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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING ______ B. WING ______	C 10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILSON	**1804 FOREST HILLS ROAD** **WILSON, NC 27893**

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to implement recommendations for vitamin C and zinc made by an in-house wound care specialist for 1 of 1 sampled residents (Resident #65) with an ulcer which deteriorated and led to an amputation. Findings included: Resident #65 was admitted to the facility on 07/10/15. The resident's documented diagnoses included right above-the-knee amputation (AKA), peripheral arterial disease, gout, and osteoarthritis. The resident's 07/17/15 admission minimum data set (MDS) documented her cognition was intact, she required extensive assistance to being dependent on staff for her activities of daily living (ADLs), and she had no pressure ulcers, arterial/venous ulcers, or open lesions. On 07/23/15 "Resident has potential for pressure ulcer development r/t (due to) decreased mobility" was identified as a problem in Resident #65's care plan. Interventions to this problem included "Administer medications as ordered."	F 309	This Plan of Correction is the center¿s credible allegation of compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. Deficiency is Corrected A. Corrective action taken for the affected resident (1) The Director of Nursing (DON) notified the Primary Care Physician (PCP) on Oct 8, 2015, regarding recommendations of wound physician for resident #65.PCP did not want recommendations implemented. (2) The DON provided in service education for wound nurse on Oct 8,	10/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/23/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 On 07/23/15 "Resident has potential/actual impairment to skin integrity r/t fragile skin" was identified as a problem in Resident #65's care plan. Interventions to this problem included, "Encourage good nutrition and hydration in order to promote healthier skin." Record review revealed Resident #65 was hospitalized for persistent nausea and vomiting from 07/26/15 until 08/04/15. The resident's August 2015 medication administration record (MAR) documented Resident #65 was readmitted from the hospital receiving Resource 2.0 (nutritional supplement) 90 cubic centimeters (cc) three times daily (TID). A 08/05/15 weekly wound tracking form documented, "Readmitted to facility yesterday, hospital reports document resident not eating well, and started on Megace (appetite stimulant). Unstageable (wound) to lower right calf. Wound bed 100% boggy eschar, no indication of infection. 11.5 x 6.2 centimeters (cm). Clean with wound cleanser, paint with Betadine, cover with ABD pad, wrap with kling daily (QD). No c/o (complaints of) pain. Scant sero-sanguinous drainage with odor." On 08/05/15 revision to Resident #65's care plan problem regarding potential for pressure ulcer development documented, "Resident was admitted with an eschar area to right calf." A 08/10/15 in-house wound care specialist initial evaluation documented, "Presents with an unstageable (due to necrosis) of the right, posterior calf of at least 7 days duration. There is	F 309	2015, regarding follow through for wound physician recommendations which includes notifying PCP and initiating orders as approved by the PCP. B. Corrective action taken for those residents having the potential to be affected by the deficient practice (1) An audit was conducted by the director of nursing and the wound care nurse on October 16, 2015, of current residents for the last three months (July-Sept. 2015) with regards to the wound doctor¿s recommendations to ensure that Primary care physician is made aware of recommendations. Orders written and implemented as directed by the primary care physician where modified. (2) The DON and wound care nurse began in service education for licensed nurses on October 16,2015, regarding follow through of recommendations which includes notifying PCP about wound physician recommendations and implementing orders that PCP approves. C. Measures Implemented and /or Systemic changes made to ensure that deficient practices will not reoccur (1) The DON and wound care nurse began in service education for licensed nurses on October 16, 2015, and the cited	

