STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as result of the complaint investigation. Event ID #72TM11.	F 000		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label personal care equipment which included a bath basin in the bathroom of room #107, failed to store a bed pan in a plastic bag or label it in the bathroom of room #147 and failed to repair a leaking toilet with brown stains inside the toilet bowl in the bathroom of room #111 in 3 of 61 resident rooms. Findings included: Observations on 03/21/17 at 4:23 PM revealed in the bathroom of resident room #107 there was a bath basin inside a clear plastic bag on a metal shelf in the bathroom with no resident name on it. Observations on 03/22/17 at 3:00 PM revealed in the bathroom of resident room #107 there was a bath basin inside a clear plastic bag on a metal shelf in the bathroom with no resident name on it. Observations on 03/23/2017 9:50 AM revealed in the bathroom of resident room #107 there was a bath basin inside a clear plastic bag on a metal shelf in the bathroom with no resident name on it. Observations on 03/21/17 at 4:32 PM revealed in the bathroom of resident room #147 there was a bed pan uncovered sitting in a bath basin on a	F 253	F 253 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to: 1) Labeling and storage of personal care equipment. The bath basin in bathroom #107 was labeled with the residents name on 3/23/17 and placed in a storage bag in the residents bathroom. 2) The bed pan in bathroom # 147 was labeled on 3/23/17 with the residents name and placed in a storage bag in the residents bathroom. 3) The leaking toilet and brown stains in bathroom #111 was repaired/corrected on 3/23/17, by the maintenance director. Current facility residents have the potential to be affected by the alleged deficient practice. 1) The Director of Nursing (DON) and unit managers conducted an audit of current facility residents bathroom on 3/23/17, to identify personal care equipment that needed to be labeled and	4/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/14/2017

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F 253	Continued From page 1 metal shelf in the bathroom with no resident name on it. Observations on 03/22/17 at 3:10 PM revealed in the bathroom of resident room #147 there was a bed pan sitting in a bath basin uncovered on a metal shelf in the bathroom with no resident name on it. Observations on 03/23/17 at 10:01 AM revealed in the bathroom of resident room #147 there was a bed pan sitting in a bath basin uncovered on a metal shelf in the bathroom with no resident name on it. During an interview on 03/23/17 at 12:15 PM with NA #5 she explained personal care equipment which included bath basins and bed pans were supposed to be labeled with the resident's name. She explained they were expected to write the resident's name and room number on the bath basin or bed pan with a black permanent marker. During a tour and interview on 03/23/17 at 12:23 PM with the Director of Nursing she explained it was her expectation for resident care equipment which included bath basins and bed pans to be labeled with the resident name. She stated she expected for staff to use a black marker to label them and confirmed there was no resident name on the bath basin in the bathroom of room #107 and the bedpan in room #147 was not labeled and should have been stored in a clear plastic bag. During an observation on 03/21/17 at 4:30 PM in the bathroom of room #111 the toilet was running constantly and there were dark brown stains inside the toilet bowl where the water was running down the back side of the bowl. During an observation on 03/22/17 at 3:05 PM in	F 253	stored according to facility protocol. No other issues were identified. 2) The Maintenance director conducted an audit of resident bathrooms to identify toilets that were not functioning properly and/or stained. Repairs/replacement was completed when identified. Measures put into place to ensure the alleged deficient practice does not recur include: The DON and/or the unit managers provided in service education for the nursing staff beginning on 4/12/17 , regarding labeling and storage of personal care items in resident rooms. The DON and/or unit managers will observe 20 bathrooms weekly /for 4 weeks and 10 bathrooms monthly for 3 months to validate personal care items are labeled and stored according to facility protocol. In service education will be provided during orientation for newly hired staff. The Maintenance director provided in service education to facility staff beginning on 4/12/17, regarding reporting of broken/stained toilets utilizing the TELS reporting system. The in service education will be provided during orientation for newly hired staff. The Maintenance Director will observe 20 bathroom toilets weekly for 4 weeks and 10 monthly for 3 months, to validate proper functioning and cleanliness. The Director of Nursing and Maintenance director will analyze audits/reviews for patterns/trends and report in the Quality	

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F 253	Continued From page 2 the bathroom of room #111 the toilet was running constantly and there were dark brown stains inside the toilet bowl where the water was running down the back side of the bowl. During an observation on 03/23/17 at 9:54 AM in the bathroom of room #111 the toilet was running constantly and there were brown stains inside the toilet bowl where the water was running down the back side of the bowl. During an environmental tour and interview on 03/23/17 at 2:40 PM with the Director of Facility Services he explained the facility used a work order system and anything that needed to be repaired should be put on a work order so the repair could be made. He stated staff had access to work orders in the computer system and he could track the repairs that he had made. He further stated the system kept him accountable for repairs and he could see who had put the repair in the system and then he could fix it. He explained he did not educate new employees in orientation about the work order system but if someone stopped him and told him about a repair that needed to be done he told them how to enter the information in the work order system. He stated it was his expectation if anything was wrong it should be put into the system so the repairs could be made. He verified the toilet was running and had stained the toilet bowl and parts needed to be replaced to fix it. He explained the water was hard and was prone to stain toilet bowls if the water ran constantly and confirmed no one had reported it to him to repair it.	F 253	Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments	F 272		4/20/17

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F 272	Continued From page 3	F 272		

(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the
care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct
observation and communication with the resident, as well as communication with licensed and
non-licensed direct care staff members on all shifts.

