STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 03/04/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 3/4/15. Event ID# U2ND11.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to encourage and provide on-going activities for 4 of 4 sampled resident with cognitive impairments (Resident #82, #20, #44 and #164) The findings included. 1.Resident #82 was admitted to the facility on 4/17/03. The cumulative diagnoses included cerebrovascular disease, anxiety, depression mental disorder and kidney disease. The Minimum Data Set (MDS) dated 1/12/15, indicated Resident #82 had cognitive impairments, short and long term memory and decision making problems. Resident#82 required assistance with all activities of daily living. Review of the therapeutic recreation assessment 3/15/13, revealed Resident #82 group interest included entertainment, spiritual, socials, and games. The individual activities included books, magazines, newspaper, arts &crafts, outside, socialization, telephone, visitors and television. During an observation 3/2/15 at 9:36AM,	F 248	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared by the provisions of Health and Safety code section 1280 and 42C.F.R. 405.1907. Deficiency Corrected 1.) How corrective action will be accomplished for those found to have been effected. Resident #82, #20, #44, and #164 activity records were reviewed and updated to reflect activities of choice and to reflect to activities to enhance engagement for each resident on 3/3/2015.	3/31/15

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

Electronically Signed | 03/27/2015

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F 248	Continued From page 1 Resident #82 was identified as one of the participation for the TLC (tender loving care) program. The TLC program was designed for residents with limited social skills, fall and behavior risk. The sit and be fit was the designated activity. There was 14 residents in the small activities room doing group exercise with staff assistance. The activity staff only worked with five of the 14 residents with the exercise. The remaining residents were in the back of the room sleep. Resident #82 briefly watched the other residents getting exercise before going to sleep with the back row of residents. The assigned staff was unable to assist any other residents before the next schedule activity was to occur. The assigned activity at 10:00AM was rest and relaxation. The residents that were sleep from the previous activity continued to sleep through the next activity. Staff did not encourage or awaken the other 9 residents to participate. The 10:30AM pony express activity did not occur. The 9 plus two other residents were also sleep. Staff only worked with the three that were awake. Resident #82 slept through 3 activities without any encouragement or being awaken. Resident#82 was primarily sleep with limited stimulation from the staff. During an interview on 3/./2/15 at 10:45AM, the act assistant(AA) indicated Resident #82 went to some activities which included exercise, food activities and some music activities. The AA indicated Resident #82 didn ' t really participate but would come. Resident #82 brief group activity included sitting in the exercise group and watching others. Resident #82 would just sit and moan even though no one would touch her. The AA indicated 1:1 in room activities were provided however, there was no set schedule or time	F 248	2.) How corrective action will be accomplished for those having potential to be affected by the same practice. Current residents that are cognitively impaired have the potential to be affected. Current residents who have a BIMS score of 8 or less were reviewed and activity plans updated to reflect activities of interest and those activities that allow each resident to engage in their activity of choice. 3.) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Activity staff and CNA's were re-educated on how to engage residents who are cognitively impaired in an activity of interest.Activity calendars were revised to implement activities for cognitively impaired residents. New participation logs were put into place that are specially targeted for cognitively impaired residents. Visual observation by the activity director will be conducted three times a week for 4 weeks, two times a week for 4 weeks and weekly for 4 weeks to ensure cognitively impaired residents are engaging in activities. 4.) How the facility plans to monitor its performance to make sure that solutions are sustained. The activity director will present the results of the visual observations of the residents to the QA&A committee monthly for three months. The QA&A committee will determine if continued monitoring is necessary.	

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F 248	Continued From page 2 frame for the provision of the activities. During an observation on 3/2/15 at 2:20PM, Resident #82 was seated in the hall. There was no scheduled activity in the TLC room, staff was coloring pictures from book. The television was on and there was 12 residents in the room. There was 1 staff to interaction with all the residents. Many of the residents were sleep in the back of the room. Resident #82 was not encouraged to go into the TLC program. During an interview on 3/3/15 at 9:00AM, the DON indicated the TLC program was designed for residents that was high risk for falls, behaviors and limited socialization. She indicated the TLC was a separate program, but there was no specific guidelines for the program activities. Residents in the TLC could also be offered participation in activities designed for resident on the main activities schedule. During an interview on 3/3/15 at 9:10AM, the activity director (AD) indicated that she was not responsible for the TLC program and the expectation was for all residents to be engaged in the designated activities. During an observation on 3/3/15 at 9:30AM, the DON acknowledged that several residents were in the back of the activity room sleep as 1 staff was providing manicures. Resident#82 was not a participant of the activity she was sitting outside of activity room in the hall.	F 248		