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F 309	Continued From page 2 no exudate. There is no indication of pain associated with this condition. Can't detect pedal pulses of right and left dorsalis pedis and posterior tibia. 9 x 13 (cm). 60% black necrosis. Present on admission for hospital with unknown etiology. Will order arterial studies. Betadine QD with dry dressing. Recommendations: MVI (multi-vitamin) QD, vitamin C 500 mg BID (milligrams twice daily), zinc sulfate 220 mg QD x 14 days, offload wound, reposition per facility protocol. Possible arterial embolic event?, FU (follow-up) within 7 days." During the review of Resident #65's gastrointestinal system the wound specialist documented, "Malnutrition. Appetite: Poor. Supplements: None." Review of Resident #65's August 2015 and September 2015 MARs revealed the resident never received any vitamin C or zinc. A 08/11/15 weekly wound tracking form documented the right calf wound measured 9 x 13 cm with scant malodorous sero-sanguinous drainage. The wound bed was described as "60% eschar and 40% skin." The same treatment was continued. It was noted Resident #65 was eating less than 25% of all meals. A 08/17/15 in-house wound care specialist follow-up evaluation documented, "Light serosanguinous exudate, no indication of pain. 9 x 15 cm, odor, 60% black necrotic tissue, wound deteriorated. Arterial studies show moderately advanced PAD (peripheral arterial disease) in both LEs (lower extremities), right greater than left, recommend vascular consult. Silver sulfadiazine qd with dry dressing. Debridement not indicated due to severe peripheral arterial disease. FU within 7 days."	F 309	deficiency was corrected regarding follow through of recommendations which includes notifying PCP about wound physician recommendation and implementing orders that PCP approves. Newly hired license nurses will receive same in-service training during orientation. (2) The director of nursing or designee will review wound doctor¿s recommendations weekly for four weeks then monthly to validate recommendations have been reviewed with primary care physician and appropriate orders written. D. How the facility plans to monitor its performance to assure ongoing compliance is sustained. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance Process Improvement committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan as directed by Committee based on outcomes/trends identified. Audit reviews will continue until Committee directs differently. E. Date Corrective Action Completed Corrective action was achieved on 10/28/15	

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F 309	Continued From page 3	F 309		

A 08/18/15 weekly wound tracking form documented the right calf wound continued to deteriorate, measuring 9 x 15 cm. The wound was cleaned with wound cleanser, Silvadene was applied to the wound, and the wound was covered with an ABD pad and wrapped with kling daily. A wedge and heel floaters were in place. Doppler results showed severe occlusive disease to the bilateral LE. A consult with the vascular surgeon was scheduled on 08/25/15.

A 08/25/15 weekly wound tracking form documented the right calf wound continued to deteriorate, and the resident was still eating less than 25% of meals.

A 08/27/15 assessment by the registered dietitian (RD) documented Resident #65's meal intake ranged from 0 - 50%, and because the Megace appetite stimulant seemed to be ineffective, it was discontinued, and the resident was started on Remeron (to promote an increase in appetite).

Hospital records documented Resident #65 was hospitalized from 08/31/15 until 09/02/15 for a right AKA.

At 11:10 AM on 10/18/15 the treatment nurse stated Resident #65's primary physician pretty much always agreed with recommendations made by the wound clinic and in-house wound service because they were the experts in the field of wound healing. She reported she could not remember any dialog with this resident's physician regarding the use or non-use of the vitamin C and zinc recommended by the in-house wound specialist to promote wound healing for Resident #65.

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F 309	Continued From page 4	F 309		

At 12:10 PM on 10/18/15 the facility's RD stated there was not a lot of nutrition research available which proved vitamin C and zinc sulfate were actually beneficial in wound healing, but some physicians and wound clinics were still utilizing the nutrients in hopes of promoting wound healing in residents who were nutritionally compromised. She reported, in the end, if the physicians or wound experts wanted residents placed on vitamin C and zinc then their recommendations should be honored.

At 12:23 PM on 10/18/15 the unit supervisor stated that the facility expectation was if the primary physicians disagreed with recommendations made during consultations, the nurses receiving this information would write a nurse's note documenting the declination of the recommendation and the rationale behind it. However, he reported maybe things were with different concerning communications between the treatment nurse and the primary physicians.

Review of Resident #65's nurse's notes revealed none which documented the primary physician's decision not to implement recommendations for vitamin C and zinc.

At 2:46 PM on 10/18/15, during a telephone interview with Resident #65's primary physician, he stated he was not a big proponent of using vitamin C and zinc in wound healing, and he sometimes did not implement recommendations for their use. However, the physician reported he could not say for sure whether this was the case with Resident #65.

