STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		1/4/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/29/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a safe and clean environment in one of eighteen resident rooms (room 122). The facility also failed to maintain a safe, clean, and homelike environment in the bathroom of one of eightee bathrooms inspected (bathroom in room 107). Holes were observed in the wall and the stucco/drywall window return was observed to be in disrepair in room 122. The drywall surrounding the bathroom ceiling light/vent had visible cracks/exposed drywall and there was improper storage of 3 urinals in bathroom of room 107. The findings included: 1. An observation of the bathroom for room 107 conducted on 12/5/17 at 11:29 AM revealed the toilet to be not secured to the floor as evidenced by brown stained floor tile to the left side of the toilet and a missing flange bolt to the right side of the toilet. There was an unlabeled, brown stained urinal sitting on the top of the toilet tank. There were two unlabeled, brown stained urinals on the floor behind the toilet, under the toilet tank. The urinals were not enclosed in a bag. The ceiling was observed to have cracked paint and exposed drywall around the combination exhaust fan/light. In addition the toilet paper dispenser was observed to be crooked on the wall and there were holes observed in the wall where it appeared the toilet paper dispenser had been mounted. Observations of the facility's environment were	F 584	All repairs and corrections have been made to the environmental deficiencies cited. In room 107 the dispenser was correctly mounted to the wall, the repairs were made to the light/vent and ceiling was painted. Urinals were properly stored in containers and the toilet flange was repaired. In room 122 holes near television mount were repaired and painted and area around window seal,along with area of wall with failing integrity were repaired and painted. Construction dust was cleaned. All current residents could be affected by the current deficient practice, as they would be affected by any problems not timely identified and corrected in their environment. Measures put in place to ensure that the alleged deficient practice does not re-occur include but are not limited to: A]In-service the maintenance staff on making rounds more often and being more observant of environmental issues, and when they do find issues to correct them immediately. B]Audit tools have been developed. C] A 100% audit was done of all rooms, any issues or concerns found through the audits are being corrected. D]To ensure that all issues are properly logged into "The equipment life systems" or TELS system. The TELS system is a building management	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584	Continued From page 2 completed with the Director of Plant Operations (Maintenance Director (MD) on 12/7/17 from 10:35 AM through 10:57 AM. The observations included an inspection of the bathroom in room 107. The MD was observed being able to move the toilet base on the floor and the MD stated the toilet flange needed to be repaired. The MD observed the toilet paper dispenser to be crooked and observed the holes in the wall adjacent to the dispenser and stated it would need to be remounted to the wall properly. The MD observed the cracks in the paint and exposed drywall in the ceiling near the combination exhaust fan/light and stated he would address the needed repair to the ceiling. An interview was conducted with Nursing Assistant (NA) #1 on 12/7/17 at 11:29 AM while conducting an observation of the bathroom of room 107. Observations revealed the three urinals remained stored in this bathroom as observed on 12/5/17. One urinal was observed on the toilet tank and two were observed on the floor behind the toilet under the toilet tank. NA #1 stated the urinals, were not stored properly. The NA stated the urinals should have been labeled with the resident's name and stored in a corresponding plastic bag, which also was labeled with the resident's name. The NA pointed out two plastic bags hanging on the wall to the left of the toilet. In regards to the dislodged toilet paper holder and cracked paint/exposed drywall on the ceiling around the exhaust fan light the NA stated she had not written a work order. The NA added she would write a work order for the areas of concern and turn it into the maintenance department. An interview conducted with the administrator on	F 584	program exclusively for senior care. The TELS program assist the maintenance department as an on line way of tracking preventative maintenance ,work orders and asset repairs. E] In-service all current staff on the TELS system. F] Ensure that all current staff are familiar with the proper procedure on filling out a work order. Maintenance will turn in the environmental audit forms to the Administrator weekly and the audit forms will be brought to the Quality Assurance meeting monthly to evaluate the effectiveness of the audits. The Administrator will be responsible for implementing an acceptable plan of correction. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584	Continued From page 3	F 584		

12/7/17 at 12:26 PM revealed that it was the administrator's expectation for the walls and construction of the facility be maintained properly so as to prevent stucco/drywall dust and debris from falling. The administrator further stated it was his expectation for the facility walls to be maintained without holes. In addition the administrator stated it was his expectation that if an issue was discovered by a staff member related to facility construction, a work order would be completed to bring the issue to the attention of the maintenance department so the problem may be addressed.

