	F 309			

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F 309	<p>Continued From page 13 study.</p> <p>An interview was conducted with Nurse #3 on 3/1/12 at 10:00 am. She described Resident #23 as making grunting sounds when he slept at night and that it sounds like he was trying to catch his breath. She stated that it sounded abnormal. She shared that sometimes when she passes medication on the hallway, across from his room, she can hearing him snoring loudly and struggling to breathe. She stated that this was why she specifically wrote her concerns on the Triage sheet because she wanted to the physician to review her comments and take action. She stated that when she worked with him this past Sunday and Monday, she didn ' t notice any problems with his breathing, while he slept. However, she stated that Resident #23 did not use a specialized machine for his sleep apnea and that ' s why she was recommended a sleep study.</p> <p>On 3/1/12 at 10:30 am, the physician was contacted. He stated that he recalled that a nurse had shared her concerns about Resident #23 ' s breathing problems at night. He had asked that the sleep study be pulled from the medical records but was unaware that it was never found. He stated that had he known that there was no sleep study, he would have taken another course of action.</p> <p>On 3/1/12 at 10:35 am, Nurse # 4 was interviewed. She stated that she informed Administrative Staff #6 to look for Resident #23 ' s sleep study for the physician to review. She recalled that they were having difficulty locating it in their archives files but she didn ' t know the outcome or if anyone communicated to the</p>	F 309			

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F 309	Continued From page 14 physician that they weren ' t able to retrieve it. She stated that she works " on call " for the facility and hadn ' t been on duty, for a length of time. She stated that she normally worked with Resident #23 during the day and hadn ' t observed him sleeping. On 3/1/12 at 11:00 am, the Administrative Staff #2 was interviewed. She stated that the purpose of the Triage Note is for the physician to investigate the nurse ' s concerns. She shared that sometimes, triage notes are overlooked by management, because they are not brought to their daily management meetings for discussions, like regular new physician orders are and they are normally filed back on the chart, after the physician reviews them. She shared that she was unaware that Nurse #3 had concerns about Resident #23 ' s breathing. She stated that now that she was aware of the problem, she would contact the physician and request an order for a sleep study. On 3/1/12 at 11:10 am, the Administrative Staff #6 was interviewed. She stated that she never received any instructions from the nurse to locate Resident #23 ' s sleep study. On 3/1/12 at 12:10 pm, the Administrative Staff #1 was interviewed. She stated that if a doctor ordered for medical records to pull an old sleep study, then her expectation was for the Administrative Staff #6 to search for it and if she was unable to find it, then she would expect her to go to the hospital to secure a copy.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312			

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F 312	<p>Continued From page 15</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews the failed to trim fingernails and prevent them from digging into the palms of 1 of 1 resident (Resident #2) with hand contractures.</p> <p>Resident #2 was admitted on 12/3/10 with diagnosis including vascular dementia, depressive disorder and osteoarthritis. She also had bilateral hand contractures at the time of admission.</p> <p>Review of the Care Plan revealed a goal last updated on 2/7/12 that read, in part, " (name of resident) will have all of their ADL (activities of daily living) needs met by staff. "</p> <p>The Quarterly Minimum Data Set (MDS) dated 2/10/12 revealed Resident #2 had short and long term memory problems and was severely impaired in decision making. The MDS also indicated Resident #2 required extensive assistance of one to two people for activities of daily living but could feed herself with set up help. She also had upper and lower extremity impairment bilaterally.</p> <p>Review of the Occupational Therapy weekly summary for 2/13 - 2/19 revealed a note that read " pt (patient) has nail marks in hands when</p>	F 312	<p>F312 483.25 (a)(3) ADL Care Provided for Dependent Residents</p> <p>Resident #2 fingernails were trimmed and splints were applied.</p> <p>A 100% audit of all resident's fingernails was conducted. Nail care was provided as necessary.</p> <p>Residents will receive nail care (to include cleaning and cutting of fingernails) during morning care by licensed nurses and/or Certified Nursing Assistants as needed.</p> <p>Resident nail care will be audited twice per week for four weeks, then twice a month thereafter by supervisors for appropriate nail care.</p> <p>Licensed Nurses and Certified Nursing Assistants were educated on appropriate nail care.</p> <p>This process will be reviewed monthly in QA & A for three months for review and further recommendations.</p>	<p>3/1/2012</p> <p>3/30/2012</p>	