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F 248	Continued From page 3 During an observation on 3/3/15 at 9:30AM, the AA had 11 residents in room, she only did one residents nails, 10 residents lined up in the back of the room sleep. NA#2 was on the unit and arrived at 10:00 AM to assist with national anthem sing along again the same half of residents remained sleep. During an interview the AA indicated that she followed the main calendar schedule of activites and on some occasions the TLC group and main calendar of events would combine activites. She indicated that she was not responsible for the activities of the TLC program unless the main calendar of events were combined. She indicated that she did 1:1 activities from 11-1pm. She indicated that there was not a specific program designed for 1:1 activities nor was there a set schedule of time frame for each of the residents to receive the 1:1. During an interview on 3//3/15 at 10: 30AM, NA#2 indicated that on average 8-10 residents were in the TLC program unless activities or other NAs brought residents in the group. The group gets overwhelming at times trying to provide activites for so many residents with different level of interest and no designated program of activities. The NA indicated that attempts were made to follow the main calendar of events but it was not always possible and some of the residents just end up sleeping. During an interview on 3/3/15 at 10: 45AM, the activity director (AD) indicated that the TLC program was separate from the main activities program. She indicated that the main activities was for the general population. The DON (director of nursing) coordinated the TLC program	F 248		

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and the activities that were provided for the group unless there was a combined activity. The activity director indicated she was unaware of why the programs were separate but nursing was primarily responsible for the designated activities for the TLC program. The AD added that the activity staff was responsible for doing the main schedule for the general population and the 1:1 activities. Review of the 1:1 program revealed that there was no identified list of residents who were scheduled to receive 1:1 activities or a time frame for these activities to be done. She confirmed during an observation on 3/3/15 at 10:30AM, several residents involved in the TLC program sleeping in the back of the room and limited to no staff involvement. Review of the activity document revealed that there was inconsistent documentation of 1:1 in room visits for Resident #82.

During an interview on 3/3/15 at 11:00AM, the administrator indicated that the TLC program was designed for residents that was at risk for falls and exhibits behaviors that would interrupt the activities of the general population. She added that the TLC program was not a separate entity of the activity program. She indicated that the activity department was responsible for designing and effective program to meet the needs of residents with limited social/behavioral skills. She acknowledged that residents should not be sleeping throughout the entire activity. The expectation was that staff actively engage residents in the assigned activity and ensure the activity was being done.

During an interview on 3/4/15 at 10:08AM, NA#4 works the TLC program and on the unit. NA#4 indicated on average there was 8-10 residents in

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F 248	Continued From page 5 the group and sometimes larger when others were brought in to sit. NA#4 indicated that it had been difficult to work with all the residents in the room when the group was larger than the designated 8-10 residents. The NA indicated they were supposed to do the activites that was on the main calendar if there was not a scheduled program for the TLC group. NA added that many times staff had to come up with things to do when the activities program was not combined. She indicated that there was no specific program designed for the TLC group. The unit staff that have been assigned to the group for the day came up with things to do for the residents and many residents would end up asleep due to limited activities or staff available to run the program. Review of Resident #82 ' s activity participation record was which had limited information of the identified activities of interest that had been done. There was no information of record for October 2014, November 2014, December 2014, limited participation for January 2015 and February and March 2015 not available. Review of the activity notes from 8/31/14 to 1/12/15, documented the same repetitive note for each month. 2.Resident #20 was admitted to the facility on 10/13/14. The cumulative diagnoses included hypertension, muscle weakness, depression, diabetes and dementia. The Minimum Data Set(MDS) dated 1/19/15, indicated that Resident #20 had cognitive impairment, short and long term memory and decision making problems. Resident #20 required assistance with activities of daily living.	F 248		

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Review of the therapeutic recreation assessment 10/27/14, revealed Resident #20 group interest included entertainment, spiritual, socials, and games. The individual activities included books, magazines, newspaper, arts & crafts, outside, socialization, visitors and games.
During an observation 3/2/15 at 9:36AM, Resident#20 was identified as one of the participation for the TLC (tender loving care) program. The TLC program was designed for residents with limited social skills, fall and behavior risk. The sit and be fit was the designated activity. There was 14 residents in the small activities room doing group exercise with staff assistance. The activity staff only worked with five of the 14 residents with the exercise. The remaining residents were in the back of the room sleep. The assigned staff was unable to assist any other residents before the next schedule activity was to occur. The assigned activity at 10:00AM was rest and relaxation. The residents that were sleep from the previous activity continued to sleep through the next activity. Staff did not encourage or awaken the other 9 residents to participate. The 10:30AM pony express activity did not occur. The 9 plus two other residents were also sleep. Staff only worked with the three that were awake. Resident #20 slept through 3 activities without any encouragement or being awaken. Resident#20 was primarily sleep with limited stimulation from the staff.