2. Observations of the facility's environment with the Maintenance Director (MD) were made on 12/7/17 from 10:35 AM through 10:57 AM. During these observations, the walls and stucco/drywall window return was inspected in room 122. There were 4 holes in the wall discovered to the right of the flat screen television mount on the wall with the bathroom entrance. The MD stated he or his maintenance assistant had installed the flat screen television mount. Three of the holes were approximately dime sized and one was approximately the size of a quarter. The quarter size hole penetrated through the drywall to the interior of the wall shared with the bathroom. Further inspection of the room revealed visible dust on an over the bed table positioned adjacent to the wall in front of the window. Inspection of the stucco/drywall window return on the left side of the window revealed impaired integrity to the drywall/stucco material which resulted in falling construction dust/debris from the window return onto the over the bed table. In addition to the dust on the over the bed table there was construction dust/debris on the window sill below the impaired integrity of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584	Continued From page 4 window surround. The MD stated he was unaware of the impaired integrity to the stucco/drywall to the left of the window. The MD stated it was his expectation for the walls and window returns to be maintained in an intact condition without impaired integrity. An interview conducted with the administrator on 12/7/17 at 12:26 PM revealed that it was the administrator's expectation for the walls and construction of the facility be maintained properly to prevent stucco/drywall dust and debris from falling. The administrator further stated it was his expectation for the facility walls to be maintained without holes. In addition the administrator stated it was his expectation that if an issue was discovered by a staff member related to facility construction, a work order would be completed to bring the issue to the attention of the maintenance department so the problem may be addressed.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments for Diagnoses (Resident #62), Antipsychotic Medications (Resident #52), and Use of a Wander/Elopement Alarm (Resident #35), for 3 of 18 sampled residents reviewed for MDS accuracy. 1. Resident #62 was admitted on 11/22/17 with	F 641	Corrections have been completed and submitted for the alleged deficient practice. Resident #35, Minimum Data Set Coordinator(MDS Coordinator) modified the assessment 10/12/17 admission/5 day Minimum Data Set (MDS) section P0200F:Wander/Elopement alarm, Resident #52 MDS Coordinator modified the assessment 11/21/17 significant	1/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 5 multiple diagnoses that included: Respiratory failure, heart failure, kidney disease, left sided weakness/paralysis, stroke, and chronic obstructive pulmonary disease (COPD). The Minimum Data Set (MDS) comprehensive admission assessment with an Assessment Reference Date (ARD) of 11/22/17 indicated Resident #62 was coded as having been cognitively intact. Resident #62 had no coded diagnoses. Resident #62 was coded as having had required extensive assistance of one person for bed mobility, transfer (i.e. from the bed to a chair), and for toilet use. A review of the care plan for Resident #62 revealed a care plan which had been most recently updated on 12/4/17. Resident #62 had focus areas in her care plan that included the following: Shortness of breath, difficulty breathing, Diabetes Mellitus, glaucoma, left above the knee amputation, chronic pain, depression, and stroke. An observation of Resident #62 on 12/7/17 at 4:10 PM revealed the resident had a left sided above the knee amputation. An interview with Resident #62 revealed she was unable to use her left arm at all, it was flaccid. The resident's left arm was observed to be resting on her left leg stump and the resident was able to move her right arm without difficulty. The resident further stated she had had a stroke over 10 years ago. During an interview conducted with NA #2 on 12/7/17 at 4:14 PM she stated Resident #62's left arm was flaccid and the resident was unable to move her left arm. During an interview conducted with NA #3 on 12/7/17 at 4:16 PM she stated Resident #62's left arm was flaccid and the resident was unable to	F 641	change MDS section N0450.1.,Resident #62 required a significant correction of a prior comprehensive assessment 11/22/17 on 12/8/17 due to impact of section I0100-I1800 A.J. diagnosis codes. Current residents have a potential to be affected by the alleged deficient practice. The Director of Nursing completed an audit for section I0100-I1800A.J,N04450.1 and P0200F from 11/7/17 to 12/7/17 to validate accurate coding. Assessments identified as inaccurate were modified and transmitted to the state on 12-14-17. Measures put into place to ensure the alleged deficient practice does not recur: Current facility staff that participate in completion of the MDS were provided education on 12/7/17,regarding accuracy of assessment ,using the MDS 3.0v1.15 manual for accuracy of all sections and for areas of alleged deficiencies and section requirements: I section (all new admissions have a completed active diagnosis code present}. N0450. A.1 {Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent} P P0200F. Alarms (wander/Elopement Alarm]. Newly hired staff members that will be responsible for completing MDS sections will receive education during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 6 move her left arm. During an interview conducted with the Clinical Reimbursement/MDS Specialist on 12/7/17 at 4:17 PM she stated the MDS comprehensive admission assessment for Resident #62 was coded inaccurately due to the assessment having had no coded diagnoses. The Clinical Reimbursement/MDS Specialist further added the nurse who had completed the comprehensive admission assessment was no longer employed at the facility. The Clinical Reimbursement/MDS Specialist stated it was her expectation for the MDS to be coded accurately. An interview conducted on 12/7/17 at 4:29 PM with the Director of Nursing (DON) revealed her expectation was for the MDS assessments to be coded accurately. 2. Resident #52 was originally admitted on 10/3/17 and was most recently readmitted on 10/10/17. Resident #52's admission diagnoses included: Left hip fracture, generalized weakness, difficulty swallowing, difficulty communicating, dementia, diabetes, and high blood pressure. The MDS significant change assessment with an ARD of 11/21/17 indicated Resident #52 was coded as having had received antipsychotic medication for seven days of the seven day assessment period. Further review of the MDS assessment revealed the resident was coded as having not received antipsychotic medications since admission/entry or the prior assessment. The resident was coded as having had required maximum assistance with activities of daily living (ADLs) including bed mobility, transfer (for example from a bed to a chair), and toileting. The resident was also coded as having had	F 641	orientation. Director of Nursing and/or nurse management will review weekly for 4 weeks then bi-weekly for 4 weeks for all scheduled assessments section I0300,N0450.1 on residents taking psychotropic,P0200F for residents utilizing wander/elopement alarms, to validate the MDS assessment is coded accurately. There after 5 assessments will be reviewed monthly for 3 months, to validate accuracy of coding. The Director of Nursing will analyze audits/reviews for patterns/trends and report to Quality Assurance committee monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcome/trends identified per committee recommendations. The Administrator will be responsible for implementing the acceptable plan of correction. Preparation and/or execution of this plan of correction does not constitute admission for 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 provision of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 7	F 641		