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F 312	<p>Continued From page 16</p> <p>opened - nursing alerted about need to get nails clipped. "</p> <p>On 2/26/12 at 5:18 PM Resident #2 was observed resting in bed on her back with the head of her bed raised 30 degrees. Both hands were contracted and tightly clenched with the middle 3 fingers pressing into her palm. Resident #2 shook her head yes and no to some questions but did not respond verbally. She was able to open her hands slightly when asked and when she did this, indentations were noted to both palms. Also, her middle 3 fingernails were approximately ¼ inch long and were curled back towards her fingernail. When asked if she wanted her fingernails cut she shook her head yes.</p> <p>On 2/27/12 at 11 AM Nurse #7 opened the resident ' s hands slightly and indentation marks were noted in the resident ' s palms. There were no open areas. The resident ' s middle three finger nails on each hand were approximately ¼ inch long and were curled back towards the fingernail. Nurse #7 indicated that Resident #2 ' s finger nails were too long and digging into her palm and stated that they needed to be trimmed.</p> <p>On 2/29/12 at 9 AM resident #2 was observed receiving morning care including a bed bath. Her finger nails and toe nails were short and appeared to have been recently trimmed.</p> <p>On 3/1/12 at 12 noon interview with the Director of Nursing (DON) revealed that both Nursing Assistants and Licensed Nurses can trim resident ' s nails. She also stated that it is her expectation that nail care be attended to daily, as needed,</p>	F 312	<p>Hand splints will be placed and taken off according to Physician orders by Restorative Aides and/or Certified Nursing Assistants.</p> <p>Hand splints will be checked and audited once per week by supervisors for one month and then twice per month thereafter.</p> <p>Licensed Nurses and Certified Nursing Assistants were educated on appropriate application and removal of hand splints by DON and/or Nurse Supervisors.</p> <p>This process will be reviewed monthly in QA& A for three months for review and further recommendations.</p>	3/30/2012	

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F 312	Continued From page 17 since it is part of the morning care assessment to see if nails need trimming or cleaning.	F 312		
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 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:	F 356	F356 483.30(e) Posted Nurse Staffing Information Nurse staffing sheet is posted daily. All Nurse Supervisors are educated on the proper posting of the staffing sheet. The weekend receptionist will post the staffing sheet on the weekends. This process will be audited three times per week for one month and weekly thereafter. This process will be reviewed in QA & A meeting monthly for three months for review and recommendations.	3/1/2012 3/30/2012 3/17/2012

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F 356	Continued From page 18 Based on observation and staff interview, the facility failed to post daily staffing information. The findings include: On 2/26/12 at 2:20 pm as well as 7:00 pm, a sign on the front lobby table, contained staff information for 2/24/12. On 2/29/12 at 8:05 am, Administrative Staff #4 was interviewed. She stated that she prepares the staff posting daily but works Monday through Friday. On Fridays, she leaves the weekend supervisor, the staff postings for Saturday and Sunday. She acknowledged that sometimes when she arrived on Mondays, the posting had not been updated over the weekend. She stated that her weekend supervisor was new to her position but that she would take the opportunity to inform her that the postings must be changed daily.	F 356			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to serve palatable food to 1 of 1 resident (Resident #40) who requested a snack.	F 364			

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F 364	<p>Continued From page 19</p> <p>The findings include:</p> <p>A copy of the Resident Council Minutes, dated 2/9/12 was reviewed. Within the minutes, was a concern expressed by Resident #40, who was admitted to the facility on 8/5/11 with diabetes. On the quarterly Minimum Data Set assessment, 2/6/12, it assessed the resident as having adequate vision, being cognitively intact and listed his former career as a Food Supervisor. He shared during this meeting, that on 2/5/12, he requested a peanut butter and jelly sandwich and was brought a stale and molded sandwich which crumbled when he opened it. He expressed that he was very angry and was glad that he looked at it before eating it. He also shared that another resident ' s name had been written on the sandwich, but someone had scratched out the name and wrote his name, before giving it to him.</p> <p>Resident #40 was interviewed on 3/1/12 at 1:57pm. He stated that during the evening of 2/5/12, he asked nurse aide #2 (NA#2) to bring him a sandwich for his evening snack. He commented that NA#2 was unable to find a sandwich at the nurse ' s station on his hall, so he saw him run to the other nurse ' s station and return with a peanut butter and jelly sandwich. He stated that he noticed another person ' s name was on the sandwich label was crossed out and his name was written in. He shared that when he was handed the sandwich, it felt stale to him. He unwrapped the plastic covering and the edge of the bread began to crumble. When he opened the sandwich, he stated that the color of the food was brown and green. Resident #40 stated that he tossed the sandwich in the trash can and told a maintenance worker, who was on duty that</p>	F 364	<p>F364 483.35(d)(1)-(2)</p> <p>The employee that provided resident #40 the "molded" peanut butter and jelly sandwich no longer is employed here.</p> <p>All sandwiches are prepared daily for freshness by dietary employees.</p> <p>Day old sandwiches will be disposed of daily.</p> <p>All dietary employees have been Educated on freshness of sandwiches and prepared foods by the CDM.</p> <p>Freshness monitoring tool is completed by CDM and/or cook daily.</p> <p>This process will be monitored through QA & A meeting for three months for review and further recommendations.</p>	3/1/2012	3/1/2012