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F 272	Continued From page 4 The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to complete Comprehensive Care Area (CAA) assessments to include an analysis of findings specific to the residents' condition for 4 of 16 sampled residents (Residents #25, #49, #4 and #108). The findings included: 1. Resident #25 was admitted to the facility on 10/19/12 with diagnoses including atrial fibrillation, hypertension, dementia and gastro esophageal reflux disease. Review of the medical record revealed Resident #25 was last seen by the dentist in the facility on 11/14/16. The report noted she was wearing upper and lower dentures that were in acceptable condition. The annual Minimum Data Set (MDS) dated 02/15/17 coded Resident #25 with moderately impaired cognitive skills, weighing 89 pounds, and being edentulous (having no natural teeth). The CAA dated 02/24/17 indicated the dental area was triggered for a comprehensive assessment as she had no natural teeth or tooth fragments. The analysis of findings stated this was a potential problem and that Resident #25 was edentulous, had no oral discomfort, and was	F 272	F 272 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to: 1) Resident #25 was discharged on 4/6/17. Upon return to facility a comprehensive assessment with CAAs will be completed to include findings specific to the resident□s condition to include the resident□s strengths and weaknesses and how it affects the resident□s day to day function. 2) Resident #49 has an annual MDS assessment with ARD of 4/3/17, to include CAAs with findings specific to resident□s condition to include the resident□s strengths and weaknesses and how it affects the resident□s day to day function. 3) Resident #4 has a significant change assessment with ARD of 4/10/17, that includes CAAs with findings specific to resident condition to include the resident□s strengths and weaknesses and how it affects the resident□s day to day function. 4) Resident #108 has an annual MDS assessment with an ARD of 4/13/17 that will include CAA□s specific to resident condition to include the resident□s strengths and weaknesses and how it	

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F 272	Continued From page 5 independent with oral care. Under care plan considerations it was noted no care plan would developed and gave no reason that a care plan was not needed. The CAA did not describe Resident #25's strengths and weaknesses, if she had dentures or how being edentulous affected her day to day function. An interview was conducted with MDS Coordinator #1 on 03/22/17 at 1:24 PM. MDS Coordinator #1 stated when she completed a dental CAA she generally wrote why the area triggered, if there was risk for infection, and what medications the resident was on. MDS Coordinator #1 stated she asked the residents if able to respond if they had dentures and asked the resident to look in their mouth for visual inspection. She was unable to recall if Resident #25 stated she had dentures or not. She did not think she was wearing dentures at the time of the assessment. MDS Coordinator #1 further stated that she did not think she had enough information to describe the effect of not having any natural teeth on Resident #25 and that there should be more information. She further stated that normally she did not ask staff if a resident had dentures but that sometimes she reviewed dental assessments if there were any in the medical record. On 03/20/17 at 11:14 AM, Resident #25 was observed with upper and lower dentures in place which had chipped front teeth and 2 missing teeth on the upper plate. On 03/21/17 at 6:04 PM, Resident #25 could not say how long her dentures were damaged but stated she would like them fixed.	F 272	affects the residents day to day function. Current facility residents have the potential to be affected by the alleged deficient practice. The MDS coordinators began an audit on 4/11/17, of current facility resident□s most recent comprehensive assessment and CAAs, to identify CAA #2 Cognitive Loss/Dementia, CAA #15 Dental Care, and CAA #16 Pressure Ulcer that does not include information specific to resident□s condition including strengths and weaknesses and how it impacts the residents day to day function. A significant correction MDS and CAAs will be completed for those that doesn□t include information specific to residents condition including strengths and weaknesses and how it impacts the residents day to day function. Measures put into place to ensure the alleged deficient practice does not recur include: The Corporate Reimbursement Specialist provided in service education for the MDS coordinators on 4/12/17, regarding how to write CAA□s according to the RAI manual. The MDS coordinator #2 attended MDS training presented by State MDS Advisor on 4/5-4/6/17 and MDS coordinator #1 will attend the next available training. The Social worker and activity director will also attend the workshop at a later date when available. The Director of Nursing (DON) will review	

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F 272	Continued From page 6 On 03/22/17 at 2:25 PM Nurse Aide #1 stated that Resident #25 actually had two sets of dentures. On 03/22/17 at 2:27 PM Resident #25 stated that her other set of dentures started to hurt her mouth so she put the current ones in. 2. Resident #49 was admitted to the facility on 05/09/15. Her diagnoses included muscle weakness, pain, dementia and diabetes. Review of the annual Minimum Data Set (MDS) dated 04/08/16 revealed she was coded with severely impaired cognitive skills, required extensive assistance with most activities of daily living skills (ADLs), walked in the room with limited assistance, and had no pressure ulcers. The pressure ulcer CAA dated 04/19/16 indicated she triggered for an assessment of pressure ulcers due to the need for extensive assistance with bed mobility and that she was at risk for developing pressure ulcers. The analysis of findings listed Resident #49's age, stated she was up in a wheelchair daily and required mostly extensive assistance with ADLs including bed mobility. She was also noted to have the diagnoses of diabetes. Under care plan decisions, the CAA stated that the facility would keep the current care plan in place to reduce the risk of pressure ulcers. This was completed by MDS Coordinator #1. Review of the MDS progress note dated 10/22/16 revealed Resident #49 developed a blister on her right heel on 10/18/17. An interview with MDS Coordinator #2 was	F 272	comprehensive assessment CAAs weekly for 4 weeks then monthly for 3 months, to validate CAAs are complete with information specific to the residents condition including strengths and weaknesses and how it impacts the residents day to day function. The Director of Nursing and MDS coordinators will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 272	Continued From page 7	F 272		

conducted on 03/23/17 at 3:12 PM. MDS Coordinator #2 explained that when she wrote an assessment she looked at the reasons the area triggered and discussed those reasons in the CAA. For Resident #49 she stated she was at risk for pressure ulcer development due to her diagnoses of diabetes and need for assistance with bed mobility. She was unable to describe Resident #49's actual abilities and her personal strengths and weaknesses at the time of the assessment in relation to her risk for developing pressure ulcers. She stated she would need to review the chart for those details. MDS Coordinator #2 stated she thought the CAA was complete but she needed to add more to the reason for proceeding to the care plan.
3. Resident #4 was admitted to the facility on 12/28/15 with diagnoses which included Parkinson's disease, muscle weakness, rheumatoid arthritis, vitamin deficiency, anemia and dementia. A review of the annual Minimum Data Set (MDS) dated 07/01/16 indicated Resident #4 was severely impaired in cognition for daily decision making. The MDS further indicated Resident #4 required extensive assistance from staff for mobility, transfers, dressing, toileting and hygiene but was totally dependent on staff for bathing.