During an interview on 3/./2/15 at 10:45AM, the act assistant(AA) indicated Resident #20 went to some activities which included exercise, food activities and some music activities. The AA

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indicated Resident #20 came to religious/church music and bingo activities. Resident #20 did well when she received assistance from staff to participate in the activity due. The AA indicated 1:1 in room activities were provided however, there was no set schedule or time frame for the provision of the activities.

During an activity on 3/2/15 at 3:00PM, Resident #20 was taken to the TLC group when they had a general group activity in progress (table games) in main dining room. Resident #20 indicated that she didn ' t know why she was in the room (TLC). She indicated that they " just pushed me in here so here I am ,I don ' t know what is going on they did not tell me " . She was coloring a picture. She indicated that she didn ' t really like to do that but this was what they gave me. " I prefer to go to church and gospel programs. "

During an interview on 3/3/15 at 9:00AM, the DON indicated the TLC program was designed for residents that was high risk for falls, behaviors and limited socialization. She indicated the TLC was a separate program, but there was no specific guidelines for the program activities. Residents in the TLC could also be offered participation in activities designed for residents on the main activities schedule.

During an interview on 3/3/15 at 9:10AM, the activity director (AD) indicated that she was not responsible for the TLC program and the expectation was for all residents to be engaged in the designated activities.

During an observation on 3/3/15 at 9:30AM, the DON acknowledged that several residents were in the back of the activity room sleep as 1 staff

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was providing manicures. Resident#20 was not a participant of the activity she was sitting outside of activity room in the hall. The DON acknowledged that Resident #20 could participate in any of the programs and would be a better candidate for the general group activites and several of the residents were in the back of the room sleep while the activity staff worked on 1 resident's nails.

During an observation on 3/3/15 at 9:30AM, the AA had 11 residents in room, she only did one residents nails, 10 residents lined up in the back of the room sleep. NA#2 was on the unit and arrived at 10:00 AM to assist with national anthem sing along again the same half of residents remained sleep.

During an interview the AA indicated that she followed the main calendar schedule of activites and on some occasions the TLC group and main calendar of events would combine activites. She indicated that she was not responsible for the activities of the TLC program unless the main calendar of events was combined. She indicated that she did 1:1 activities from 11-1pm. She indicated that there was not a specific program designed for 1:1 activities nor was there a set schedule of time frame for each of the residents to receive the 1:1. `

During an interview on 3//3/15 at 10: 30AM, NA#2 indicated that on average 8-10 residents were in the TLC program unless activities or other NAs brought residents in the group. The group gets overwhelming at times trying to provide activites for so many residents with different level of interest and no designated program of activities. The NA indicated that attempts were made to

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follow the main calendar of events but it was not always possible and some of the residents just end up sleeping.

During an observation on 3/3/15 at 10:35AM, Resident #20 was asleep in wheelchair in the hallway. Resident #20 was not offered the opportunity to participate in any of the morning activites.

During an interview on 3/3/15 at 10: 45AM, the activity director (AD) indicated that the TLC program was separate from the main activities program. She indicated that the main activities are for the general population. The DON (director of nursing)coordinated the TLC program and the activities that were provided for the group unless there was a combined activity. The activity director indicated she was unaware of why the programs were separate but nursing was primarily responsible for the designated activities for the TLC program. The AD added that the activity staff was responsible for doing the main schedule for the general population and the 1:1 activities. Review of the 1:1 program revealed that there was no identified list of residents who were scheduled to receive 1:1 activities or a time frame for these activities to be done. She confirmed during an observation on 3/3/15 at 10:30AM, several residents involved in the TLC program sleeping in the back of the room and limited to no staff involvement. Review of the activity document revealed that there was inconsistent documentation of 1:1 in room visits for Resident #20.

During an interview on 3/3/15 at 11:00AM, the administrator indicated that the TLC program was designed for residents that was at risk for falls

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and exhibits behaviors that would interrupt the activities of the general population. She added that the TLC program was not a separate entity of the activity program. She indicated that the Activity department was responsible for designing and effective program to meet the needs of residents with limited social/behavioral skills. She acknowledged that residents should not be sleeping throughout the entire activity. The expectation was that staff actively engage residents in the assigned activity and ensure the activity was being done.

