CENTER	S FOR MEDICARE &	MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345520	B. WING			11/	/04/2015
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		0-112010
				1	028 BLAIR STREET		
AVANIEA	AT THOMASVILLE			т	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 164 SS=D	PRIVACY/CONFIDEN	<ul> <li>PERSONAL</li> <li>NTIALITY OF RECORDS</li> <li>right to personal privacy and</li> <li>or her personal and clinical</li> </ul>	F	164			12/2/15
	Personal privacy inclumedical treatment, with communications, personal growth of family and does not require the form for each resider except as provided in section, the resident release of personal and individual outside the section.	sonal care, visits, and d resident groups, but this acility to provide a private nt. a paragraph (e)(3) of this may approve or refuse the nd clinical records to any					
	resident is transferred institution; or record r The facility must keep	oes not apply when the d to another health care elease is required by law.					
	the form or storage m release is required by	r transfer to another law; third party payment					
	by: Based on record revi interview, the facility f during care by not pu between residents for sampled residents ob Findings included:	is not met as evidenced ew, observation and staff failed to provide privacy lling the privacy curtain 1 (Resident #41) of 3 served during care.			F 164 Deficiency corrected 1. Corrective action has been accomplished for the alleged deficient practice in regards to providing privacy during care. The Director of Nursing		(X6) DATE

Electronically Signed

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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.

11/25/2015

PRINTED: 12/04/2015 FORM APPROVED

				PLE CONSTRUCTION		O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	G		E SURVEY IPLETED
		345520	B. WING		1'	1/04/2015
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
	T THOMASVILLE			1028 BLAIR STREET		
AVANTEA	THOMASVILLE			THOMASVILLE, NC 27360		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF		COMPLETION DATE
IAG				DEFICIENCY)		
F 164	Continued From page	o 1				
F 104	Continued From pag	eı	F 16		41- NI	
	Posidont #41 was as	dmitted to the facility on		provided in service education w 3 on 11/03/2015, regarding the	ith Nurse #	
		diagnoses including pressure		expectation of staff to provide pl	rivacy by	
		Minimum Data Set (MDS)		pulling the privacy curtain betwee		
		0/13/15 indicated that		residents when providing care/s		
	Resident #41's cogn	ition was intact and had a				
	stage III pressure ulo	cer.				
	The same along data d			2. Current facility residents have		
	•	9/2/15 indicated that stage III pressure ulcers on		potential to be affected by the a deficient practice. On 12/01/201		
	the sacrum and left b			Director of Nursing and 3rd shift		
				completed privacy audits on all		
	On 11/3/15 at 1:05 P	M, Resident #41 was				
		essing change. When				
		to her right side, the		3. Measures put into place to er		
		rea was exposed. The		alleged deficient practice does r		
		een the resident's beds was Imate was in her bed and the		include: The Director of Nursing in-service education on 11/20/20	-	
		rea was visible to the		regarding "providing resident pri		
	roommate.			confidentiality during care/service		
				12/01/2015 the Director of Nurs		
		M, Nurse #3, the nurse who		3rd shift RN completed random		
	•	ent, was interviewed. She		observational privacy audits on		
	•	t to pull the privacy curtain ident #41's buttocks was		The Director of Nursing and HR will ensure providing resident pr	-	
	exposed to her room			education be included upon nev	-	
				orientation and annually. The Di		
	On 11/4/15 at 3:50 P	M, administrative staff #1		Nursing and/or Unit Coordinator		
	was interviewed. Sh	e stated that she expected		observe 2 residents during wo	und-care	
		privacy by pulling the privacy		and/or resident care 3 times a w		
	curtain between the	beds during care.		weeks, weekly for 4 weeks, and	•	
				other week for 4 weeks, and the monthly for 3 months to include		
				and weekends, to validate priva		
				provided during care services.	- ,	
				4. The results from the random-	audits	
				reviewed daily/PRN by the Direct		
				Nursing to analyze observations	s for	

Event ID: LEKD11

Facility ID: 20020005

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PRINTED: 12/04/2015 FORM APPROVED

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		345520	B. WING		11/	04/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
	T THOMASVILLE		1	028 BLAIR STREET		
			Т	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 164 F 280 SS=D	PARTICIPATE PLAN The resident has the incompetent or other incapacitated under t participate in plannin changes in care and A comprehensive car within 7 days after th comprehensive asse interdisciplinary team physician, a registere for the resident, and disciplines as determ and, to the extent pra the resident, the resid legal representative;	(k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment. re plan must be developed	F 164	patterns/trends and report in the Q Assurance committee meeting more evaluate the effectiveness of the p will adjust the plan based on outcomes/trends identified. Preparation and/or execution of the of correction does not constitute admission or agreement by the pro- the truth of the facts alleged or conclusions set forth in the statement deficiencies. The plan of correction prepared and/or executed solely b it is required by the provisions of fe and state law.	nthly to lan and his plan ovider of ent of h is ecause	12/2/15

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					OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345520	B. WING		11/04/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AVANTE A	T THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
F 280	Continued From page	e 3	F 280		
	by:	is not met as evidenced		F 280 Deficiency corrected	
	facility failed to review and revise the care plan to reflect the discontinuation of a right hand splint for one of three residents (Resident #23) reviewed for range of motion. The findings included: Resident #23 was originally admitted to the facility on 8/12/05 and was readmitted on 3/29/12 with multiple diagnoses including history of cerebrovascular accident (CVA) with upper extremity weakness and contracture of hand joint. The quarterly Minimum Data Set (MDS) assessment dated 8/17/15 indicated the resident			<ol> <li>Corrective action has been accomplished for the alleged deficien practice in regards to care plan revis for Resident #23. The MDS coordina reviewed and updated the care plan Resident #23 on 11/12/2015, to refle discontinuation of splinting.</li> <li>Current facility residents have the potential of being affected by the alle discipatorection.</li> </ol>	ion ator for ct the eged
	in range of motion on extremity, and was in program for active ran passive range of moti brace assistance. A review of Resident	cognitively intact, had a functional limitation nge of motion on one side of the upper emity, and was in the restorative nursing tram for active range of motion (AROM), sive range of motion (PROM), and splint or e assistance. view of Resident #23's care plan revealed an vention that indicated a splint was applied todeficient pra MDS coord 11/11/15, or compared t receiving re active and/or services an up to date v	deficient practice. The DON and/or the MDS coordinator completed an audited 11/11/15, of current physician orders compared to residents identified that receiving restorative services, to ide active and/or discontinued restorative services and validated that care plant up to date with current orders.	t on s and ; are entify /e	
lu A re Ri nu A or wa hi	lunch time six days per A review of the restor revealed a note dated Resident #23 was dis nursing due to his ref A review of the physic order dated 9/4/15 the was discharged from his refusal to participation	er week. ative nursing documentation d 9/1/15 that indicated scharged from restorative usal to participate. cian orders revealed an at indicated Resident #23 restorative nursing due to		3.Measures put into place to ensure alleged deficient practice does not re include: The Director of Clinical Reimbursement/MDS, RN RAC-CT provided in-service education to the coordinator and Director of Nursing of 11/13/2015, regarding reviewing and updating care plans to support the ne and care of the resident. The MDS coordinator will review	MDS on
	11/2/15 at 2:55PM. S had a right hand cont splint.	She stated that the resident racture and did not wear a ducted with Administrative		telephone orders daily to identify new discontinued restorative services and update care plan as needed. The De will review restorative orders and car	d will ON