A review of Care Area Assessments (CAAs) dated 07/08/16 completed by a social worker indicated delirium triggered and the analysis of findings indicated Resident #4 did not appear to have any delirium at that time but had a diagnosis of dementia. The CAA did not identify strengths or weaknesses or how delirium impacted Resident #4's day to day function. The CAA also indicated cognitive loss/dementia triggered and the analysis of findings indicated Resident #4 had

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F 272	Continued From page 8	F 272		

dementia that was related to cognitive deficits but did not identify how cognitive loss or dementia strengths or weaknesses or how if affected his day to day function. The CAA further indicated Resident #4 triggered for mood state but the analysis of findings indicated Resident #4 seemed to be in a good mood state and he roamed round the facility and his family visited him often. The CAA did not identify strengths or weaknesses or how it impacted his day to day function.

During an interview on 03/23/17 3:13:14 PM with MDS Coordinator #2 she explained the CAAs completed by the social worker were lacking in detail. She stated the analysis of findings did not identify how the problems impacted Resident #4 on a day to day basis and needed to be more thorough. She explained she typically did not review the CAAs completed by the social worker unless something had triggered on a section she completed that related to cognition.

During an interview on 03/23/17 at 3:44 PM with the Director of Nursing she stated she was not very familiar with MDS or with CAAs. She stated after review of the CAAs for Resident #4 the information did not identify strengths or weaknesses and she would have expected to see more documentation.

4. Resident #108 was admitted to the facility on 07/06/16 with diagnoses which included heart failure, high blood pressure, muscle weakness, kidney disease and a stroke. A review of the admission Minimum Data Set (MDS) dated 07/13/16 indicated Resident #108 was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #108

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F 272	Continued From page 9 required extensive assistance for bed mobility, transfers, dressing, toileting and hygiene but was totally dependent on staff for bathing. A review of a Care Area Assessment (CAA) dated 07/19/16 completed by a social worker indicated cognitive loss and dementia triggered. The analysis of findings indicated Resident #108 did not have a diagnosis of dementia but the physician had reported some mild confusion and would proceed to care plan for cognition. The CAA did not identify strengths or weaknesses or how this impacted Resident #108's day to day function. During an interview on 03/23/17 3:13:14 PM with MDS Coordinator #2 she explained the CAAs completed by the social worker were lacking in detail. She stated the analysis of findings did not identify how the problems impacted Resident #108 on a day to day basis and needed to be more thorough. She explained she typically did not review the CAAs completed by the social worker unless something had triggered on a section she completed that related to cognition. During an interview on 03/23/17 at 3:44 PM with the Director of Nursing she stated she was not very familiar with MDS or with CAAs. She stated after review of the CAAs for Resident #108 the information did not identify strengths or weaknesses and she would have expected to see more documentation.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 278		4/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 10 (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code 1 of 1 sampled residents utilizing the Minimum Data Set (MDS) to reflect hospice care (Resident #130) and 1 of 3 sampled residents for dental (Resident #51).	F 278	F 278 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #130. The MDS coordinator corrected the MDS dated	

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F 278	Continued From page 11 Findings included: 1. Resident #130 was admitted to the facility on 01/04/17 with diagnosis of cancer. A review of the Coordination of Care Agreement between hospice and the facility indicated Resident #130 was admitted to the facility on 01/04/17 and hospice had provided the facility on 01/04/17 with a copy of the hospice initial and comprehensive plan of care and the medication and treatment profile and a copy of Resident #130's informed consent for election of hospice benefits which was signed by Resident #130. A review of Resident #130's admission Minimum Data Set (MDS) assessment dated 01/11/17 indicated Resident #130 had been coded under section J1400 as having a condition or chronic disease that could result in a life expectancy of less than 6 months and did not indicate Resident #130 had received hospice care. On 03/21/17 at 2:42 PM an interview was conducted with MDS Coordinator #1 who stated she coded Section O0100 Special Procedures Treatments and Programs and stated Resident #130 should have been coded for hospice care. The MDS Coordinator #1 stated Resident #130 was receiving hospice care and she missed coding Resident #130 for hospice. The MDS Coordinator #1 stated she would immediately submit a correction to Resident #130's admission MDS assessment dated 01/11/17 to reflect hospice care. On 03/21/17 at 2:51 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident	F 278	1/11/17 on 3/22/17, to reflect Hospice services and submitted the corrected MDS on 3/22/17. Resident #51. The MDS coordinator corrected the MDS dated 1/13/17 on 3/22/17, to reflect that the resident was edentulous and submitted the corrected MDS on 3/22/17. Current facility residents have the potential to be affected by the alleged deficient practice. The MDS coordinators conducted an audit beginning on 3/22/17, to identify residents that are on Hospice services, and validated that the most recent MDS assessments for those residents were coded accurately. A corrected MDS assessment was completed when identified for one resident. The MDS coordinators conducted and audit of current facility residents most current MDS beginning on 4/12/17, to validate that section L0200B was coded to reflect resident□s dental status. A corrected MDS assessment will be completed when identified for assessments that are not coded accurately. Measures put into place to ensure the alleged deficient practice does not recur include: The Corporate Reimbursement Specialist provided in service education for the MDS coordinators on 4/12/17, regarding accurate coding of assessments. The Director of Nursing will review 3 MDS assessments weekly for 4	