During an interview on 3/4/15 at 10:08AM, NA#4 works the TLC program and on the unit. NA#4 indicated on average there was 8-10 residents in the group and sometimes larger when others were brought in to sit. NA#4 indicated that it had been difficult to work with all the residents in room when the group was larger than the designated 8-10 residents. The NA indicated they were supposed to do the activites that was on the main calendar if there was not a scheduled program for the TLC group. NA added that many times staff had to come up with things to do for the residents when the activities program was not combined. She indicated that there was no specific program designed for the TLC group. The unit staff that have been assigned to the group for the day came up with things to do for the residents and many residents would end up asleep due to limited activities or staff available to run the program.

Review of Resident: #20 ' s activity participation record was which had limited information of the identified activities of interest that had been done. There was limited information of record for November 2014, December 2014, January 2015

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and February and March 2015 .Review of the activity notes from 10/20/14 to 1/13/15, documented the limited information about Resident #20 participation in activities.

3.Resident #44 was admitted to the facility on 12/23/11. The cumulative diagnoses included dementia, anxiety, depression and mental disorder. The Minimum Data Set (MDS) dated 2/1/15, indicated Resident #44 had cognitive impairments, short and long term memory and decision making problems. Resident# 44 required assistance with all activities of daily living.
Review of the therapeutic recreation assessment 8/1/14, revealed Resident #44 group interest included entertainment, spiritual, socials, and games. The individual activities included books, magazines, newspaper, arts &crafts, outside, socialization and television.
During an observation 3/2/15 at 9:36AM, Resident#44 was identified as one of the participation for the TLC (tender loving care) program. The TLC program was designed for residents with limited social skills, fall and behavior risk. The sit and be fit was the designated activity. There was 14 residents in the small activities room doing group exercise with staff assistance. The activity staff only worked with five of the 14 residents with the exercise. The remaining residents were in the back of the room sleep. The assigned staff was unable to assist any other residents before the next schedule activity was to occur. The assigned activity at 10:00AM was rest and relaxation. The residents that were sleep from the previous activity continued to sleep through the next activity. Staff did not encourage or awaken the other 9 residents to participate. The 10:30AM

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F 248	Continued From page 12 Pony Express activity did not occur. The 9 plus two other residents were also sleep. Staff only worked with the three that were awake. Resident #44 slept through 3 activities without any encouragement or being awaken. Resident#44 was primarily sleep with limited stimulation from the staff. . During an observation on 3/3/15 at 10:35AM, Resident #44 sleep in front of the bedroom door. The scheduled activity was manicure. Resident #44 was not awakened or offered to participate in the activity. During an interview on 3/./2/15 at 10:45AM, the act assistant(AA) indicated Resident #44 went to some activities which included exercise, food activities and some music activities. The AA indicated Resident #44 came to religious/church music activities. Resident #44 did well when she received assistance from staff to participate in the activity due. The AA indicated 1:1 in room activities were provided however, there was no set schedule or time frame for the provision of the activities. During an interview on 3/3/15 at 9:00AM, the DON indicated the TLC program was designed for residents that was high risk for falls, behaviors and limited socialization. She indicated the TLC was a separate program, but there was no specific guidelines for the program activities. Residents in the TLC could also be offered participation in activities designed for resident on the main activities schedule. During an interview on 3/3/15 at 9:10AM, the activity director (AD) indicated that she was not	F 248		

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responsible for the TLC program and the expectation was for all residents to be engaged in the designated activities.

During an observation on 3/3/15 at 9:30AM, the DON acknowledged that several residents were in the back of the activity room sleep as 1 staff was providing manicures. Resident#44 was not a participant of the activity she was sitting outside of activity room in the hall. The DON acknowledged that several of the residents were in the back of the room sleep while the activity staff worked on 1 resident's nails.

During an observation on 3/3/15 at 9:30AM, the AA had 11 residents in room, she only did one residents nails, 10 residents lined up in the back of the room sleep. NA#2 was on the unit and arrived at 10:00 AM to assist with national anthem sing along again the same half of residents remained sleep.

During an interview the AA indicated that she followed the main calendar schedule of activites and on some occasions the TLC group and main calendar of events would combine activites. She indicated that she was not responsible for the activities of the TLC program unless the main calendar of events were combined. She indicated that she did 1:1 activities from 11-1pm. She indicated that there was not a specific program designed for 1:1 activities nor was there a set schedule of time frame for each of the residents to receive the 1:1.

During an interview on 3//3/15 at 10: 30AM, NA#2 indicated that on average 8-10 residents were in the TLC program unless activities or other NAs brought residents in the group. The group gets

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overwhelming at times trying to provide activites for so many residents with different level of interest and no designated program of activities. The NA indicated that attempts were made to follow the main calendar of events but it was not always possible and some of the residents just end up sleeping.