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F 364	Continued From page 20 evening. On 3/1/12 at 3:25 pm, Administrative Staff #7 was interviewed. She stated that at the time of her investigation, she was not told who gave the sandwich to Resident #40, even though the resident gave a general description of the aide ' s appearance. She shared that the dietary staff rotate responsibilities for cleaning out the nourishment refrigerators. However, she has always emphasized that all sandwiches must be discarded after one day, because she wants them to taste fresh. She estimated that it would take a refrigerated sandwich, one to two weeks to get stale and molded. On 3/1/12 at 3:30 pm, the maintenance worker was interviewed. He stated that he was working on 2/5/12 and had a conversation with Resident #40, who mentioned that he was given a molded/stale sandwich, earlier that evening. He shared that he did not have the opportunity to look at the sandwich, but stressed to the resident, that he should always examine his food before eating it and encourage him to report the incident to someone.	F 364			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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F 371	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the dietary staff failed to label and date, all perishable foods; discard outdated foods from the refrigerators as well as record daily temperature records for appliances.</p> <p>The findings include:</p> <p>A copy of the facility 's May, 2002 Dietary Policies and Procedures, Section: Storage, was reviewed. It read that " All foods in storage shall be wrapped or covered to prevent contamination and shall be dated. Undated items will be discarded. "</p> <p>On the unit hall refrigerators, an additional sign was observed, which read: " This refrigerator is checked on a daily basis per the regulations of the facility and the state of North Carolina. The following rules will apply without exception. 1) All food items must be labeled with name and date. 2) Items not dated or labeled with a name will be thrown away. 2) Items older than three days will be thrown away. "</p> <p>1. On 2/26/12 at 2:38pm, during the initial tour of the kitchen, the following observations were made. In the walk-in cooler, there were two trays of meat sausage patties that were unlabeled and dated. On a shelf, an aluminum bowl of egg salad was dated 2/22/12. In the reach in cooler, two meat and cheese sandwiches and 4 bowls of cottage cheese were placed on a tray, along with several bowls of garden salad. The sandwiches</p>	F 371	<p>F371 483.35(i) Food Procure, Store/Prepare/ Serve – Sanitary</p> <p>All dietary staff have been educated on labeling and dating all perishable food items; discarding outdated foods; recording of daily temperatures for appliances by CDM.</p> <p>Out dated foods is described by Manufacturer expiration dates and prepared foods for three days after date of preparation.</p> <p>The expired food log will be completed by the CDM and /or cook daily.</p> <p>This process will be monitored daily for two months and three times per week thereafter.</p> <p>These processes will be reviewed through monthly QA & A for three months for review and recommendations.</p>	3/1/2012	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD RD CONCORD, NC 28025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 22</p> <p>and cottage cheese were not labeled or dated. There was a tray of a chunky white food substance, placed in several bowls that were unlabeled and dated. A container of whipped cream was dated 2/21/12.</p> <p>On 2/29/12 at 9:15am, during a 2nd observation to the kitchen, the following was noted. In the reach in cooler, there remained 2 bowls of cottage cheese that were unlabeled and undated; 1 side salad and 3 bowls of sliced onions and tomatoes that were unlabeled and undated.</p> <p>On 3/1/12 at 8:55am, the Administrative Staff #7 was interviewed. She commented that the dietary staff will often place a self stick label with the date on the tray in the reach in cooler, to indicate the date of preparation instead of individually labeling each item. She thought that the sliced onions and tomatoes looked fresh, but discarded the cottage cheese.</p> <p>3. On 2/26/12 at 2:59pm, two dietary aides were observed running the dish washer. The dishwasher was a high temp unit and had a wash cycle recorded at 165 degrees and rinse cycle at 190 degrees. The dietary aide was able to verbalize the desired temperature for the wash and rinse cycles. However, the temperature logs did not have daily temps recorded by staff, to indicate that the machinery was being monitored.</p> <p>The machine had a box of sanitizing solution on the wall, that was attached to the machine. A copy of the February, 2012 dish machine temperature/sanitizer log was examined. Instructions read: " To ensure that the wash and rinse temperatures are properly monitored and</p>	F 371			