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	345133	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 278	Continued From page 12 #130's admission MDS assessment dated 01/11/17 would have been accurately coded to reflect Resident #130 was receiving hospice care. The DON stated Resident #130 was receiving hospice care on admission to the facility. The DON stated hospice residents were discussed during morning meeting and she was unsure how Resident #130 was missed for coding hospice. The DON stated her expectation was that the admission MDS assessment dated 01/11/17 would be corrected and submitted to reflect Resident #130 was receiving hospice care. On 03/21/17 at 2:58 PM an interview was conducted with the Administrator who stated his expectation was that the admission MDS assessment dated 01/11/17 would have been accurately coded to reflect Resident #130 was receiving hospice care. The Administrator stated his expectation was that the admission MDS assessment dated 01/11/17 would be corrected and submitted to reflect Resident #130 was receiving hospice care. 2. Resident #51 was admitted to the facility on 06/01/11. A review of the care plan initiated on 06/10/11 and was updated on 02/03/17 indicated Resident #51 had a potential problem for oral/dental health related to edentulous status. A review of the dental history record completed by the dentist on 11/14/16 indicated Resident #51 was edentulous. A review of the annual Minimum Data Set (MDS) assessment dated 01/13/17 indicated Resident #51 was coded under Section L0200 B Dental as	F 278	weeks then 5 monthly for 3 months, to validate accurate coding of section J1400 and L0200B. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 278	Continued From page 13 not being edentulous. On 03/22/17 at 10:41AM an interview was conducted with the MDS Coordinator #1 who stated she coded section L0200 Dental on the annual MDS assessment dated 01/13/17 and missed coding that Resident #51 was edentulous. The MDS Coordinator #2 confirmed that Resident #51 was edentulous and the annual MDS assessment should have reflected Resident #51 was edentulous. The MDS Coordinator #1 stated she would immediately submit a correction to the annual MDS assessment dated 01/13/17 to reflect Resident #51 was edentulous. On 03/22/2017 10:48 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the annual MDS assessment dated 01/13/17 would have been accurately coded to reflect Resident #51 was edentulous. The DON stated her expectation was that the annual MDS assessment dated 01/13/17 would be corrected and submitted to reflect Resident #51 was edentulous. On 03/22/2017 at 10:55 AM an interview was conducted with the Administrator who stated his expectation was that the annual MDS assessment dated 01/13/17 would have been accurately coded to reflect Resident #51 was edentulous. The Administrator stated his expectation was that the annual MDS assessment dated 01/13/17 would be corrected to reflect Resident #51 was edentulous.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20	F 279		4/20/17

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	345133	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 279	Continued From page 14	F 279		

(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

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F 279	Continued From page 15 (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete an interim admission care plan that included measurable goals and approaches or interventions for 1 of 2 sampled residents who were new admissions to the facility (Resident #139). Findings included: Resident #139 was admitted to the facility on 03/16/17 with diagnoses which included chronic lung disease with oxygen dependence, high blood pressure and sleep apnea. A review of the admission Minimum Data Set (MDS) dated 03/23/17 indicated Resident #139 was cognitively intact for daily decision making. The MDS further indicated Resident #139 required limited assistance with bed mobility and transfers but extensive assistance with dressing, toileting and	F 279	F 279 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #139. A comprehensive care plan was completed on 3/24/17, to include measurable goals and approaches. Current facility residents have the potential to be affected by the alleged deficient practice. The DON, unit managers and MDS coordinators conducted an audit of current facility residents admitted in March 2017, to validate completion of the Interim care plan. Care plans were initiated and/or completed as necessary.	

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	345133	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 279	Continued From page 16 hygiene and was totally dependent on staff for bathing. A review of a facility document titled Interim Admission Care Plan revealed a 2 sided form with a list of problems on the front and back of the document and instructions to check each box as applied. A review of the Interim Admission Care Plan with Resident #139's name handwritten on it had a check next to a box which indicated orientation to environment and adjustment to the facility but there were no other boxes on the front or back of the form that were checked. A section on the back of the form for signatures of the admitting nurse and nurse review and dates were blank. During an interview on 03/23/17 at 11:11 AM with the Director of Nursing (DON) she explained they used a paper interim care plan that staff were supposed to complete when a resident was admitted. She stated the Medical Records Director picked up the forms after they were completed and scanned them into the computer system. During an interview on 03/23/17 at 11:18 AM with the Medical Records Director she confirmed staff had only checked one box on the front of the care plan for Resident #139 but had not completed the back side of the form or signed or dated the form. She stated she could not identify who had completed the document since it had not been signed. During an interview on 03/23/17 at 11:27 AM with Nurse #3 who was assigned to care for Resident #139 stated he did not fill out the interim care	F 279	Measures put into place to ensure the alleged deficient practice does not recur include: The DON, unit managers and MDS coordinators provided in service education for the licensed nurses beginning on 4/12/17, regarding completion of the Interim Care Plan for newly admitted residents, which includes measureable goals and approaches. The DON and/or the unit managers and supervisors will review the newly admitted residents record within 24 hours of admission ongoing, to validate completion of the Interim care plan with measurable goals and approaches. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 279	Continued From page 17 plan. He further stated he did not document on care plans because he did not know if he was supposed to and thought someone else completed them. During an interview on 03/23/17 at 3:07 PM with Nurse #4 she confirmed she completed the admission nursing assessment for Resident #139 but did not complete the Interim Admission Care Plan. She stated she was not sure who had documented on the front side of the form because it had not been signed or dated. During a follow up interview on 03/23/17 at 11:56 AM with the DON she verified the Interim Admission Care Plan was incomplete and was not signed or dated. She stated it was her expectation for any self-care deficits or anything staff needed to make sure they took care of should be documented on the care plan. She further stated each problem should include goals and approaches or interventions. She explained it was her expectations for the nurse on the hall to complete the admission nursing assessment and the Interim Admission Care Plan after the resident was admitted to the facility.	F 279		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		4/20/17