severe cognitive impairment.

A review of the care plan for Resident #52, which was most recently updated on 12/2/17 revealed the following focus areas: Activities of daily living, dementia with behaviors, refuses medications at times, at risk of falls, weight loss, and at risk for pressure ulcers.

A review of the Medication Admission Record (MAR) for Resident #52 for the period of 11/15/17 through 11/21/17 revealed the resident received antipsychotic medication for each day of the assessment period.

During an interview conducted with the Clinical Reimbursement/MDS Specialist on 12/7/17 at 4:22 PM she stated the MDS comprehensive admission assessment for Resident #52 was coded inaccurately due to the assessment having not been coded correctly in regards to the resident having received antipsychotic medication. The Clinical Reimbursement/MDS Specialist additionally reviewed the resident's MAR and stated the resident had received antipsychotic medication each day during the assessment period. The Clinical Reimbursement/MDS Specialist further added the nurse who had completed the comprehensive admission assessment was no longer employed at the facility. The Clinical Reimbursement/MDS Specialist stated it was her expectation for the MDS to be coded accurately.

An interview conducted on 12/7/17 at 4:29 PM with the Director of Nursing (DON) revealed her expectation was for the MDS assessments to be coded accurately.

3. Based on staff interviews and record reviews,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 8	F 641		

the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of restraints and alarms for 1 of 7 sampled residents (resident # 35) reviewed for MDS accuracy. Findings included:

Resident #35 was admitted to the facility on 10-5-17. Resident #35 was admitted with multiple diagnoses including pneumonia, shortness of breath, dementia with behaviors, chronic obstructive pulmonary disease and depression.
A review of the elopement risk assessment dated 10-5-17 revealed that resident #35 was a risk for elopement with a score of 12.
A review of the nursing notes dated 10-5-17 at 4:41pm revealed that a wander guard bracelet was placed to resident #35's right ankle.
A review of the physician orders dated 10-6-17 revealed that the physician ordered placement of the wander guard bracelet to resident #35.