Facility ID: 20020005

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TATEMENT (	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		345520	B. WING		11/04/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
AVANTE A	AT THOMASVILLE			028 BLAIR STREET THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 280	Staff #2 on 11/4/15 a she was responsible reviewed Resident #2 orders. She revealed accurate. She stated Resident #23 was dis he was discharged fr stated that she shoul plan on 9/4/15 to rem	e 4 t 12:22PM. She stated that for revising care plans. She 23's care plan and physician d that the care plan was not d that the right hand splint for scontinued on 9/4/15 when om restorative nursing. She d have updated the care hove the intervention for the e stated that this was a	F 280	<ul> <li>plan updates weekly for four weeks th monthly for 3 months to validate care plans are updated when orders are written.</li> <li>4. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance comm meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.</li> <li>Preparation and/or execution of this p of correction does not constitute admission or agreement by the provid the truth of the facts alleged or conclusions set forth in the statement deficiencies. The plan of correction is prepared and/or executed solely beca it is required by the provisions of feder</li> </ul>	ttee st lan er of of
F 312 SS=D	DEPENDENT RESID	DENTS able to carry out activities of	F 312	and state law.	12/2/15

Event ID: LEKD11

Facility ID: 20020005

If continuation sheet Page 5 of 28

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
		345520	B. WING _			11/04/2015
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE,		
				1028 BLAIR STREET		
AVANTE A	T THOMASVILLE			THOMASVILLE, NC 27360		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLA	N OF CORRECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	COMPLETIO DATE
F 312	Continued From page	- 5	F 3	12		
	1.0	ere dependent on staff for			rovinion of nail	
		esident #66, #55, #10, #19		practice in regards to p care for dependent res		
	and #2). The finding			was provided for Resid		
		admitted to the facility		#19 and #2 on 11/04/20		
	5/1/14. Cumulative d	-		2.Current facility reside	ents dependent on	
		dent with hemiplegia on		staff for provision of ca		
		acture of the hand and		potential to be affected		
	diabetes.			deficient practice. The		
				(DON) and unit coordin		
	A Quarterly Minimum	Data Set (MDS) dated		service education for n	ursing staff	
		esident #66 had short term		beginning 11/04/2015 r		
		ry impairment and severely		of care for dependent r	•	
	-	making. He required total		nail care. The DON an		
	care with personal hy	giene and bathing.		observed current facilit	-	
	A care plan dated E/1	3/15 and last reviewed		identify needs for nail of nail care to those ident	-	
		esident #66 had an ADL			ineu.	
		ng) performance deficit		3.Measures put into pla	ace to ensure the	
		. Interventions included, in		alleged deficient practic		
		66 was totally dependent on		include: The Director of		
	staff for personal hyg	· ·		and unit coordinator pr		
				education for nursing s		
		"Care of fingernails/toenails"		11/04/2015, regarding		
		er 2010 stated, in part, "1.		for dependent resident	-	
		ily cleaning and regular		care. The DON and/or		
	trimming."			will observe 5 residents	•	
	On 11/2/15 at 4:02PM	A Resident #66 was		weeks, then 5 residents weeks to validate that r	-	
		ngated fingernails on both		provided as needed.	ומו כמוב וומס שככוו	
		vere approximately 1/4 inch				
		lack material under each		4.The Director of Nursi	ng will analyze	
	nail.			observation reviews for		
				and report in the Qualit		
	On 11/3/15 at 9:50AN	<i>I</i> , an observation of		committee meeting mo		
		ed Resident #66 continued to		the effectiveness of the		
		rnails and black material		adjust the plan based of	on outcomes/trends	
	was noted under eac	h nail.		identified.		

Facility ID: 20020005

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PRINTED: 12/04/2015

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		;	COM	PLETED
		345520	B. WING		11	/04/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
AVANTE A	T THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 312	On 11/4/15 at 9:20AW observed receiving m NA#2. Both NA#1 an required total ADL car and NA#2 completed washed and dried Re nail care was perform When asked what wa care, both NA#1 and included bathing, mou included bathing, mou included shaving, hair stated they cleaned u clipped nails if they w resident was diabetic, fingernails and notifie could be clipped/ trim observed Resident #6 they should have bee they had overlooked t they would clean und the nurse that the naii On 11/4/15 at 10:00A conducted with Admir Resident #66 needed cleaned and trimmed. On 11/4/15 at 11:20Al been at the facility sin and worked Monday to provided care for Res resident was diabetic, trim the nails (fingerna	<ul> <li>A. Resident #66 was orning care by NA#1 and d NA#2 stated Resident #66 re by nursing staff. NA#1 morning care. NA#1 sident #66 's hands. No red during the morning care.</li> <li>s included in daily morning NA#2 stated morning care uth care, grooming which r care and nail care. They nder the fingernails and ere not diabetic. If the , they cleaned under the d the nurse so the nails med. Both NA#1 and NA#2 56's fingernails and indicated n cleaned and clipped and the nail care. They stated er the fingernails and notify Is needed to be clipped.</li> <li>M, an observation was histrative staff #1 who stated to have his fingernails</li> <li>M, Nurse #1 stated she had nee the middle of October through Friday. Nurse #1 ident #66. She stated, if a , licensed staff would clip/ ails/ toes). She stated she d by any nursing staff that needed to have their</li> </ul>	F 31	2 Preparation and/or execu of correction does not cor admission or agreement to the truth of the facts alleg conclusions set forth in th deficiencies. The plan of of prepared and/or executed it is required by the provis and state law.	estitute by the provider of ed or e statement of correction is I solely because	
	On 11/4/15 at 120PM	, Administrative staff #1 staff to trim fingernails and				