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NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD RD CONCORD, NC 28025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 23</p> <p>controlled, please log Wash and Rinse temperatures and Sanitizer strength when washing dishes after each meal. The log should be filled in and initialed by those who are directly involved in the dishwashing process.</p> <p>The following dates on the dish machine temperature/sanitizer log had blank entries: 2/13/12 and 2/23/13 at lunch and dinner. On 2/29/12, a copy of the final dish machine log was requested from the Dietary Manager. There were additional blank recorded entries for 2/27/12, 2/28/12 and 2/29/12 at lunch and dinner.</p> <p>There were no test strips for sanitation purposes, recorded anywhere on the dish machine temperature/sanitizer log, in February, 2012. On 2/29/12 at 8:40am, dietary aide #1, who stood by the dish washer, as a cycle had finished, stated that they don't use a test strip on the dishwasher.</p> <p>On 2/29/12 at 9:00am, the nourishment room refrigerator on the C/D halls was examined. There was no food inside; it only contained beverages. On the outside of the unit, there was Refrigerator/Freezer Temperature Record, for February, 2012. The unit temperatures were within normal limits. It had columns to record the temperatures twice a day, AM and PM hours for the refrigerator and freezer units.</p> <p>The log was reviewed and it revealed that the temperatures were not recorded twice a day. On 2/7, 2/9, 2/10, 2/15-2/24 there was blank entries for the refrigerator temps. On 2/7, 2/9, 2/15, 2/18-2/24 and 2/28, there were no recorded temps for the freezer.</p>	F 371			

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NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD RD CONCORD, NC 28025		
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F 371	Continued From page 24 On 3/1/12 at 8:30 am, the nourishment refrigerator on the A/B halls was examined. There was no perishable food stored within the unit. However, the temperature log sheet for February, 2012 was noted to have many blank entries. On 3/1/12 at 3:30 pm, Administrative Staff #7 was interviewed. She stated that she routinely checked behind the dietary staff to make sure they are discarding food on the nourishment units, but she had assigned another dietary staff, to supervise the recording of the temperature logs. When she reviewed the logs, she commented that the form had many blank entries and that the staff was not recording the information correctly. She stated that the form might not have clear instructions and that she would revise it to make it easier to staff to know where to record the refrigerator and freezer temperatures, twice a day.	F 371			
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) 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 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.	F 425			

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NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD RD CONCORD, NC 28025		
(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 425	Continued From page 25 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to discard expired medications on 3 of 4 medication carts (A, B and C hall carts) and in 1 of 2 medication rooms (A/B hall med room), and failed to date Advair and insulin when opened on 2 of 4 medication carts (C and D hall carts). The findings included: A facility policy last revised 4/8/11 entitled " Recommended Minimum Medication Storage Parameters " read in part for Advair Diskus, " Date the Diskus when removed from the foil pouch and discard one month after removal from foil pouch or after all blisters have been used, whichever comes first. " A facility policy last revised 4/8/11 entitled " Insulin Storage Recommendations " read in part that vials of Novolin insulin can be stored for 42 days after opening. 1. Observation of the D Hall medication cart on 2/29/12 at 3:45 PM revealed one Advair Diskus opened but undated. Nurse #1 was interviewed at this time and indicated that she normally wrote	F 425	F425 483.60(a),(b) Pharmaceutical Services- Accurate Procedures, RPH All medications found to be expired, were destroyed. All medication carts and medication Rooms have been checked for any further expired medications by the Nurse Supervisors. All Nurses have been educated to check all medication carts and medication rooms nightly for expired medications by the Director of Nurses and /or Nurse Supervisors. All expired medications will be disposed of properly. Licensed Nurses will check medication carts and medication rooms nightly for expired medications. All expired medications will be disposed of properly by Licensed Nurses weekly.	3/1/2012	3/1/2012
				3/30/2012	