F 371	483.35(i) FOOD PROCURE,	F 371		10/28/15

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F 371 SS=E

Continued From page 5

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 observation and staff interview the facility failed to air dry tray pans before stacking them on top of one another in storage, failed to cover food and beverage while gnats were present in the kitchen, failed to sanitize meal carts per facility expectation, and failed to label and date opened food items. Findings included:

1. During initial tour of the kitchen, beginning at 9:30 AM on 10/05/15, 5 of 11 tray pans stacked on top of one another in storage had moisture inside of them.

At 3:05 PM on 10/07/15 the dietary manager (DM) stated the tray pans found stacked wet on 10/05/15 had been placed in storage the night before. She explained dietary staff were trained that all kitchenware was supposed to be clean and dry before being stacked in storage. However, she reported it was possible that two new employees on the PM shift forgot.

At 3:12 PM on 10/07/15 a cook/assistant dietary manager (ADM) stated the dietary staff was

F 371

This Plan of Correction is the center¿s credible allegation of compliance.

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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.

Deficiency is Corrected

A. Corrective action taken for the affected resident

1. On 10/05/15, opened food items without dates and labels were immediately removed and discarded, Wet Kitchenware (tray pans) was secured and reprocessed

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F 371

Continued From page 6

repeatedly in-serviced about how to store kitchenware. She reported staff were instructed if kitchenware such as cups and tray pans were stacked on top of one another they had to be clean and dry.

2. During initial tour of the kitchen, beginning at 9:30 AM on 10/05/15, there was no lid on the tea canister which was full to the top with brewed tea. Gnats were also observed at this time in the kitchen, mainly hovering around the steam table.

A follow-up tour of the kitchen began at 9:35 AM on 10/07/15. Again the tea canister was without a lid, and it was full of brewed tea. A sheet cake was also uncovered. Gnats were observed at this time in the kitchen, mainly hovering around the steam table.

At 10:30 AM on 10/07/15 there was still no lid on the tea, and the cake remained uncovered. Several gnats were observed in the kitchen.

At 3:05 PM on 10/07/15 the dietary manager (DM) stated the facility had lids for beverage canisters. She reported she thought the lids were sometimes washed and not returned to cover the canisters. According to the DM, the tea should be covered to keep from being contaminated by gnats and flies. The DM also stated staff could have covered the cake with parchment paper or other inverted cake pans to prevent contamination from insects.

At 3:12 PM on 10/07/15 a cook/assistant dietary manager (ADM) stated she was educated to cover food items, especially those that would drop in temperature below 165 degrees Fahrenheit before being serving. However, she

F 371

per sanitation protocol, food items that were uncovered after preparation were covered, The solution in sanitizer bucket was emptied and fresh sanitizing solution was prepared and verified to be the proper strength at greater than 50 PPM. Re- checked for proper PPM once again. Staff were instructed to follow the protocol on wiping/sanitizing the carts coming from outside the kitchen.

2. The dietary staff members were in-serviced on 10/07/15 by the Dietary Manager (DM) regarding (a) dietary protocols for air drying and storage of food preparation and serving kitchenware (tray pans); (b) covering the prepared food and drinks to prevent contamination; (c) proper sanitation practices for wiping meal carts with appropriate PPM strength sanitizing solution; (d) dating and labeling new and opened food items storage protocols.

B. Corrective action taken for those residents having the potential to be affected by the deficient practice

1. The facility has determined that all residents who consume food by mouth have the potential to be affected.

2. All dietary staff members were in-serviced and retrained beginning on 10/07/15, with observation, by the Certified Dietary Manager on (a) dietary protocols for washing, sanitizing, drying

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F 371

Continued From page 7
commented she did not want to compromise the quality of the cake while it cooled. She reported the tea canister should be covered, when full of tea, to prevent contamination.

3. At 9:50 AM, 10:05 AM, and 10:20 AM on 10/07/15 the dietary employee operating the dish machine was observed taking a cloth from the draining board (the cloth had been in a red bucket of sanitizing solution in earlier observations), running it under water, and wiping down the outside and inside of meal carts which she emptied.

At 10:22 AM on 10/07/15 a strip used to measure the strength of the bleach-based sanitizing solution in the red bucket at the dish machine registered 25 parts per million (PPM) hypochlorite.