Facility ID: 20020005

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/04/2015 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE	
		345520	B. WING				11/	04/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
AVANTE A	T THOMASVILLE				28 BLAIR STREET HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE		(X5) COMPLETION DATE
F 312	<ul> <li>2/3/12. Cumulative di cerebrovascular accio dominant side and co</li> <li>An Annual MDS dated #55 had short term ari impairment and was ri daily decision-making required for personal</li> <li>A care plan last review Resident #55 had a si due to hemiplegia. In extensive assistance assistance for incontin</li> <li>A facility policy titled "last revised on Octobe Nail care includes dai trimming."</li> <li>An observation condurevealed Resident #55 all of the fingernails a elongated about 1/4 in</li> <li>On 11/3/15 at 9:53AW Resident#55 revealed</li> </ul>	the fingernails she eptable. admitted to the facility fagnoses included lent with hemiplegia on the gnitive deficit. d 10/9/15 indicated Resident ad long term memory noderately impaired with . Extensive assistance was hygiene and bathing. wed 8/12/15 indicated elf-care performance deficit terventions included, in part, for repositioning and total nent care. Care of fingernails/toenails" er 2010 stated, in part, "1. ly cleaning and regular ected on 11/2/15 at 4:29PM 5 had black material under nd all of the fingernails were nch. I, an observation of I the fingernails continued to ck material was noted under	F 3	12				

Facility ID: 20020005

If continuation sheet Page 8 of 28

	-					FORM	APPROVED
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	SURVEY
		345520	B. WING			11/0	04/2015
NAME OF P	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
AVANTE A	T THOMASVILLE				30		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	TIVE ACTION SHOULD BE CED TO THE APPROPRIA		(X5) COMPLETION DATE
F 312	NOF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       COMPLETED         345520       B. WING       11/04/2015         IF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       1028 BLAR STREET         THOMASVILLE       STREET ADDRESS, CITY, STATE, ZIP CODE       1028 BLAR STREET         D       SUMMARY STATEMENT OF DEPROFINATES       ID       PROVIDER PAY AND CORRECTIVE ACTION BYOLD BE       COMPLETED         X       (REQULATORY OR LSC IDENTIFYING INFORMATION)       PREEN       ID       PREENT TO EDEROFINATE       COMPLETED         12       Continued From page 8       F 312       F 312       Conducted with Administrative staff #1 who stated Resident #55 needed to have his fingernails cleaned and trimmed.       F 312       ID       Completion was conducted with Administrative staff #1 who stated the had been at the facility since the middle of Cotoer and worked Monday through Friday, Nurse #1 stated she had been at the facility since the middle of Cotoer and worked Monday through Friday, Nurse #1 stated she had been at the facility since the middle of Cotoer and worked to have his fingernails cleaned and trimmed.       On 11/4/15 at 1:20PM, Administrative staff #1 stated she had been rails and dean under rails and the fingernails node do have their fingernails cleaned to have their fingernails cleaned at the their fingernails cleaned at the their fingernails cleaned at the their fingernails cleaned to have their fingernails and clean under facility thromed.       On 11/04/2015 at 3:15PM, NA#3 stated Resident #55 resisted care at times but the allowed staff to th						
	conducted with Admir Resident #55 needed	nistrative staff #1 who stated to have his fingernails					
	been at the facility sin and worked Monday to provided care for Ress resident was diabetic, trim the nails (fingerna had not been informe any of the residents n	through Friday. Nurse #1 sident #55. She stated, if a , licensed staff would clip/ ails/ toes). She stated she d by any nursing staff that needed to have their					
	stated she expected s clean under nails and	staff to trim fingernails and the fingernails she					
	#55 was total care wit Resident #55 resisted allowed staff to clean	th ADL's. She stated I care at times but he					
	3/30/2001. Cumulativ						
		ed 8/26/15 indicated verely impaired in cognition. e assistance with personal					
	-	wed 9/25/15 indicated ADL self-care performance iplegia. Interventions					

Facility ID: 20020005

If continuation sheet Page 9 of 28

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/04/2015 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE	
		345520	B. WING			11/	04/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AVANTE /	AT THOMASVILLE				1028 BLAIR STREET THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 312	included, in part, that extensive assistance care. A facility policy titled ' last revised on Octob Nail care includes dai trimming." On 11/2/15 at 3:51PM observed to have elon hands. Fingernails we long and there was bl nail. On 11/3/15 at 9:52AM Resident #10 reveale have elongated finger was noted under each On 11/4/15 at 9:30AM Resident #10 reveale have elongated finger under each nail. On 11/4/15 at 10:00A conducted with Admir Resident #10 needed cleaned and trimmed done today. On 11/4/15 at 11:20A been at the facility sir and worked Monday f provided care for Res resident was diabetic trim the nails (fingerna	Resident #10 required with toileting and incontinent 'Care of fingernails/toenails" er 2010 stated, in part, "1. ily cleaning and regular 4, Resident #10 was ngated fingernails on both ere approximately ¼ inch lack material under each 4, an observation of d Resident #10 continued to mails and black material h nail. 4, an observation of d Resident #10 continued to mails and black material h nail. 5, an observation was histrative staff #1 who stated to have his fingernails . She stated they would be M, Nurse #1 stated she had here the middle of October through Friday. Nurse #1 hident #10. She stated, if a , licensed staff would clip/ ails/ toes). She stated she d by any nursing staff that	F	312			

Facility ID: 20020005

If continuation sheet Page 10 of 28

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 12/04/2015 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE : COMPL	SURVEY
		345520	B. WING			11/0	04/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI	E, ZIP CODE		
AVANTE A	AT THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 312	fingernails clipped/ tri On 11/4/15 at 1:20PM stated she expected s clean under nails and observed were unacc On 11/4/15 at 3:15PM required assistance w staff to perform nail/ h 4. Resident #19 was 8/21/15. Cumulative mellitus. An Admission MDS d Resident #19 was cog extensive assistance bathing. A care plan dated 9/8 required assistance w included, in part, to as completion of ADL's. A facility policy titled ' last revised on Octob Nail care includes dai trimming."	mmed. A, Administrative staff #1 staff to trim fingernails and the fingernails she ceptable. A, NA#3 stated Resident #10 with grooming and required hand care. admitted to the facility diagnoses included diabetes ated 8/28/15 indicated gnitively intact. He required with personal hygiene and b/15 stated Resident #19 with ADL's. Interventions ssist as needed for 'Care of fingernails/toenails" er 2010 stated, in part, "1. ily cleaning and regular	F 312				
	have elongated nails on both hands and bla Resident #19 stated h and they needed to b had not asked anyone	A, Resident #19 was noted to approximately ¼ inch long ack material under nails. ne did not like them that long e cut/ cleaned. He stated he e to cut them recently.					
	On 11/3/15 at 9:53AM Resident #19 was co	<ol> <li>an observation of nducted. The fingernails on</li> </ol>					