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NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD RD CONCORD, NC 28025	
(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 425	<p>Continued From page 26</p> <p>the date on the diskus at the time she opened it. Nurse #1 indicated that the she was unsure how long the diskus was good after removal from the foil wrap.</p> <p>2. Observation of the C Hall medication cart on 2/29/12 at 4:08PM revealed one opened, undated vial of Novolin 70/30 insulin, one Advair Diskus opened 1/19/12 and another opened 1/26/12. Nurse #2 was interviewed at this time and indicated that the Advair should have been discarded after 30 days and the insulin should have been dated when opened. Nurse #2 added that he did not know how long the insulin had been opened.</p> <p>Interview with the Director of Nursing (DON) on 3/1/12 at 12:00 noon revealed that third shift nurses are responsible for checking the medication rooms and medication carts for expired medications. She also stated that it is her expectation that expired medications are discarded prior to expiration and not left on the medication carts or stored in the medication room.</p> <p>3. Observation of the A Hall medication cart on 3/1/12 at 10 AM revealed 2 blister packs of Fiber lax caplets each with 9 of 10 caplets remaining and an expiry date of 12/11. Nurse #3 was interviewed at this time and indicated that the Fiber lax had expired and should have been discarded, once it expired, by putting it in the box to send back to pharmacy. She then discarded the expired Fiber lax in the pharmacy box in the medication room.</p> <p>Interview with the DON on 3/1/12 at 12:00 noon</p>	F 425	<p>Nurse Supervisor will check Medication carts and medication rooms twice per week for three months and weekly thereafter to ensure medications are in proper date.</p> <p>This process will be reviewed monthly in QA & A meetings for three months for review and further recommendations.</p> <p>All inhalers and vials were checked for proper date by Nurse Supervisors.</p> <p>Any inhalers and vials that were not dated when opened were disposed of.</p> <p>Nurse Supervisors will check medication carts for opened inhalers and vials for proper dates of when opened twice per week for three months and weekly thereafter.</p> <p>This process will be reviewed monthly in QA & A meetings for three months for review and recommendations.</p>	<p>3/1/2012</p> <p>3/1/2012</p>

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NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD		STREET ADDRESS, CITY, STATE, ZIP CODE 616 LAKE CONCORD RD CONCORD, NC 28025		
(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 425	<p>Continued From page 27</p> <p>revealed that third shift nurses are responsible for checking the medication rooms and medication carts for expired medications. She also stated that it is her expectation that expired medications are discarded prior to expiration and not left on the medication carts or stored in the medication room.</p> <p>4. Observation of the B Hall medication cart on 3/1/12 at 10:30 AM revealed 1 packet of loperamide hydrochloride caplets with 8 of 20 caplets remaining and an expiry date of 11/11. Nurse #4 was interviewed at this time and indicated that the loperamide hydrochloride had expired and should have been discarded, once it expired, by putting it in the box to send back to pharmacy. She then discarded the expired loperamide hydrochloride in the pharmacy box in the medication room.</p> <p>Interview with the DON on 3/1/12 at 12:00 noon revealed that third shift nurses are responsible for checking the medication rooms and medication carts for expired medications. She also stated that it is her expectation that expired medications are discarded prior to expiration and not left on the medication carts or stored in the medication room.</p> <p>5. Observation of the A and B Hall medication room on 3/1/12 at 10:45 AM revealed the following expired medications: Fiber lax (unopened), expiry 12/11 Potassium 99 milligram capsules, expiry 11/10 Nurse #3 was interviewed at this time and indicated that these expired medications should have been discarded, once they expired, by putting them in the box to send back to</p>	F 425		

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NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD RD CONCORD, NC 28025		
(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 425	Continued From page 28 pharmacy. She then discarded the expired medications in the pharmacy box in the medication room. Nurse #3 also stated that 3rd shift nurses usually check the medication room for expired medications. Interview with the DON on 3/1/12 at 12:00 noon revealed that third shift nurses are responsible for checking the medication rooms and medication carts for expired medications. She also stated that it is her expectation that expired medications are discarded prior to expiration and not left on the medication carts or stored in the medication room.	F 425			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345130	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2012
NAME OF PROVIDER OR SUPPLIER AVANTE AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD RD CONCORD, NC 28025	
(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
K 000	INITIAL COMMENTS	K 000		
K 012 SS=D	<p>This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III protected construction, one story with a complete automatic sprinkler system.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 3/21/2012 it was determined that the facility failed to provide the proper protection in the rated ceiling.</p> <p>The findings include the rated ceiling in the soiled linen room on the "A" hall had unsealed penetrations above the ceiling tile in the one hour enclosure.</p> <p>CFR#: 42 CFR 483.70 (a)</p>	K 012	<p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusion 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 the federal and state law.</p> <p>The one hour enclosure above the A Hall soiled linen room ceiling tiles has been sealed.</p> <p>All one hour enclosures above the ceiling tiles has been inspected for proper seal by the Facilities Director.</p> <p>No other areas have been identified.</p> <p>An audit will be conducted by Facilities Services Director and/or Assistant monthly of the one hour enclosures above the ceiling tiles to ensure a proper seal.</p> <p>This process will be reviewed monthly for three months in QA & A meeting.</p>	<p>3/21/2012</p> <p>4/5/2012</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Imabelle

Administrator

4/5/12

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.