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	345133	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 323	Continued From page 18 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to maintain a safe environment by maintaining side rails securely fastened to the bed frames and free of gaps between the mattress and the side rails. This affected 2 of 3 residents sampled for accidents (Residents #36 and #25). The findings included: 1. Resident #36 was admitted to the facility most recently on 03/03/16. Her diagnoses included contracture of the left knee, chronic pain, muscle weakness, vascular dementia, osteoporosis, hemiplegia and hemiparesis affecting the left non-dominant side, and anxiety disorder. The annual Minimum Data Set dated 03/06/17 coded her with moderately impaired cognitive skills, requiring extensive assistance with bed mobility, total assistance with transfers, being	F 323	F 323 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to: 1) Resident #36. Maintenance director removed the current rails and attached the proper rails to the bed. The Director of Nursing (DON) assessed the resident on 3/23/17 for use of rails for bed mobility. 2) Resident #25. The Maintenance director tightened the rails on the bed so there was no movement of the rails. Current facility residents have the potential to be affected by the alleged deficient practice. The Maintenance director conducted a 100% audit of bed rails on facility beds on 3/23/17, to identify loose bed rails, improper fitting bed rails,	

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	345133	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

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F 323	Continued From page 19 nonambulatory and having had no falls. The Care Area Assessment for activities of daily living skills (ADLs) dated 03/17/17 noted she required extensive to total assistance with ADLs, was able to feed herself after set up and used a brace on her upper left extremity. The care plan for impaired mobility and self care deficit had the goal for the resident to maintain her highest level of function and prevent further degree of mobility decline. On 03/16/16 the intervention of "half rails to bed, use of positioning, bed mobility and ADL assistance" was added to the interventions. Observations made on 03/20/17 at 11:46 AM revealed the side rails were positioned on the bed and a fist could fit easily between the mattress and the siderail on the right side and three fingers could fit between the mattress and the siderail on the left side of the bed. Resident #36 was not in bed at this time. The wide gap between the siderail and the mattress was observed on 03/21/17 at 2:48 PM. Resident #36 stated at this time that she was weak, could not get out of bed on her own but did use the side rails to try to turn self. The resident was not in bed at this time. Resident #36 was observed in bed with the side rails upright and the gaps were filled with pillows when she was observed on 03/22/17 at 8:07 AM, on 03/22/17 at 8:23 AM, and on 03/22/17 at 8:32 AM at which time Resident #36 again stated she used the siderails to turn. On 03/22/17 at 9:18 AM Nurse Aide (NA) #1	F 323	and gaps between bed rails and mattress. Bed rails that were identified that did not fit properly or had too much gap between bed rails were corrected when identified. The DON and unit managers assessed current residents for use of bed rails beginning on 4/12/17, to validate safety and continued need for bed rail. Measures put into place to ensure the alleged deficient practice does not recur include: The Maintenance director provided in service education for facility staff beginning on 4/12/17, regarding use of electronic (TELS) system to notify him when equipment needs to be repaired. The Maintenance director will observe all facility beds weekly for 4 weeks then all monthly ongoing; to validate bed rails are attached properly without gaps or safety concerns. The DON and unit managers provided in service education for the nursing staff regarding proper use of bed rails utilizing the bed rail assessment upon admission, readmission or significant change of condition. The DON and unit managers will review bed rail assessments and observe resident use ongoing for new admissions, readmissions and significant change of condition, to validate assessment complete and appropriate bed rail in use as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 323	Continued From page 20 stated at this time Resident #36 was able to grab the siderail when she turned to the left but that staff have to help her turn to the right. NA #1 further stated that she will scoot down in the bed and need to be pulled further toward the head of the bed at times. NA #1 further stated on 03/22/17 at 9:36 AM that Resident #36 directed staff to put pillows on both sides of her by the siderails and 2 under her head and 2 under her feet. On 03/22/17 at 11:12 AM, Resident #36 was observed using her right hand to propel her wheelchair down the hall independently. On 03/22/17 at 11:24 AM with a tape measure, the gap between the mattress and right side rail was 4.25 inches at the top of the rail and 3 inch at bottom of rail and the gap between the mattress and the side rail measured 2.5 inch at top of the rail and 3 inch gap at bottom of rail. On 03/22/17 at 3:35 PM, NA # 2 stated Resident #36 needed physical assistance to roll to the right side of the bed. On 03/22/17 at 4:05 PM NA #3 stated during interview that the resident needed assistance to turn to the right but will hold the left side rail when she turns to the left. On 03/23/17 at 9:44 AM, Resident #36 was out of bed. The gap between the siderail and the mattress was wide enough to place a hand with fingers spread wide in the gap. An interview with NA #4 on 03/23/17 at 11:12 AM revealed that if she noticed a problem with side rails she would report to the nurse who then	F 323	The Director of Nursing and Maintenance director will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months, to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 21	F 323		

reported to the maintenance staff. If she was to pass the maintenance staff she would tell him verbally. She stated the only concern she had noticed regarding side rails was on Resident #36's bed which had a wide gap between the mattress and the side rails. She further stated that staff normally filled the gap with pillows. She also stated she had reported to a nurse who would make the report to the maintenance staff. She stated this report was a while ago, estimated over a year, and she saw no change in the gap.

Interview with the Nurse #2 on 03/23/17 at 11:25 AM revealed there was a computer system to alert maintenance of things that needed attention. She could not recall any reports regarding side rail issues that she had reported to maintenance.

Another interview with NA #1 on 03/23/17 at 12:22 PM revealed that Resident #36 received a new bed less than a year ago and that she reported the gap between the mattress and the side rail. She further stated the resident liked having pillows on each side of her. NA 1 could not recall who she reported the gap to but it was not Nurse #2.

The Director of Facility Services (DFS) (maintenance) was interviewed on 03/23/17 at 2:40 PM. DFS stated that the beds were checked monthly to ensure the siderails were not loose and the head and foot boards were not loose. In addition, there was a computer system used by nursing to alert him to things that they noticed that needed attention. This system was checked constantly during the day. Regarding the beds, DFS stated the beds were 36 inches wide and the mattresses were 36 inches wide and should fit the bed and the side rails should fit the mattress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 22	F 323		

He was unaware of any gaps between the mattress and side rails.