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	OF DEFICIENCIES	MEDICAID SERVICES					10. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		PLE CONST		· · ·	MPLETED	
		345520	B. WING			11/04/201		
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
AVANTE A	T THOMASVILLE				AIR STREET SVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 312	Continued From page	e 11	F 3	12				
	both hands remained	l elongated with black						
	material under each r one had provided car	nail. Resident #19 stated no re for his fingernails.						
	On 11/4/15 at 10:00A	M, an observation of						
		nducted. The fingernails on						
		l elongated with black nail. Resident #19 stated no						
		re for his nails and he did not						
	know who to ask abo							
		M, an observation was						
		nistrative staff #1 who stated						
		to have his fingernails . She told Resident #19 his						
		ed and trimmed that day.						
		M, Nurse #1 stated she had						
		nce the middle of October						
	-	through Friday. Nurse #1 sident #19. She stated, if a						
		, licensed staff would clip/						
		ails/ toes). She stated she						
	any of the residents r	ed by any nursing staff that						
	fingernails clipped/ tri							
		I, Administrative staff #1						
		staff to trim fingernails and						
	clean under nails and observed were unacc							
		/l, NA#3 stated Resident #19						
	required staff to do ca nails.	are for his fingernails/ trim						
		admitted to the facility						
	cerebrovascular acci	ve diagnoses included						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/04/2015 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE	
		345520	B. WING				11/	04/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	;	STREET ADDRESS, CITY, STATE, ZIP CODE			
AVANTE A	AT THOMASVILLE				1028 BLAIR STREET THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 312	Continued From page	÷ 12	F	312	2			
	impairment and was r decision-making. He assistance with perso A care plan last review Resident #2 had an A deficit related to hemi included, in part, that dependent on staff for care. A facility policy titled " last revised on Octob Nail care includes dai trimming." On 11/2/15 at 3:40PM to have all fingernails approximately ¼ inch noted under each nai	t and long term memory moderately impaired in required extensive onal hygiene and bathing. wed on 9/15/15 indicated ADL self-care performance iplegia. Interventions Resident #2 was totally r transfers and incontinent 'Care of fingernails/toenails" er 2010 stated, in part, "1. ily cleaning and regular 1, Resident #2 was observed on both hands elongated and black material was I. Resident #2 stated he did						
	11/3/15 at 9:52AM. H with black material un stated nursing staff do On 11/4/15 at 10:00A Resident #2 revealed elongated with black n On 11/4/15 at 10:00A conducted with Admir Resident #2 needed t cleaned and trimmed.	sident #2 was conducted on lis nails remained elongated oder each nail. Resident #2 o nails now and then. M, an observation of his fingernails remained material under each nail. M, an observation was histrative staff #1 who stated						

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-		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/04/2015 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE	
		345520	B. WING				11/	04/2015
NAME OF PROVIDER OR	SUPPLIER			ST	REET ADDRESS, CITY	, STATE, ZIP CODE	-	
AVANTE AT THOMAS	VILLE				28 BLAIR STREET	27360		
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD I RENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 312 Continue	d From page	9 13	F	312				
<ul> <li>been at ti and work provided resident v trim the r had not b any of the fingernail</li> <li>On 11/4/' stated sh clean und observed</li> <li>On 11/4/' was total nail care.</li> <li>483.25(c) PREVEN</li> <li>Based or resident, who ente does not individua they were pressure services prevent r</li> <li>This REC by: Based o facility fai</li> </ul>	he facility sir ed Monday f care for Res was diabetic pails (fingern- been informe e residents r s clipped/ tri 15 at 1:20PM e expected s der nails and were unacc 15 at 3:15PM care and rea ) TREATMEI T/HEAL PRI n the compre the facility m rs the facility develop pre l's clinical co e unavoidabl sores received to promote h new sores from QUIREMENT n staff interv led to asses	1, Administrative staff #1 staff to trim fingernails and the fingernails she	F	314	F 314 Deficie 1.Corrective act	ency corrected ion has been		12/2/15

Facility ID: 20020005

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			()(0)			O. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>		· · · ·	E SURVEY IPLETED		
		345520	B. WING		11	/04/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	DE			
AVANTE A	AT THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE		
F 314	<ul> <li>Continued From page 14</li> <li>Resident #52 was admitted 7/25/15 with diagnoses including Alzheimer's disease and abnormal involuntary movements.</li> <li>The Admission Minimum Data Set (MDS) indicated Resident #52 was cognitively intact and did not have a pressure ulcer.</li> <li>Review of the Progress Notes revealed a Skin Assessment dated 8/9/15 that indicated Resident #52 had 3 small open areas on her left buttock and that treatment was initiated according to the facility wound care protocol, with a note for the physician to review. There were no notes indicating the wound measurements or that described the condition of the wounds. Nurse #2, who wrote the note was not available for interview.</li> <li>The Care Plan was updated on 8/12/15 and revealed a new care plan for risk of pressure ulcers due to fragile skin. Interventions included treatment per orders to left buttock, notify</li> </ul>		F 314	<ul> <li>accomplished for the alleged practice in regards to Residen Resident #52 was discharged 8/13/15.</li> <li>2.Current facility residents had potential to be affected the sad practice. The Director of Nurr provided in service education licensed nurses beginning 11 regarding Assessment and documentation of wounds up admission/readmission, and/or new wound is identified. The coordinator and licensed nurses skin assessments on current 11/10/2015, to identify resider wounds and validate measured.</li> </ul>	nt #52. d home on we the ame deficient sing for the /10/2015, on or when a DON, unit ses began residents on nts with			
	device on bed. Resident #52 was dis On 11/4/15 at 3:57 Pl stated that she and A looked in the Medical Treatment Nurse's of locate an assessmen pressure ulcers. She expectation that an a	e added that it was her ssessment of the resident's I have been completed when		<ul> <li>documentation and treatment been initiated. (if any were id Documentation, measurement treatments were initiated, and physician/family were notified discrepancies that were ident were identified) There were in discrepancies identified.</li> <li>3. Measures put into place to alleged deficient practice doe include: The Director of Nursi in service education for the lid nurses beginning 11/10/2015 Assessment and documentat wounds upon admission/read and/or when a new wound is The Director of Nursing and/o coordinator will review new</li> </ul>	lentified) hts, d for tified. (if none to ensure the es not recur ing provided censed regarding tion of lmission, identified.			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/04/2015 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE	
		345520	B. WING _			11/	04/2015
NAME OF P	ROVIDER OR SUPPLIER		_	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	AT THOMASVILLE			10	28 BLAIR STREET		
				TH	HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 314 F 318 SS=D	IN RANGE OF MOTH Based on the compre resident, the facility m with a limited range o	ASE/PREVENT DECREASE ON whensive assessment of a nust ensure that a resident f motion receives t and services to increase or to prevent further		314	admission/readmission charts during of clinical review at least 5 times per wee to validate skin assessments are completed and wound measurements treatments are initiated as needed. Th DON will observe/review 2 new admissions or readmission residents skin, weekly for four weeks, then 2 residents monthly to validate skin assessment accuracy and documentat to support assessment. 4. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance commi meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Preparation and/or execution of this p of correction does not constitute admission or agreement by the provide 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 becau it is required by the provisions of feder and state law.	k, and he tion ttee st lan er of of use	12/2/15