During an interview on 3/3/15 at 10: 45AM, the activity director (AD) indicated that the TLC program was separate from the main activities program. She indicated that the main activities are for the general population. The DON (director of nursing) coordinated the TLC program and the activities that were provided for the group unless there was a combined activity. The activity director indicated she was unaware of why the programs were separate but nursing was primarily responsible for the designated activities for the TLC program. The AD added that the activity staff was responsible for doing the main schedule for the general population and the 1:1 activities. Review of the 1:1 program revealed that there was no identified list of residents who were scheduled to receive 1:1 activities or a time frame for these activities to be done. She confirmed during an observation on 3/3/15 at 10:30AM, several residents involved in the TLC program sleeping in the back of the room and limited to no staff involvement. Review of the activity document revealed that there was inconsistent documentation of 1:1 in room visits for Resident #20.

During an interview on 3/3/15 at 11:00AM, the administrator indicated that the TLC program was designed for residents that was at risk for falls and exhibits behaviors that would interrupt the activities of the general population. She added

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that the TLC program was not a separate entity of the activity program. She indicated that the activity department was responsible for designing and effective program to meet the needs of residents with limited social/behavioral skills. She acknowledged that residents should not be sleeping throughout the entire activity. The expectation was that staff actively engage residents in the assigned activity and ensure the activity was being done.

During an interview on 3/4/15 at 10:08AM, NA#4 works the TLC program and on the unit. NA#4 indicated on average there was 8-10 residents in the group and sometimes larger when others were brought in to sit. NA#4 indicated that it had been difficult to work with all the residents in room when the group was larger than the designated 8-10 residents. The NA indicated they were supposed to do the activites that was on the main calendar if there was not a scheduled program for the TLC group. NA added that many times staff had to come up with things to do when the activities program was not combined. She indicated that there was no specific program designed for the TLC group. The unit staff that have been assigned to the group for the day mainly came up with things to do for the residents and many residents would end up asleep due to limited activities or staff available to run the program.

Review of Resident: #44 ' s activity participation record was which had limited information of the identified activities of interest that had been done. There was limited information of the record for January 2015 and February and March 2015 .Review of the activity notes from 10/29/14 to

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F 248	Continued From page 16 2/26/15, documented repetitive note. 4.Resident #164 was to the facility on 10/13/14. The cumulative diagnoses included hypertension, muscle weakness, depression, diabetes and dementia. The Minimum Data Set(MDS) dated 2/21/15, indicated that Resident #164 had cognitive impairment, short and long term memory and decision making problems. Resident #164 required assistance with activities of daily living. Review of the therapeutic recreation assessment 2/27/15, revealed Resident #164 revealed the resident was unable to answer the questions. During an interview on 3/./2/15 at 10:45AM, the act assistant(AA) indicated Resident #164 went to some activities which included exercise, food activities and some music activities. The AA indicated Resident #164 came to religious/church music and craft activities. Resident #164 did well when he received assistance from staff to participate in the activity due. The AA indicated 1:1 in room activities were provided however, there was no set schedule or time frame for the provision of the activities. During an interview on 3/3/15 at 9:00AM, the DON indicated the TLC program was designed for residents that was high risk for falls, behaviors and limited socialization. She indicated the TLC was a separate program, but there was no specific guidelines for the program activities. Residents in the TLC could also be offered participation in activities designed for residents on the main activities schedule.	F 248		

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F 248	Continued From page 17 During an interview on 3/3/15 at 9:10AM, the activity director (AD) indicated that she was not responsible for the TLC program and the expectation was for all residents to be engaged in the designated activities. During an observation on 3/3/15 at 9:30AM, the DON acknowledged that several residents were in the back of the activity room sleep as 1 staff was providing manicures. Resident#164 was not a participant of the activity he was sitting outside of activity room in the hall. The DON acknowledged that several of the residents were in the back of the room sleep while the activity staff worked on 1 resident's nails. During an observation on 3/3/15 at 9:30AM, the AA had 11 residents in room, she only did one residents nails, 10 residents lined up in the back of the room sleep. NA#2 was on the unit and arrived at 10:00 AM to assist with national anthem sing along, again the same half of residents remained sleep. Resident #164 was brought into the activity and went to sleep in the back of the room. During an interview the AA indicated that she followed the main calendar schedule of activites and on some occasions the TLC group and main calendar of events would combine activites. She indicated that she was not responsible for the activities of the TLC program unless the main calendar of events were combined. She indicated that she did 1:1 activities from 11-1pm. She indicated that there was not a specific program designed for 1:1 activities nor was there a set schedule of time frame for each of the residents to receive the 1:1.	F 248		