On 03/23/17 at 2:51 PM, Resident #36's bed and siderail was observed with DFS. At that time the mattress was pushed against one side of the side rail and the gap measured 6.5 inches. DFS stated that the side rails on this bed were not the side rails which were made for this bed. They were bolted to the bed and could not be adjusted to fit he mattress. He stated the side rails did not belong to this bed but was not sure who attached them to the bed. On follow up interview on 03/23/17 at 3:06 PM, DFS stated that he last checked the siderails last month and when Resdient #36 is in bed, there were pillows on each side and he may not have observed the gap. He further stated that this was a newer bed but could not say how long it had been in place.

Review of the monthly bed checks revealed the beds were last checked for preventative maintenance on 02/25/17 to include beds, mattresses and bed rails.

On 03/23/17 at 3:26 PM the Administrator stated the side rails were the wrong rails for this bed.

2. Resident #25 was admitted to the facility on 10/19/12. Her diagnosis included atrial fibrillation, a status post fractured femur, low back pain, osteoarthritis, dementia and a history of falling.

The annual Minimum Data Set dated 02/15/17 coded her with moderately impaired cognitive skills, requiring supervision with bed mobility and being independent with transfers and ambulation.

The Care Area Assessment dated 02/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 03/23/2017

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AVANTE AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

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F 323	Continued From page 23	F 323		

stated she required supervision with limited assistance for bed mobility and used half side rails for turning and bed mobility.

The care plan which addressed activities of daily living skills (ADLs) which was last reviewed on 02/28/17 addressed the resident's self performance deficit with a goal to maintain her current function. Interventions included the use of half rails in bed for bed mobility and ADL assistance.

Observations on 03/20/17 at 11:22 AM revealed there was a turn bar on the right side of the bed and a half rail on the left side of the bed. The turn rail moved back and forth to and away from the bed a couple of inches.

The turn bar was observed loose several inches when observed on 03/21/17 at 2:46 PM.

Resident #25 stated during interview on 03/21/17 at 6:04 PM that she used the side rail.

An interview with Nurse Aide (NA) #4 on 03/23/17 at 11:12 AM revealed that if she noticed a problem with side rails she would report to the nurse who then reported to the maintenance staff. If she was to pass the maintenance staff she would tell him verbally. She stated the only concern she had noticed regarding side rails was not for Resident #25.

Interview with the Nurse #2 on 03/23/17 at 11:25 AM revealed there was a computer system to alert maintenance of things that needed attention. She could not recall any reports regarding side rail issues that she had reported to maintenance.

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F 323	Continued From page 24 NA #1 stated during interview on 03/23/17 at 12:22 PM that if she noticed a loose siderail she would tell the nurse and they would put the concern into the computer so maintenance staff could fix it. The Director of Facility Services (DFS) (maintenance) was interviewed on 03/23/17 at 2:40 PM. DFS stated that the beds were checked monthly to ensure the siderails were not loose and the head and foot boards were not loose. In addition, there was a computer system used by nursing to alert him to things that they noticed that needed attention. This system was checked constantly during the day. Review of the preventative maintenance report indicating that the beds, mattresses and side rails were checked revealed the last bed check conducted was on 02/25/17. This report did not specify if any adjustments were needed. With DFS, Resident #25's turn rail was checked on 03/23/17 at 2:55 PM. The rail moved several inches. DFS stated that the bolts and where the rail attached to the bed wear out and there may be a little play in the rail. He stated he may be able to tighten it.	F 323		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		4/20/17

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F 431	Continued From page 25 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

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F 431	Continued From page 26 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to discard an opened NovoLOG insulin FlexPen that was available for use in 1 of 4 medication carts. Findings included: A review of the facilities manufacturer/supplier guidelines titled Insulin Storage Recommendations dated 09/28/16 indicated NovoLog Flexpen was good for 28 days once it was opened. Resident #14 was admitted to the facility on 07/15/16 with diagnosis of diabetes mellitus. A physician's order dated 01/20/17 indicated Resident #14 was to receive NovoLOG insulin as per sliding scale before meals and at bedtime for diabetes mellitus. On 03/22/17 at 11:30 AM Resident #14's NovoLog FlexPen insulin was observed on the Immediate Care Facility (ICF) B medication cart ready for resident use and was opened and undated. The NovoLOG FlexPen insulin had no date on the sticker label as to when it had been opened. On 03/22/17 at 11:40 AM an interview was conducted with Nurse #1 who was preparing to administer Novolog Flexpen insulin 4 units to	F 431	F 431 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #14 Novolog Flexpen. Nurse #1 discarded the pen on 3/22/17, and obtained a new pen to administer to the resident. Nurse #1 dated the pen when it was opened on 3/22/17. The DON validated that Omnicare Pharmacy delivered (3) 100 unit pens on 2/21/17. The resident received 330 units of Novolog insulin between the dates of 2/21/17 and 3/22/17, indicating that the pen being used had not been open greater than 28 days. On 3/21/17, a Novolog pen was ordered from the facility back up pharmacy, to be available if necessary, until the regular shipment arrived. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and unit managers conducted an audit beginning on 3/22/17of current facility residents receiving insulin, to validate insulin was dated when opened and expiration date. There were no discrepancies identified. Measures put into place to ensure the	