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F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	OMB N (X3) DA	IO. 0938-039
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	MPLETED
	345520	B. WING		1	1/04/2015
ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		1	028 BLAIR STREET		
THOMASVILLE		1	HOMASVILLE, NC 27360		
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
Continued From page	e 16	F 318			
	is not met as evidenced				
Based on record rev interview, the facility the bilateral hand spli passive range of mot ordered for 1 (Reside	failed to consistently apply ints and to provide the ion six times a week as ent #21) of 3 sampled		practice in regards to Resident #2 Resident # 21 was re-evaluated b	:1. y	
3/12/07 with multiple Alzheimer's disease a Minimum Data (MDS indicated that Reside decision making prob range of motion on be extremities. The asso Resident #21 had rec motion (PROM) and s days in the last 7 cale nursing program. The occupational the reviewed. The notes Resident #21 was ref and tear on her left has evaluated and treated facilitate splinting tole splinting device and i new device. On 7/17 discharged from OT s	diagnoses including and hypertension. The ) assessment dated 10/2/15 nt #21 had memory and olems and had limitation in oth sides of the upper essment also indicated that ceived passive range of splint/brace assistance for 4 endar days by the restorative rapy (OT) notes were dated 7/6/15 indicated that ferred due to the contracture and. Resident #21 was d to fit for orthotic device, erance, assess safety with instruct in scheduling/care of 7/15, Resident #21 was services to restorative		<ul> <li>#21 will continue Restorative serv ROM and splinting 6 x/week.</li> <li>2. Current residents receiving resiservices for ROM and splinting has potential to be affected by the alled deficient practice. The DON, MDS coordinator and/or Therapy mana began in-service education for residents on 11/06/2015, regarding priservices as ordered and/or accordinator and Therapy program manager audited/reviewed the resiservices for ROM and splinting, to that services remain necessary and appropriate, and residents are reciservices as ordered. The physicia notified regarding discrepancies in</li> </ul>	ices for torative we the ged ger storative roviding ding to 4DS sidents rative validate nd/or seiving an was dentified	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER T THOMASVILLE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page This REQUIREMENT by: Based on record rev interview, the facility the bilateral hand spli passive range of moto ordered for 1 (Reside residents with limited included: Resident #21 was add 3/12/07 with multiple Alzheimer's disease a Minimum Data (MDS indicated that Reside decision making prob range of motion on be extremities. The assis Resident #21 had rec motion (PROM) and a days in the last 7 cale nursing program. The occupational the reviewed. The notes Resident #21 was ref and tear on her left have evaluated and treated facilitate splinting tole splinting device and i new device. On 7/17 discharged from OT s	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345520         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 16         This REQUIREMENT is not met as evidenced by:         Based on record review, observation and staff interview, the facility failed to consistently apply the bilateral hand splints and to provide the passive range of motion six times a week as ordered for 1 (Resident #21) of 3 sampled residents with limited range of motion. Findings included:         Resident #21 was admitted to the facility on 3/12/07 with multiple diagnoses including Alzheimer's disease and hypertension. The Minimum Data (MDS) assessment dated 10/2/15 indicated that Resident #21 had memory and decision making problems and had limitation in range of motion on both sides of the upper extremities. The assessment also indicated that Resident #21 had received passive range of motion (PROM) and splint/brace assistance for 4 days in the last 7 calendar days by the restorative	S FOR MEDICARE & MEDICAID SERVICES	S FOR MEDICARE & MEDICAID SERVICES         0F DEFICIENCIES       (11) PROVIDERSUPPLIERCLIA         0345520       8. WNO         345520       9. WNO         STREET ADDRESS, CITY, STRE, ZP CODE         THOMASVILLE         STREET ADDRESS, CITY, STRE, ZP CODE         THOMASVILLE, NC 27360         ID PRETX REQUIREMENT IS NOT MUST BE PRECEDED BY FULL REQUIREMENT IS NOT MET as evidenced by:         Deficiency wust be preceded by:         Deficiency corrected         THOMASVILLE, NC 27360         OCONTINUE SPLAN OF CORRECT REQUIREMENT IS not met as evidenced by:         Based on record review, observation and staff interview, the facility failed to consistently apply the bilateral hand splinits and to provide the passive range of motion. Findings included:       F 318       F 318       Deficiency corrected         Resident #21 was admitted to the facility on 31/207 with multiple diagnoses including Alzheimer's disease and hypertension. The Minimum Dat (MDS) assessment date of 10/215 indicated that Resident #21 had memory and decision making problems and had limitation in range of motion on both sides of the upper reviewed. The notes dated 7/6/15 indicated that Resident #21 was admitted to the facility on 31/207 with multiple diagnoses including Alzheimer's disease and hypertension. The Minimum Date date #21 was revealuated to coordinator and/or Therapy mana began in-service education for re- aides on 110/6/2015, regarding pi services for ROM and spl	S FOR MEDICARE & MEDICAID SERVICES       OMB N         OP DEFICIENCIES       (X) PROVIDERSUPPLERCIA         A BUILDING       (X) PROVIDERSUPPLERCIA         345520       n. WING         A BUILDING       (X) PROVIDERSUPPLERCIA         THOMASVILLE       STREET ADDRESS, CITY, STATE, ZP CODE         1228 BLAR STREET       THOMASVILLE, NC 27360         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DENTFINING INFORMATION)       ID PREFIX         This REQUIREMENT is not met as evidenced by:       PROVIDERS TAIN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Continued From page 16       F 318         This REQUIREMENT is not met as evidenced by:       F 318         Based on record review, observation and staff inderview, the facility failed to consistently apply the bilaterail hand splints and to provide the passive range of motion six times a week as ordered for 1 (Resident #21) of 3 sampled resident #21 was admitted to the facility on 31/207 with multiple diagnose including Alzheimer's disease and hypertension. The Minimum Data (MDS) assessment dated 10/2/15 indicated that Resident #21 had memory and decision making problems and had limitation in range of motion no bot sides dise of the upper reviewed. The notes dated 7/6/15 indicated that Resident #27 had received passive range of motion (RCM) and splintUrbace assistance for 4 days in the last 7 calendar days by the restorative and tear on he left hand. Resident #21 was device to replan. The Director of Nursing (DON), MDS coordinator and herapy program manag