At 3:05 PM on 10/07/15 the dietary manager (DM) stated the red bucket made up at the dish machine contained bleach-based sanitizer which was supposed to register 50 PPM hypochlorite when checked with a strip. She also reported the operator of the dish machine was supposed to leave the rag/cloth in the sanitizing solution at all times when not in use. She explained washing the rag out under water without returning it to the bucket would remove most of the sanitizer. According to the DM, meal carts were out in the dining rooms and resident care hallways so they needed to be sanitized when emptied between meals.

At 3:12 PM on 10/07/15 a cook/assistant dietary manager (ADM) stated meal carts were supposed to be emptied between meals and wiped down with rags coming directly from

F 371

and storage of food preparation and serving kitchenware; (b) protocol to cover any prepared food and drink before serving to prevent contamination; (c) use the proper strength bleach based sanitizing solution for wiping the meal carts; (d) dating and labeling new and opened food items storage protocols.

C. Measures Implemented and /or Systemic changes made to ensure that deficient practices will not reoccur

1. All dietary staff members were in-serviced and retrained beginning on 10/07/15, with observation, by the Certified Dietary Manager on (a) dietary protocols for washing, sanitizing,drying and storage of food preparation and serving kitchenware; (b) protocol to cover any prepared food and drink before serving to prevent contamination; (c) use the proper strength bleach based sanitizing solution for disinfecting the meal carts; (d)dating and labeling new and opened food items storage protocols.

2 The Dietary Manager began monitoring dietary staff on 10/05/15 to determine if the employee was performing procedures for (a) dietary protocols for air drying and storage of food preparation and serving kitchenware in compliance with facility safety and sanitation protocols; (b) covering the prepared food and drinks to prevent contamination by Gnats, flies; (c) proper sanitization practices for wiping the

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F 371	Continued From page 8 sanitizer buckets in which the solution registered at least 50 PPM hypochlorite when checked with strips. 4. During initial tour of the kitchen, beginning at 9:30 AM on 10/05/15, there were no labels/open dates on a gallon container of pickle relish, two one-gallon containers of light mayonnaise, and an eight-pound, ten-ounce container of chunky salsa. These items had been opened, and were stored in the reach-in refrigerator. There were also no labels/open dates on an opened bag of potato "tots" in the reach-in freezer, on an opened bag of pecan pieces in the dry storage room, on an opened box of Danish pastries in the walk-in refrigerator, and on opened bags of hamburger steak, blueberries, and pastry in the walk-in freezer. At 3:05 PM on 10/07/15 the dietary manager (DM) stated the cooks and assistant dietary manager (ADM) checked storage areas daily to make sure opened food items had labels and open dates on them. She reported she usually checked behind everyone in the storage areas twice weekly. The DM commented labels/open dates helped make sure older foods were used up first and helped employees make decisions about the freshness and quality of food items. At 3:12 PM on 10/07/15 a cook/ADM stated all employees who opened food items were responsible for placing labels and open dates on the remaining product. She also reported that she checked all storage areas daily to make sure the policy was being followed, and the DM performed checks in storage areas twice weekly. The ADM commented labeling/dating was an on-going challenge.	F 371	carts with appropriate PPM strength sanitizing solution; (d) dating and labeling new and opened food items storage protocols. Findings were reviewed with each employee. Corrective action was provided as needed. D. How the facility plans to monitor its performance to assure ongoing compliance is sustained 1. The Dietary Manager (DM) or designee will complete the Validation Audit tool on kitchenware air drying and storage protocol, covering the prepared food and drinks, using the proper PPM strength sanitizing solution to wipe/disinfect surfaces, food product dating and labeling requirement compliance at least 2 times daily for four weeks to ensure staff is performing the procedures in accordance with facility policy. 2. The Dietary manager will review the audits and observations to identify patterns and/or trends for the next three month period, the results of the audit tools will be presented at the monthly QAPI (Quality Assurance & Performance Improvement) meeting for compliance monitoring and any audit modification directives from the committee. E. Date Corrective Action Completed Corrective action was achieved on	

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F 371	Continued From page 9	F 371	10/28/15	