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F 431	Continued From page 27 Resident #14 as per sliding scale before lunch and verified the Novolog Flexpen insulin was opened and undated and was on the medication cart ready for resident use. Nurse #1 stated NovoLog Flexpen was good for 28 days once it had been opened and placed on the medication cart. Nurse #1 stated the NovoLog Flexpen should have been discarded from the ICF B medication cart because there was no indication of when the insulin had been opened and nursing staff were unable to determine when the insulin had expired. Nurse #1 stated it was the responsibility of the nurse on the medication cart to determine if insulin was dated prior to administering insulin to Resident #14. Nurse #1 stated she would obtain another NovoLog Flexpen to administer insulin to Resident #14 because she was unable to determine when the insulin had expired because it had not been dated when opened. On 03/22/17 11:40 PM an interview was conducted with the Director of Nursing (DON) who verified Resident 14's NovoLog Flexpen had not been dated when opened per facility policy and was on the medication cart ready for resident use. The DON stated the NovoLog Flexpen should have been dated when opened and placed on the medication cart per facility policy. The DON stated because the NovoLog Flexpen was not dated when opened than there was no way to determine when the insulin had expired and no way to determine how many doses of expired insulin that Resident #14 received. On 03/23/2017 at 11:58AM an interview was conducted with the Administrator who stated his expectation was that NovoLog Flexpen insulin for Resident #14 would have been dated when	F 431	alleged deficient practice does not recur include: The DON and unit managers provided in service education for the licensed nurses beginning on 3/12/17, regarding dating/labeling medications when opened and removing and discarding from medication when expired. The DON, unit managers and supervisors will observe all medication carts 3 times a week for 4 weeks then weekly for 3 months, to validate medications are dated, labeled and discarded according to facility protocol. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 431	Continued From page 28 opened and placed on the medication cart per facility policy.	F 431		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this	F 520		4/20/17

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F 520	Continued From page 29 section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March 2016. This was for three recited deficiencies which were cited in February of 2016 on a Recertification survey and subsequently recited on the current recertification survey. The deficiencies were in the areas of environment, accuracy of assessments and drug labeling and storage. The deficiency for environment was originally cited on a recertification survey in October 2012 and then was recited again on the recertification surveys in December 2014, April 2015 and February 2016 and again on the current recertification survey. A fourth deficiency was cited in August 2016 on a complaint investigation and subsequently recited on the current recertification survey. This deficiency was in the area to provide supervision to prevent accidents. The continued failure of the facility during six federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. a. F 253 Environment: Privacy and	F 520	F 520 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to: F 253: 1) Labeling and storage of personal care equipment. The bath basin in bathroom #107 was labeled with the residents name on 3/23/17 and placed in a storage bag in the residents bathroom. 2) The bed pan in bathroom # 147 was labeled on 3/23/17, with the residents name and placed in a storage bag in the residents bathroom. 3) The leaking toilet and brown stains in bathroom #111 was repaired/corrected on 3/23/17, by the maintenance director. F 278: 1) Resident #130. The MDS coordinator corrected the MDS dated 1/11/17 on 3/22/17, to reflect Hospice services and was submitted the corrected MDS on 3/22/17. 2) Resident #51. The MDS coordinator corrected the MDS dated 1/13/17 to reflect that the resident was edentulous and submitted the corrected MDS on 3/22/17. F 323: 1) Resident #36. Maintenance director	

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F 520	Continued From page 30 Confidentiality: Based on observations and staff interviews the facility failed to label personal care equipment which included a bath basin in the bathroom of room #107, failed to store a bed pan in a plastic bag or label it in the bathroom of room #147 and failed to repair a leaking toilet with brown stains inside the toilet bowl in the bathroom of room #111 in 3 of 61 resident rooms. The facility was recited for F 253 for failing to label personal care equipment which included a bath basin in the bathroom, failed to store a bed pan in a plastic bag or label it in the bathroom and failed to repair a leaking toilet with brown stains inside the toilet bowl. F 253 was originally cited during the October 23, 2012 recertification survey for failing to provide clean floors without dirt accumulation in corners and dust accumulation on baseboards in 6 resident rooms and failed to replace a heavily soiled privacy curtain in 1 resident room. (Rooms 112, 115, 121, 124, 127, and 137), F 253 was cited again during the December 5, 2013 recertification survey for failing to maintain wheelchairs and tube feeding poles in a clean, sanitary, and orderly manner for 6 residents residing on 2 of 4 halls (Resident# 4, 15, 28, 38, 65, and 129), F 253 was cited again on the April 20, 2015 recertification survey for failing to repair a hole in the wall, a hole in a resident bathroom door, clean privacy curtains in 2 resident rooms and failed to clean a sit to stand lift for providing maintenance and housekeeping services, F 253 was cited again on the February 12, 2016 recertification survey for failing to repair resident room doors and/or bathroom doors with broken and splintered laminate and wood for 9 of 61 resident rooms. (Resident room #112, #122, #127, #132, #136, #138, #140, #143 and #147) and F 253 was cited again on the current	F 520	removed the current rails and attached the proper rails to the bed. The Director of Nursing (DON) assessed the resident on 3/23/17 for use of rails for bed mobility. 2) Resident #25. The Maintenance director tightened the rails on the bed so there was no movement of the rails. F 431: Resident #14 Novolog Flexpen. Nurse #1 discarded the pen on 3/22/17, and obtained a new pen to administer to the resident. Nurse #1 dated the pen when it was opened on 3/22/17. The DON validated that Omnicare Pharmacy delivered (3) 100 unit pens on 2/21/17. The resident received 330 units of Novolog insulin between the dates of 2/21/17 and 3/22/17, indicating that the pen being used had not been open greater than 28 days. On 3/21/17, a Novolog pen was ordered from the facility back up pharmacy, to be available if necessary, until the regular shipment arrived. Current facility residents have the potential to be affected by the alleged deficient practice. F 253: 1) The Director of Nursing (DON) and unit managers conducted an audit of current facility residents□ bathroom on 3/23/17, to identify personal care equipment that needed to be labeled and stored according to facility protocol. No other issues were identified. 2) The Maintenance director conducted	