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			()(0)		OMB NO. 0938		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345520	B. WING	11/04/201			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
AVANTE A	AT THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		CTION SHOULD BE COMPL O THE APPROPRIATE DA		
F 318	Continued From page	e 17	F 31	8			
	<ul> <li>Continued From page 17         restorative nursing to provide PROM to both upper extremities with leeder grip hand splint on left hand and resting hand splint on the right hand, on after AM care and off with PM care 6 times per week.     </li> <li>The care plan dated 10/2/15 was reviewed. One of the care plan problems was alteration in musculoskeletal status related to contractures of the right and left hands, restorative nursing for passive range of motion and bilateral hand splints. The goal was to remain free of injuries or complications related to right and left contractures through the next review date. The approaches included keep both hands clean and dry, monitor right and left hands for skin breakdown and passive range of motion given per order and splints applied to bilateral hands per orders.</li> </ul>			alleged deficient practice include: The DON, MDS and/or Therapy manager education for restorative 11/06/2015, regarding pr as ordered and/or accord The DON and/or MDS co review the restorative gri rendered to at least 5 res week for four weeks ther monthly for four weeks, the shifts and weekends, to are provided as ordered plan. The MDS coordina program manager will re residents that are receivi services weekly/monthly documentation and provi have occurred as recomi continued services are n update care plan and ord necessary.	coordinator began in-service aides on oviding services ding to care plan. bordinator will d for services sidents, 5 times a to 5 residents o include all validate services and/or per care ator and Therapy view/observe the ng restorative to validate ision of services mended and eeded and		
	splints on. The monthly restorat reviewed. The July, 2015 record was provided the res (PROM and applicati week instead of 6 tim The week of July 20 the restorative nursin The week of July 27-	M, Resident #21 was i chair with bilateral hand ive care flow records were d revealed that Resident #21 torative nursing program on of splints) 5 times per hes per week as ordered. - 25, the resident received ng program on July 20-24. Aug 1, the resident received ng program on July 27-31.		<ul> <li>4. The Director of Nursin audits/reviews for pattern qday/PRN and report in Assurance committee me evaluate the effectivenes will adjust the plan based outcomes/trends identifie</li> <li>Preparation and/or exect of correction does not co admission or agreement the truth of the facts alleg conclusions set forth in ti</li> </ul>	ns/trends the Quality eeting monthly to as of the plan and d on ed. sution of this plan institute by the provider of ged or		

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		MEDICAID SERVICES				<u> </u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		345520	B. WING		11/04/2015		
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
AVANTE A	T THOMASVILLE			1028 BLAIR STREET FHOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	,		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 318	Continued From page	<u>• 18</u>	F 318				
	restorative 5 times (A August 16-22, the res times (Aug 17, 18, 21	ug 3, 4, 5, 6, 8), the week of sident received restorative 3 ) and the week of August ceived restorative 5 times		it is required by the provisions of for and state law.	ederal		
	week of Sept 13-19, t restorative 5 times (S 21-24) the week of Se 30, Oct 1, 2) the week (Oct 18, 21, 22, 23), t	i times (September 7-11),					
	was interviewed. She responsible for the re for Resident #21. She #21 had an order to re per. She indicated th Friday to provide the and another NA work provide restorative nu She acknowledged th provided restorative s she was pulled to wor time. She added that work on the floor as a	AM the NA (nurse aide) #4 e stated that she was storative nursing program e was aware that Resident eceived restorative six times at she worked Monday to restorative nursing program ed during the weekends to ursing and to do the weights. hat Resident #21 was not six times per week because rk on the floor most of the t today she was pulled to a nurse aide and it was hard corative nursing as well.					
	On 11/4/15 at 2:40 Pl was interviewed. She restorative nurse and restorative nursing pr she was aware that F	M, Administrative staff #2 e stated that she was the was responsible for the ogram. She indicated that Resident #21 had an order g program 6 times per week.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345520	B. WING _		11/04/2015
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	CODE
AVANTE A	AVANTE AT THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360	
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN(	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 318 F 431 SS=E	consistently provided the restorative nursing program 6 times per week as ordered due to restorative aide was pulled to work on the floor as nurse aide most of the time. 483.60(b), (d), (e) DRUG RECORDS,		F 3		12/2/15
	a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliatio records are in order a	loy or obtain the services of t who establishes a system and disposition of all ifficient detail to enable an n; and determines that drug and that an account of all aintained and periodically			
		y and cautionary			
	facility must store all locked compartments	tate and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to eys.			
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t package drug distribu	ride separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the imal and a missing dose can			

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			0.00			938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SUR COMPLETE	
		345520	B. WING		11/04/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AVANTE A	AT THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE CO	(X5) DMPLETIO DATE
F 431	Continued From page	e 20	F 43	1		
	by: Based on record rev interview, the facility medications and to d in 3 (unit 2 - cart 1 & medication carts and room refrigerators. 1. On 11/4/15 at 11:0 unit 2 was observed v Vitamin D was alread she would discard it. shift nurses were resp medication cart for ev On 11/4/15 at 3:50 Pl was interviewed. She were responsible for carts 3 times a week. nurse might have mis bottle.	agreed that the bottle of ly expired and stated that She also stated that 11-7 ponsible for checking the kpired medications. M, administrative staff #1 e stated that 11-7 nurses checking the medication . She indicated that the ssed the expired Vitamin D 5 AM, medication cart #2 on with Nurse #3. Two		<ul> <li>F 431 Deficiency corrected</li> <li>1. Corrective action has been accomplished for the alleged defice practice in regards to dating and la and expired medications. The Unit Coordinator disposed of expired medications on 11/04/2015.</li> <li>2. Current resident s medication potential to be affected the same of practice. The Director of Nursing a Unit coordinator audited current remedication and over the counter medication beginning on 11/05/20 identify medications that have exp and/or not dated when opened. Medications identified were dispose facility policy. On 11/18/2015, the pharmacy representative provided in-service education for current lice staff regarding medications.</li> <li>3.Measures put into place to ensuralleged deficient practice does not include: On 11/18/2015, the facility pharmacy representative provided</li> </ul>	abeling t nas the deficient und/or sident 15, to ired ed per facility ensed nance	
	opening. The instruc "discard 3 months aft On 11/4/15 at 11:10 A			staff regarding medication mainter pertaining to dating, labeling and expiration of medications. The lice nurses on the 11-7 shift will audit		