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F 248	Continued From page 18 During an interview on 3//3/15 at 10: 30AM, NA#2 indicated that on average 8-10 residents were in the TLC program unless activities or other NAs bring residents in the group. The group gets overwhelming at times trying to provide activites for so many residents with different level of interest and no designated program of activities. The NA indicated that attempts were made to follow the main calendar of events but it was not always possible and some of the residents just end up sleeping. During an observation on 3/3/15 at 10:35AM, Resident #164 was asleep in the activities During an interview on 3/3/15 at 10: 45AM, the activity director (AD) indicated that the TLC program was separate from the main activities program. She indicated that the main activities are for the general population. The DON (director of nursing) coordinated the TLC program and the activities that were provided for the group unless there was a combined activity. The activity director indicated she was unaware of why the programs were separate but nursing was primarily responsible for the designated activities for the TLC program. The AD added that the activity staff was responsible for doing the main schedule for the general population and the 1:1 activities. Review of the 1:1 program revealed that there was no identified list of residents who were scheduled to receive 1:1 activities or a time frame for these activities to be done. She confirmed during an observation on 3/3/15 at 10:30AM, several residents involved in the TLC program sleeping in the back of the room and limited to no staff involvement Resident #164 was	F 248		

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identified. Review of the activity document revealed that there was inconsistent documentation of 1:1 in room visits for Resident #164.

During an interview on 3/3/15 at 11:00AM, the administrator indicated that the TLC program was designed for residents that was at risk for falls and exhibits behaviors that would interrupt the activities of the general population. She added that the TLC program was not a separate entity of the activity program. She indicated that the activity department was responsible for designing and effective program to meet the needs of residents with limited social/behavioral skills. She acknowledged that residents should not be sleeping throughout the entire activity. The expectation was that staff actively engage residents in the assigned activity and ensure the activity was been done.

During an interview on 3/4/15 at 10:08AM, NA#4 works the TLC program and on the unit. NA#4 indicated on average there was 8-10 residents in the group and sometimes larger when others were brought in to sit. NA#4 indicated that it had been difficult to work with all the residents in room when the group was larger than the designated 8-10 residents. The NA indicated they were supposed to do the activites that was on the main calendar if there was not a scheduled program for the TLC group. NA added that many times staff had to come up with things to do when the activities program was not combined. She indicated that there was no specific program designed for the TLC group. The unit staff that have been assigned to the group for the day mainly came up with things to do for the residents and many residents would end up asleep due to

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F 248	Continued From page 20 limited activities or staff available to run the program. Review of Resident: #164 ' s activity participation record was which had limited information of the identified activities of interest that had been done. There was limited information of record for February and March 2015 .Review of the activity notes from 10/20/14 to 1/13/15, documented the limited information about Resident #164 participation in activities.	F 248		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and resident interview and record review, the facility failed to apply right hand splint for 1 of 3 sampled residents with contractures (Resident #103). The findings included: Resident#103 was admitted to the facility on 12/10/14. The cumulative diagnoses included right side hemiplegia due to cerebrovascular disease, neurogenic bladder, diabetes and generalized muscle weakness. The Minimum	F 318	Deficiency Corrected 1.) How corrective action will be accomplished for those found to have been effected. Splint was applied to the right hand of resident #103, orders were updated in the system and the CNA's were trained on frequency and duration of the splint for resident #103 on 3/3/2015 2.) How corrective action will be accomplished for those having potential to	3/31/15

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F 318	Continued From page 21 Data Set (MDS) dated 2/6/15 indicated Resident #103 had cognitive impairments and required total assistance with all activities of daily living. He was coded with contractures of right hand. Review of the physical evaluation and physician order dated 12/11/14, revealed Resident#103 would tolerate the appropriate RUE splints/orthotics for greater than 4 hours with no increase pain or decreased skin integrity and decrease risk of contractures secondary to hemiplegia. Review of the PT evaluation dated 12/22/14. Resident#103 was seen due to history of left cerebral vascular disease with right side weakness, significant deconditioning resulting in decline in functional mobility endurance and independency. The physician signed order for treatment for occupational therapy services 5 x week x 4 weeks for activities of daily living training, orthotic management and therapeutic activities/exercise. Review of the care plan dated 12/23/14 identified the problem as: Resident #103 had activities of daily living deficit related to right side hemiplegia and disease process. The goal included he would not have activities of daily living decline. The interventions included placing call bell within reach and therapy as ordered. During an observation on 3/2/15 at 8:46AM. Resident#103 was lying in bed with contracture of the right hand. The blue palmer splint was placed in the seat of the wheelchair located in the chair. Instructions for PROM (passive range of motion) activities for upper and lower extremities (UE/LE)	F 318	be affected by the same practice. Current residents with contractures that require splints have the potential to be affected. An audit was conducted on current residents that have splints to determine if frequency and duration is reflected in the orders and that documentation is in place under "Task" in point click care. 3.)What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Re-education of therapy staff to ensure documentation, orders and training of nursing staff are in place prior to the discharge of a resident with a splint to nursing staff. Re-education to licensed and non-licensed nursing staff on how to document on splints under "Tasks". Both therapy and nursing staff were re-educated on the importance of splint management for residents with contractures. An audit was completed on current residents to ensure residents that require splints have splints and that the documentation is in place in "Tasks". An audit will be conducted weekly times 12 weeks by the therapy program manger on residents discharged from therapy caseload to ensure documentation and orders are in place for splint management by the nursing staff. 4.) How the facility plans to monitor its performance to make sure that solutions are sustained. The therapy program manager will present the results of weekly audits to the	