A review of the care plan dated 10-8-17 had a goal that resident #35 would not leave the facility unattended. The interventions included that staff would identify patterns of wandering and check for function and placement of the wander guard bracelet daily.
A review of the Minimum Data Set (MDS) dated 10-12-17 revealed that resident #35 was moderately cognitively impaired. The MDS also revealed no mood disturbances, however resident #35 had verbal behaviors that interfered with the participation in activities or social interactions. Resident #35 was documented as independent with set up help only for bed mobility and eating, limited assistance with one person for transfers and walking in her room, supervision with set up help only for locomotion on and off the unit as well as personal hygiene and limited

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 9 assistance with one person for dressing and toileting. The MDS revealed that resident #35 was not coded for wandering behaviors or the use of the wander guard bracelet. An interview with the corporate MDS person occurred on 12-6-17 at 4:20pm. The MDS person reviewed the 10-12-17 MDS as well as documentation and physician orders and stated the MDS for 10-12-17 was coded incorrectly regarding resident #35's wandering and the placement of the wander guard bracelet. She stated the correct procedure was for the MDS coordinator to review physician's orders, receive information from the morning meetings and interview the resident to make sure the information entered onto the MDS is accurate. An interview with the Director of Nursing (DON) occurred on 12-7-17 at 4:06pm. The DON stated her expectations were that the residents were assessed completely through interviews and that the resident's record would be reviewed so the information recorded in the MDS is accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		1/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 656	Continued From page 10 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to develop a comprehensive person-centered plan to address pressure ulcers and pain per Care Area Assessment Summery (CAA) for one of 18 residents reviewed for comprehensive care plans (Resident # 40).	F 656	Resident #40 comprehensive care plan was updated 12/7/17 to accurately reflect pressure ulcers and pain per the MDS 3.0 v 1.15 based on triggered Care Area Assessments (CAA's). Current residents have the potential to be affected by the deficient practice. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 656	Continued From page 11 Findings included: Resident #40 was admitted 10/24/2017 and readmitted on 11/24/2017 with diagnoses to include chronic obstructive pulmonary disease, chronic pain syndrome and sacral decubitus ulcer. The admission Minimal Data Set (MDS) assessment dated 10/31/2017 assessed the resident to be cognitively intact. The admission MDS dated 10/31/2017 assessed the resident to have one Stage 3 pressure ulcer. The admission MDS dated 12/1/2017 assessed the resident to have one Stage 3 pressure ulcer and one Stage 4 pressure ulcer. The MDS dated 10/31/2017 and 12/1/2017 assessed the resident to have frequent pain and he received both scheduled and as needed (PRN) medications for pain. The CAA dated 10/31/2017 indicated care planning was needed for pressure ulcer, and pain. A review of the care plans dated 12/1/2017 revealed no care plans to address pressure ulcer or chronic pain. An MDS narrative note dated 12/4/2017 was reviewed and the MDS coordinator made note of Stage 3 and Stage 4 pressure ulcers with tunneling noted. There was no mention of pain the resident experienced. A review of the physician orders revealed orders for tramadol (pain medication for mild pain) 50 milligram (mg) every 8 hours, and Opana (pain medication for moderate to severe pain) ER (extended release) 20 mg every 8 hours by mouth, both initiated 10/26/2017 and	F 656	Director of Nursing/Nurse Management completed an audit of section V CAA area Assessments for each triggered care area; If care planning decision has been checked , the care plan was reviewed for accurate triggered care plan. Care plans identified as inaccurate have been corrected. Measures put in place to ensure the alleged deficient practice does not recur: Current facility staff that participate in completion of the MDS were provided education on 12/7/17 regarding accurate completion of the Care Area Assessment, using the MDS 3.0 V1.15 manual, MDS accuracy for areas of alleged deficiencies and section requirements: V section Care Area Assessment column B from the most recent comprehensive assessment audit was completed. Care plans that required updating, of identified CAA triggered items were printed and placed in the plan of correction book. Newly hired staff members that will be responsible for completing MDS sections will receive education during orientation. Director of Nursing and/or Nurse Management will review weekly for 4 weeks, then bi-weekly for 4 weeks for all Comprehensive Care Area assessment for triggered care plans. There after 5 assessments will be reviewed monthly for 3 months to validate accuracy of coding. Director of Nursing will analyze audits/review for patterns/trends and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 656	Continued From page 12 discontinued with hospitalization on 11/7/2017. Hydromorphone (pain medication for severe pain) 2 