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	S FOR MEDICARE &		0.00	E CONCEPTION	OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345520	B. WING		11/04/2015
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	
AVANTE A	AT THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 431	Continued From page	e 21	F 43	1	
	have been dated whe that 11-7 shift nurses checking the medicat On 11/4/15 at 3:50 PI was interviewed. She were responsible for carts 3 times a week. nurses were checking date when the medica 3. On 11/4/15 at 11:10 unit 2 was observed y used advair discus (u chronic obstructive pi was that undated. Th read " discard 30 day foil pouch. " On 11/4/15 at 11:12 A interviewed. She stat have been dated whe pouch. She also stat were responsible for carts. On 11/4/15 at 3:50 PI was interviewed. She were responsible for carts 3 times a week. nurses were checking date when the medica	AM, Nurse #3 was ted that 11-7 shift nurses checking the medication of the medication sfor ation was opened. 0 AM, medication cart #1 on with Nurse #3. There was a use to treat asthma and ulmonary disease) 250/50 he instruction on the box ys after removing from the AM, Nurse #3 was ted that the advair should an removed from the foil ed that 11-7 shift nurses checking the medication M, administrative staff #1 e stated that 11-7 nurses checking the medication She was not sure if the g multi dose medications for		<ul> <li>medication carts and over the count medications at least 3 times a week assure medications are dated and I and disposed of when expired, accord to facility policy. The Director of Nur and/or the Unit coordinator will audi medication carts and over the count medications at least 5 times a week four weeks and then 3 times a week four the Quality Assurance correction for preparation and/or execution of thi of correction does not constitute admission or agreement by the provisions of feat and state law.</li> </ul>	k to abeled ording rsing it ter k for k n yze nd nmittee djust s plan vider of ent of is ecause
		as observed. There was an ein derivatives (PPD)			

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		MEDICAID SERVICES			OMB NO. 093		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED		
		345520	B. WING		11/04/20 <sup>,</sup>	)15	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AVANTE	AT THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         (EACH CORREC CROSS-REFERENCY		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMF	(X5) IPLETIC DATE		
F 431	On 11/4/15 at 11:23 A interviewed. She stat for 30 days after oper PPD was expired and discard it. On 11/4/15 at 3:50 PI was interviewed. She were responsible for carts 3 times a week the checking included refrigerator. 5. On 11/4/15 at 2:20 cart was observed wi following items were Aspirin 325 mg (millig date of 10/15. Lantus insulin dated as 10/2/15 and dated as 10/29/15. According t instructions Lantus in unrefrigerated for 28 discarded. Lidocaine 1 % that ha have the date of first Centers for Disease O multi-dose has been o needle-punctured) the discarded within 28 d specifies a different (s that opened vial".	M, Nurse #3 was ted that the PPD was good hing and she agreed the d she stated that she would M, administrative staff #1 e stated that 11-7 nurses checking the medication but she did not indicate that d the medication room PM the 100 hall medication th Nurse #1. On the cart the observed: grams) with an expiration as having been opened to be discarded by to the manufacturer's sulin vials may be kept days and then must be ad been used but did not use on it. According to Control guidelines "If a opened or accessed (e.g., e vial should be dated and ays unless the manufacturer shorter or longer) date for	F 43				

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		MEDICAID SERVICES		CONSTRUCTION		<u>IO. 0938-039</u> TE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:				MPLETED		
		345520	B. WING		1	1/04/2015		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COE	DE			
AVANTE A	AT THOMASVILLE		1028 BLAIR STREET THOMASVILLE, NC 27360					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
F 431	Continued From page	e 23	F 431					
	were no residents wh Lidocaine so it should the medication cart.	as first used and that there o currently had an order for d have been removed from Nurse #1 did not know why ere still on the medication						
F 520 SS=E	cart. 483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS		F 520			12/2/15		
	assurance committee nursing services; a pl	in a quality assessment and consisting of the director of nysician designated by the other members of the						
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies.						
		ords of such committee h disclosure is related to the ommittee with the						
		by the committee to identify ficiencies will not be used as						
	This REQUIREMENT by: Based on record rev	is not met as evidenced		F 520 Deficiency corrected				

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					OMB NO. 093		
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	(X3) DATE SURV COMPLETED				
		345520	B. WING		11/04/20	015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
AVANTE AT THOMASVILLE				1028 BLAIR STREET THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE CON TO THE APPROPRIATE	(X5) IPLETIO DATE	
F 520	Continued From page	e 24	F 5	20			
	<ul> <li>520 Continued From page 24 interview, the facility's Quality Assessment and Assurance (QAA) committee failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 12/4/14 in order to achieve and sustain compliance in the areas of Informed of services/charges/Resident Rights (F156), range of motion (F318) and proper labeling of drugs and biological (F431). These deficiencies were cited again on the current recertification survey of 11/4/15. The findings included: This tag is cross referenced to: F156 - Informed of services/charges/Resident's rights - Based on record review and staff interview the facility failed to notify a resident of the denial of payment for Medicare services and appeal rights before the end date of those services for 1 of 3 residents (Resident #34) reviewed for liability notices.</li> <li>During the recertification survey of 12/4/14, the facility was cited F156 for failing to post the names, addresses and telephone numbers of the state survey and certification agency, state licensure office and Medicaid fraud control unit and also failed to insert the name and toll free number of the Quality Improvement Organization</li> </ul>			<ol> <li>Corrective action has accomplished for the all practice in regards to: R received notice of Medic 09/16/2015. Resident # re-evaluated by Occupa 11/10/2015, with recomm continue restorative/spli Resident #21 will contin services for ROM and s The Unit Coordinator dis medications on 11/04/20</li> <li>Current facility reside potential to be affected R deficient practice. The R manager will provide to POA a Notice of coverag 3 days prior to discontin and a copy of the letter or retained in the residents Current residents receiv services for ROM and s potential to be affected R deficient practice. The D coordinator and/or There began in-service educat</li> </ol>	eged deficient lesident #34 care change on 21 was tional Therapy on mendation to nting services. ue Restorative plinting 6 x/week. sposed of expired 015. nts have the by the alleged Business office resident and/or ge change at least uation of services, will be dated and a financial file. ring restorative plinting have the by the alleged DON, MDS apy manager		
	review, observation a failed to consistently splints and to provide six times a week as c	care non coverage. on - Based on record and staff interview, the facility apply the bilateral hand the passive range of motion ordered for 1 (Resident #21) ts with limited range of		services as ordered and care plan. The Director of Nursing coordinator and Therapy manager audited/review records that have orders services for ROM and s that services remain neo appropriate, and resider	(DON), MDS y program yed the residents s for restorative plinting, to validate cessary and/or		