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F 520	Continued From page 31 recertification survey for failure to label a bath basin and bed pan and store the bed pan in a clear plastic bag and failed to repair a leaking toilet with brown stains in the toilet bowl. b. F 278 Assessment Accuracy: Based on record review and staff interviews the facility failed to accurately code 1 of 1 sampled residents utilizing the Minimum Data Set (MDS) to reflect hospice care (Resident #130) and 1 of 3 sampled residents for dental (Resident #51). During the recertification survey of 02/12/16 the facility was cited for failure to accurately code the Minimum Data Set (MDS) assessment to reflect the use of a physical restraint for 1 of 3 residents (Resident #163). On the current recertification survey F278 was again recited for failing to accurately code on the Minimum Data Set (MDS) to reflect hospice care and dental. c. F 323 Provide Supervision to Prevent Accidents: Based on observations, record review, resident interview and staff interviews, the facility failed to maintain a safe environment by maintaining side rails securely fastened to the bed frames and free of gaps between the mattress and the side rails. This affected 2 of 3 residents sampled for accidents (Residents #25 and #36). During a complaint investigation of 08/18/16 the facility was cited for F 323 for failure to secure a side rail during incontinence care to prevent a resident who used side rails for turning and positioning from falling from bed and resulted in fractures of the femurs (thigh bones) on both legs for 1 of 3 sampled residents for supervision to prevent accidents (Resident #3). F323 was again	F 520	an audit of resident bathrooms to identify toilets that were not functioning properly and/or stained. Repairs/replacement was completed when identified. F 278 The MDS coordinators conducted an audit on 3/22/17, to identify residents that are on Hospice services, and validated that the MDS assessments for those residents were coded accurately. No other discrepancies were identified. The MDS coordinators conducted and audit of current facility residents most current MDS on 4/12/17, to validate that section L0200B was coded to reflect resident□s dental status. F 323 The Maintenance director conducted an audit of bed rails on facility beds on 3/23/17, to identify loose bed rails, improper fitting bed rails, and gaps between bed rails and mattress. Bed rails that were identified that did not fit properly or too much gap between bed rails were corrected when identified. The DON and unit managers assessed current residents for use of bed rails beginning on 4/12/17, to validate safety and continued need for bed rail. F 431 The Director of Nursing and unit managers conducted an audit beginning on 3/22/17of current facility residents receiving insulin, to validate insulin was dated when opened and expiration date.	

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F 520	Continued From page 32 recited on the current recertification survey for failing to maintain a safe environment by maintaining side rails securely fastened to the bed frames and free of gaps between the mattress and the side rails. d. F 431 Drug Labeling and Storage: Based on observation, record review, and staff interviews the facility failed to discard an opened NovoLOG insulin FlexPen that was available for use in 1 of 4 medication carts. During the recertification survey of 02/12/16 the facility was cited for failure to remove a medication left at bedside for 1 of 1 resident (Resident #79) and failed to remove expired medication from 2 of 4 medication carts. F431 was again recited for failing to discard an opened NovoLOG insulin FlexPen that was available for use in 1 of 4 medication carts. An interview on 03/23/17 at 3:52 PM with the Director of Nursing and the Administrator revealed the Administrator was newly hired at the facility and hadn't been in the facility long enough to attend a Quality Assurance and Assessment Committee. The Director of Nursing explained she had routinely attended the Quality Assurance and Assessment Committee meetings. She further explained they had discussed concerns and had implemented audits related to the previous deficiencies to try and make sure they didn't make the same mistakes again but it was a work in progress and more work was needed. The Administrator stated in regard to repeat deficiencies it was his expectation for the Quality Assurance and Assessment Committee to evaluate and audit deficiencies until they were confident the deficiencies were resolved. He	F 520	There were no discrepancies identified. Measures put into place to ensure the alleged deficient practice does not recur include: F 253 The DON and/or the unit managers provided in service education for the nursing staff beginning on 4/12/17, regarding labeling and storage of personal care items in resident rooms. The DON and/or unit managers will observe 20 bathrooms weekly for 4 weeks and 10 bathrooms monthly for 3 months to validate personal care items are labeled and stored according to facility protocol. In service education will be provided during orientation for newly hired staff. The Maintenance director provided in service education to facility staff beginning on 4/12/17 regarding reporting of broken/stained toilets utilizing the TELS reporting system. The in service education will be provided during orientation for newly hired staff. The Maintenance Director will observe 20 bathroom toilets weekly for 4 weeks and 10 monthly for 3 months, to validate proper functioning and cleanliness. F 278 The Region Reimbursement Specialist provided in service education for the MDS coordinators on 4/12/17, regarding accurate coding of assessments. The Director of Nursing will review 3 MDS assessments weekly for 4 weeks then 5 monthly for 3 months, to validate accurate	

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F 520	Continued From page 33 further stated it had been his experience if they did not stay on top of the deficiencies they would not stay corrected but he felt confident the clinical issues would be resolved.	F 520	coding of section J1400 and L0200B. F 323 The Maintenance director provided in service education for facility staff beginning on 4/12/17, regarding use of electronic (TELS) system to notify him when equipment needs to be repaired. The Maintenance director will observe all facility beds weekly for 4 weeks then all monthly ongoing; to validate bed rails are attached properly without gaps or safety concerns. The DON and unit managers provided in service education for the nursing staff regarding proper use of bed rails utilizing the bed rail assessment upon admission, readmission or significant change of condition. The DON and unit managers will review bed rail assessments and observe resident use ongoing for new admissions, readmissions and significant change of condition, to validate assessment complete and appropriate bed rail in use as necessary. F 431 The DON and unit managers provided in service education for the licensed nurses beginning on 4/12/17, regarding dating/labeling medications when opened and removing and discarding from medication when expired. The DON, unit managers and supervisors will observe all medication carts 3 times a week for 4 weeks then weekly for 3 months, to validate medications are dated, labeled and discarded according to facility	

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F 520	Continued From page 34	F 520	protocol. The Administrator and Interdisciplinary team which includes at least the Medical Director, DON, MDS coordinators, Maintenance director, Social worker, dietary manager, Pharmacist and nursing assistants to identify areas of improvement through daily rounds, observations, grievances, quality measures and develop plans for improvement and ongoing monitoring for continued compliance and improvement. The Administrator and Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 6 months or until compliance to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified to maintain compliance.	