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F 318	Continued From page 22 were located on the closet door. Resident #103 indicated that he was only involved in speech therapy program. During an observation on 3/2/15 at 12:13PM, Resident#103 was being escorted from his room to the hall area without right hand palmer splint. The splint was located on the table near the resident's TV. During an interview on 3/2/15 at 12:13PM, NA#1(nursing assistant) indicated that the NA ' s was responsible for performing the daily PROM(passive range of motion) after personal care to UE/LE(upper/lower extremities). He added that resident was not being seen by physical therapy and therapy staff had instructed the nursing assistants on how to perform the PROM. The NA indicated he was uncertain when the splints should be applied since his only instructions were to perform the PROM. During an observation on 3/2/15 at 12:20PM, Resident#103 was escorted down to therapy services without the right hand palmer splint in place. Resident #103 received speech therapy only. Resident #103 was able to feed self and hold cup with the use of his left hand. The splint was lying on the table near the television in the room. During an interview on 3/2/15 at 12:20PM, the speech therapist indicated she was unaware of Resident#103 use of a splint or when it was to be applied. During an observation on 3/2/15 at 2:00PM, resident seated in the hallway near nursing area, there was no splint in place. The splint was	F 318	QA&A committee monthly times three months. The QA&A committee will determine if continued monitoring is necessary	

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located on the table near the television.

During an observation on 3/2/15 at 4:00PM, Resident#103 was lying bed in and splint remained in the same location near the television.

During an observation on 3/3/15 at 8:20AM, Resident#103 was lying in bed without splint. The splint was located on the table near the television.

During an observation on 3/3/15 at 10:40AM, Resident#103 was seated in hallway and he did not have splint in place. The splint was lying on table near the television.

During an observation on 3/3/15 at 12:30PM, Resident #103 was in ST without splint on hand. The splint was on table near the television.

During an observation on 3/3/15 at 2:00PM, Resident#103 was lying in bed and there was no splint on right hand. The splint was on the table near the television.

During an observation at 4:00PM on 3/3/15, Resident#103 was lying in bed and had right hand palmer guard splint in applied. Resident#103 stated that this was the 1st time in a long time staff had put the splint on. He indicated that he did not know why they put it on this time.

During an interview on 3/3/15 at 4:35PM, NA#2 indicated that when she worked 1st shift she would put it on for an average 4 hours. The NA indicated the expectation was when staff applied the palmer guard it should be reported to nursing after it was applied. NA#2 indicated there was no set schedule of when the splint should be applied.

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F 318	Continued From page 24 During an interview on 3/3/15 at 4:40PM, Nurse #1 indicated that the palmer guard should be applied when the resident got up in the morning. During an interview on 3/3/15 at 4:45PM, NA#3 indicated she was unaware of when the palmer guard splint should be applied to the resident. During an interview on 3/3/15 at 5:00PM, the Administrator and DON (director of nursing) indicated the expectation was staff should apply splint to residents as ordered by physician. The DON further stated therapy department was responsible for putting the therapy and treatment plan in the data system under task section to be communicated down to the nursing assistants. Administrator confirmed that therapy should have entered the plan of treatment for splints in the system and trained staff on the frequency and duration of the splints. During an interview on 3/4/15 at 9:00AM, the rehabilitation director and occupational staff indicated that splint application order was revised effective 3/3/15, to include instructions for staff. The rehabilitation director indicated it was the responsibility of the assigned occupational therapist to ensure staff were aware of the splint application/ frequency the resident should wear the palmer grip. The treatment plan should have been entered into the task communication section of the computer system for nursing assistant to follow program.	F 318		