Facility ID: 20020005

				LE CONSTRUCTION		O. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520		A. BUILDING	· · · ·	(X3) DATE SURVEY COMPLETED			
		B. WING		1 <sup>,</sup>	11/04/2015		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
AVANTE AT THOMASVILLE				1028 BLAIR STREET THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		I SHOULD BE	OULD BE COMPLETI	
F 520	Continued From page	e 25	F 52	0			
	<ul> <li>520 Continued From page 25</li> <li>During the recertification survey of 12/4/14, the facility was cited F318 for failing to apply the carrot splint and to provide the passive range of motion as ordered and care planned.</li> <li>F431 - Proper labeling of drugs and biological - Based on record review, observation and staff interview, the facility failed to discard expired medications and to date multi dose medications in 3 (unit 2 - cart 1 &amp; 2 and unit 1 cart) of 3 medication carts and 1 (unit 2) of 2 medication room refrigerators.</li> <li>During the recertification survey of 12/4/14, the facility was cited F431 for failing to discard expired medications and to date multi dose medication room refrigerators.</li> <li>During the recertification survey of 12/4/14, the facility was cited F431 for failing to discard expired medications and to date multi dose medications when opened.</li> <li>On 10/4/15 at 3:40 PM, administrative staff #1 and #3 were interviewed for quality assessment and assurance (QAA). Administrative staff #3 indicated that he was new to the facility but he was the head of the facility's QAA committee.</li> </ul>			<ul> <li>notified regarding discrepanciand services were initiated as Current resident s medicatio potential to be affected the sapractice. The Director of Nurs Unit coordinator audited current medication beginning on 11/0 identify medications that have and/or not dated when opene Medications identified were difacility policy. On 11/18/2015, pharmacy representative provin-service education for current staff regarding medications.</li> <li>Measures put into place to alleged deficient practice doe include: The Administrator, Th Program Manager, DON and office manager will review rest changes at least 5 times a were morning meeting, and a letter</li> </ul>	hitiated as ordered. medication has the ted the same deficient or of Nursing and/or dited current resident r the counter ng on 11/06/2015, to that have expired ten opened. ed were disposed per /18/2015, the facility tative provided n for current licensed ication maintenance labeling and ations. o place to ensure the actice does not recur strator, Therapy DON and Business review residents payor imes a week during		
	medical director, adm nursing, dietary mana director, environment the pharmacist and th committee had met m Administrative staff # aware that F156, F31 deficiencies. She rev monitoring the liability up meetings. She sta	nittee consisted of the ninistrator, director of ager, activity director, rehab al director, social worker, ne MDS nurse. The		provided to the resident and/o least 3 days prior to discontin services and/or payor source. The DON, MDS coordinator a Therapy manager began in-se education for restorative aides 11/06/2015, regarding providi as ordered and/or according t The DON and/or MDS coordin review the restorative grid for rendered to at least 5 residen week for four weeks then 5 re monthly for four weeks, to val services are provided as order	uation of nd/or ervice s on ng services o care plan. nator will services ts, 5 times a sidents idate		

Facility ID: 20020005

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345520		(X2) MULTIP	(X3) DA	OMB NO. 0938-039			
		A. BUILDING			COMPLETED		
		B. WING		1	11/04/2015		
		STREET ADDRESS, CITY, STATE, Z		IP CODE			
AVANTE AT THOMASVILLE				1028 BLAIR STREET THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 520	that she was aware the program was not com- ordered due to the re- work on the floor as re- staff #1 indicated that responsible for check three times a week. If the monitoring sheet checked the medicati might have missed the also stated that she co	hat the restorative nursing sistently provided as storative aide was pulled to nurse aide. Administrative t the 11-7 shift nurses were sing the medication carts She added that according to the 11-7 shift nurses had ion carts on 11/2/15 and they be expired medications. She lidn't know if the nurses multi dose medications had	F 52	<ul> <li>per care plan. The MDS Therapy program mana review/observe the resid receiving restorative ser validate documentation services have occurred continued services are r update care plan and or necessary. On 11/18/2015, the facil representative provided education for current lice regarding medication m pertaining to dating, lab expiration of medication nurses on the 11-7 shift medication carts and ov medications at least 3 ti assure medications are and disposed of when e to facility policy. The Dir and/or the Unit coordina medication carts and ov medications at least 5 ti four weeks and then 3 ti ongoing to assure medi- dated/labeled and dispo- expired according to fac The Administrator will pi education for the depart beginning on 11/30/201 Quality Assurance proce and maintaining complia</li> <li>The Director of Nursin Administrator will analy for patterns/trends and no Quality Assurance comm monthly to evaluate the</li> </ul>	ger will dents that are vices monthly to and provision of as ordered and needed and ders as ity pharmacy in-service ensed staff aintenance eling and s. The licensed will audit er the counter mes a week to dated and labeled xpired, according rector of Nursing ator will audit er the counter mes a week for imes a week for imes a week for imes a week cations are used of when cility policy. rovide in service ment managers 5, regarding ess, monitoring ance. mg and/or the ze audits/reviews report in the mittee meeting		

Event ID: LEKD11

Facility ID: 20020005

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345520		(X2) MULTIPL	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		A. BUILDING			
		B. WING	11/04/2015		
NAME OF PROVIDER OR SUPPLIER AVANTE AT THOMASVILLE			:		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC
F 520	Continued From page 27		F 520	) the plan and will adjust the plan outcomes/trends identified.	based on
				Preparation and/or execution or of correction does not constitute admission or agreement by the the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correct prepared and/or executed solely it is required by the provisions of and state law.	ment of on is because

Event ID: LEKD11

Facility ID: 20020005

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