

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345063	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/8/2015
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NAME OF PROVIDER OR SUPPLIER AVANTE AT WILSON	STREET ADDRESS, CITY, STATE, ZIP CODE 1804 FOREST HILLS ROAD WILSON, NC
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to complete an accurate bowel and bladder assessment for 1 of 2 sampled residents (Resident #65) who experienced a decline in their level of continence. Findings included:</p> <p>Resident #65 was admitted to the facility on 07/10/15. The resident's documented diagnoses included right above-the-knee amputation (AKA), gout, and osteoarthritis.</p> <p>The resident's 07/17/15 admission minimum data set (MDS) documented her cognition was intact, and she was occasionally incontinent of bowel and bladder.</p> <p>Hospital records documented Resident #65 was hospitalized from 08/31/15 until 09/02/15 for a right AKA.</p> <p>A 09/02/15 Bowl and Bladder Evaluation Tool documented Resident #65 was a good candidate for a bowel and bladder retraining program with mildly impaired mental status, stable health, mobility with assistance, mental awareness at all times of toileting needs, no redness of skin, continence of urine and stool all the time, and no diagnosis/diseases which were contributing factors to continence issues.</p> <p>The resident's 09/09/15 5-day Medicare assessment and her 09/28/15 quarterly MDS documented her cognition was moderately impaired and she was always incontinent of bowel and bladder.</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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F 278	<p>Continued From Page 1</p> <p>At 12:42 PM on 10/08/15 the unit manager stated Resident #65 had not been a good candidate for a toileting program since her return from the hospital on 09/02/15 due to a decline in cognition and the loss of the ability to know when she needed to go to the bathroom. He reported the resident's major decline in health and cognition had placed her on a protection and containment program. On review of the 09/02/15 bowel and bladder evaluation for Resident #65, the unit manager commented the assessment was inaccurate. According to this supervisor the resident's mental status was at least moderately impaired, her general health status was declining, at best she was only aware of her toileting needs sometimes, she was never continent of urine and stool, and three or more disease factors contributed to her continence decline. The unit manager reported he thought there were three admissions on 09/02/15, and maybe the nurse got her residents mixed up when completing their bowel and bladder assessments. He stated in order for the nurse to complete the assessment accurately she should do an observation of the resident and review discharge information from the hospital.</p> <p>At 1:04 PM on 10/08/15, during an telephone interview with Nurse #4 who completed Resident #65's 09/02/15 Bowel and Bladder Evaluation Tool, she stated she obtained the information she needed to complete this assessment from a family member who was present during the resident's readmission process.</p> <p>At 2:10 PM on 10/08/15 Nurse #1, who cared for Resident #65 on first shift, stated when Resident #65 returned from the hospital on 09/02/15 she was not as alert or communicative, and she was totally incontinent. She reported the resident lost the ability to tell when she needed to go to the bathroom and to even tell when she was wet or soiled. This nurse commented the resident was not a good candidate for a toileting program.</p> <p>At 2:14 PM on 10/08/15 nursing assistant (NA) #3, who cared for Resident #65 on first shift, stated when the resident returned from the hospital on 09/02/15 she could no longer tell when she needed to go to the bathroom or when she was wet or soiled. She reported she checked the resident every two hours and changed her when needed.</p>		