mg 1-2 tablets by mouth every 3-4 hours as needed for pain was ordered on 11/24/2017. The resident was also prescribed Acetaminophen 500 mg by mouth every 6 hours for mild pain dated 11/24/2017. A review of the recorded levels of pain for the week of December 1, 2017 through December 6, 2017 revealed the resident expressed pain levels from 6 to 9 (1-10 pain scale) and expressed relief of pain with medication. An interview was conducted with the regional MDS coordinator on 12/7/2017 at 9:29 AM. She reported the former MDS coordinator had quit the previous day. The regional MDS coordinator reviewed the CAA for the resident and the active care plans. The regional MDS coordinator reported she did not know why the former MDS coordinator would not have initiated care plans addressing pressure ulcer and pain for the resident. The regional MDS coordinator initiated the missing care plans for the resident. The director of nursing (DON) was interviewed on 12/7/2017 at 12:10 PM. She reported that it was her expectation if a CAA was triggered by the MDS assessment, a care plan was developed to prevent further decline or injury to a resident.	F 656	report to the Quality Assurance Committee monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcome/trends identified. The Administrator will be the person responsible for implementing the acceptable plan of correction. Preparation and/or execution of this plan of correction does not constitute admission for 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 provision of federal and state law.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State	F 865		1/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 865	Continued From page 13 Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 10/27/16 recertification survey. This was for two deficiencies in the areas of: Assessment Accuracy and Care Plan Timing and Revision. The deficiencies were recited again on the current recertification survey of 12/7/17. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. 483.20- Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments for Diagnoses (Resident #62), Antipsychotic	F 865	In-service education was provided on 12/22/17 to the interdisciplinary team by the Regional Clinical Consultant regarding the facility Quality Assessment and Assurance (QA&A)program which includes developing, implementing, monitoring and maintaining interventions to promote quality of care and quality of life. The facility will diligently follow the facility's policy and procedure of the QA&A process to prevent a repeat deficiency from reoccurring. The Director of Nursing and/or Nurse management will review weekly for 4 weeks , then bi-weekly for 4 weeks for all comprehensive Care Area Assessment for triggered care plans. There after 5 assessments will be reviewed monthly for 3 months to validate accuracy of coding. Director of Nursing will analyze audits/review for patterns/trends and report to the QA&A committee monthly for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 865	Continued From page 14 Medications (Resident #52), and Use of a Wander/Elopement Alarm (Resident #35), for 3 of 18 sampled residents reviewed for MDS accuracy. During the recertification survey of 10/27/16 the facility was cited for failing to accurately code the MDS assessment for Preadmission Screening and Resident Review (PASRR) for 1 of 1 sampled residents. 2. 483.21- Based on record review and staff interviews, the facility failed to develop a comprehensive person-centered plan to address pressure ulcers and pain per Care Area Assessment Summery (CAA) for 1 of 18 residents reviewed for comprehensive care plans, (Resident # 40). During the recertification survey of 10/27/16 the facility failed to update a care plan for contracture management for 1 of 9 residents reviewed for care plans. An interview was conducted with the Administrator on 12/7/17 at 5:58 PM. The Administrator stated that the facility had a Quality Assurance (QA) Committee. The QA Committee consisted of the Administrator, Director of Nursing (DON), Medical Director, Business Office Manager, Therapy Coordinator, Admissions Coordinator, Maintenance Director, Dietitian, Dietary Manager, and the Activities Director. The Administrator stated his first day of employment at the facility was on 11/20/17 and the DON had started at approximately the same time. The Administrator further explained the facility had not had a monthly QA Committee meeting since he and the DON had started, therefore neither of them have had an opportunity to participate in the	F 865	3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes trends identified. The Administrator and Director of Nursing will analyze the audits and requests to identify patterns/trends and will adjust plan as needed and discuss during monthly QA&A meeting X 6 months for continued compliance. Following each monthly QA&A meeting, the meeting minutes will be reviewed by the Regional Vice president of Operations and the Regional Clinical Consultant to assure compliance for addressing the plan of correction deficiency. The Administrator will be the person responsible for implementing the acceptable plan of correction. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	**1028 BLAIR STREET THOMASVILLE, NC 27360**

(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 865	Continued From page 15 monthly QA Committee meeting yet.	F 865		