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F 318	Continued From page 25	F 318		
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 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to discard spoiled vegetables, fruits and dented cans. The facility failed to cover and date stored food and to clean the oven and oven hood, steamer, two plate warmers and strainer pan. The findings included: On 2/23/15 at 10:45 AM, during the kitchen observation in the walk-in cooler there were three paper boxes of spoiled and rotten tomatoes, green peppers, zucchini and oranges mixed in with good quality produce on the shelves ready for use. A plastic bag of bread sticks was not labeled or dated.	F 371	Deficiency Corrected 1.) How corrective action will be accomplished for those found to have been affected. The three paper boxes of spoiled and rotten tomatoes, green peppers, zucchini and oranges were removed on 2/23/2015 Plastic bag of bread sticks that were not labeled was removed on 2/23/2015 Two meal plate warmers and steamer were cleaned on 2/23/2015 The strainer pan was removed and washed, rinsed and sanitized on 2/23/2015 The oven and oven hood were cleaned on 2/23/2015	3/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 03/04/2015

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

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F 371	Continued From page 26 On 2/23/15 at 10:50 AM, during an interview, the Food Service Director stated any staff member, who placed the boxes in the cooler, were responsible for ensuring that all produce was in good condition and to remove the spoiled vegetables and fruits. He stated that the plastic bag with bread sticks should have been labeled and dated. On 2/23/15 at 10:55 AM, during an observation in the kitchen, there were two meal plate warmers and steamer which was greasy and had food debris. The oven and oven hood were dirty with dry black and dark brown food debris as well as a dirty strainer pan on the drying rack. On 2/23/15 at 11:00 AM, during the interview, the Food Service Director stated that the meal plate warmers, strainer pan, oven, and oven hood, needed to be cleaned. The oven hood was cleaned by contracted company twice a year. The Food Service Director indicated the last cleaning date of the oven hood was October 2014. On 2/23/15 at 11:05 AM, during an observation, of the dry food storage room there were three dented cans of Sauerkraut, Diced Beets and Marinara source on the shelf. One of three plastic containers with opened bag of flour was observed without the lid. On 2/23/15 at 11:10 AM, during the interview, the Food Service Director indicated dented cans could not be used and need to be removed from shelves. She confirmed that all of the containers for dry food needed to be kept covered with lids.	F 371	The three dented cans were removed on 2/23/2015 The lid was replaced on the flour bin on 2/23/2015 The oven hood was cleaned of debris on 3/3/2015 The one dented can was removed on 3/3/2015 The lid was replaced on the dry food storage container on 3/3/2015 2.) How corrective action will be accomplished for those having potential to be affected by the same practice. Current residents that consume food by mouth have the potential to be affected. The dining services staff were re-educated on food storage, and sanitary conditions. 3.) What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The dining services staff were re-educated on food storage, cleaning schedules and sanitary conditions. Cleaning schedules were revised to include the oven and hood. The dietary manager will complete a validation checklist five days week for 12 weeks that includes adherence to cleaning schedules, labeling of food, removing dented cans, lids being placed on bins and work areas being clean and sanitized. 4.) The dietary manger will present the results of the checklist to the QA&A committee monthly times three months. The QA&A committee will determine if	

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F 371	Continued From page 27 On 2/23/15 at 11:15 AM, during the interview, the Food Service Director indicated that she had a cleaning schedule for all kitchen staff for the week as well as daily assignments, included cleaning. She indicated that all kitchen employees were assigned to clean their working area at the end of the shift and as needed. The Food Service Director indicated she could not recall the last time when a deep cleaning took place. On 2/23/15 at 11:20 AM, during the interview, the cook indicated the kitchen staff does constant cleaning during the shift. She was aware there was deep cleaning and did not remember last time she participated in deep cleaning. On 2/23/15 at 11:25 AM, during the interview, the dietary aide stated that she cleaned her work area several times per shift and could recall a deep cleaning in January 2015. She confirmed that she personally cleaned the hood above the oven in January 2015. The dietary aide indicated that all spoiled, rotten vegetables and fruits needed to be trashed and all the dented cans needed to be removed from the shelves. On 3/3/15 at 10:35 AM, during the kitchen observation, the oven hood was observed with dry dark food debris. On 3/3/15 at 10:45 AM, during the dry food storage room observation, one of the three plastic containers for dry food was without the lid, and there was one dented can of tomatoes. On 3/3/15 at 10:50 AM, during the interview, the Food Service Director that dented cans cannot be used and needed to be removed from shelves and staff members were to check and remove the	F 371	continued monitoring is necessary.	

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F 371	Continued From page 28 dented cans every day.	F 371		