STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to provide assistance for facial grooming (Residents #98 and #65), nail care and facial hygiene(Resident #99) for three (3) of six (6) sampled residents dependent for activities of daily living. The findings include: 1.Resident #98 was re-admitted April 2011 with diagnoses of Anoxic Brain Damage. A quarterly Minimum Data Set (MDS) dated 9/14/12 indicated Resident #98 had cognitive impairment, required total assistance with toileting and was frequently incontinent of bowel and bladder. A plan of care dated 9/21/12 indicated Resident #98 had self care performance deficit and required total assistance with personal hygiene care. During an observation on 10/2/12 at 9:43 AM Resident #98 was observed to have approximately ¼ - ½ inch of facial hair to her bilateral cheeks and chin. On 10/3/12 at 10:28 AM, Resident #98 was	F 312	F312 1. Deficiency corrected. The residents' faces were shaved and nails were trimmed and cleaned. 2. A full-house audit of dependent residents was completed to identify residents needing shaving and/or nail care. All CNA's will be in-serviced on providing shaving and nail care during morning care, and also on providing nail care prior to meals. 3. Nursing administration (or designee) will implement closer monitoring of CNA compliance with the system for ADL care by making random observations of ADL care for at least three residents weekly and utilizing an audit tool. Any areas of concern will be addressed and corrections implemented as appropriate to ensure compliance is achieved. Staff will be reprimanded accordingly. 4. The trends and results from the audits will be reviewed at the monthly Quality Assurance Committee Meeting to maintain compliance and evaluate effectiveness for at least a three month period of time until the requirements of #3 are met.	NOV 17 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stefanie [signature] Administrator | TITLE: Administrator | (X6) DATE: 10/24/12

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.

original signature 10/19/12 mh

RECEIVED
OCT 25 2012
BY: mh

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 312	Continued From page 1	F 312		

observed receiving a bed bath. Nursing assistant (NA) #1 washed the Resident's face. Resident #98's face had facial hair to her bilateral cheeks and chin varying from approximately ¼ - ½ inch in length. The Resident's facial hair was not removed during morning care.

An interview with staff Nurse #3 on 10/3/12 at 12:01 PM revealed morning care included a bed bath or shower, oral care, nail care and shaving for both men and women as needed.

During an interview with NA #1 on 10/3/12 at 12:23 PM, NA #1 stated that shaving was definitely part of morning care. The NA then entered Resident # 98's room and rubbed her hand across the Resident's cheeks and chin and stated, the Resident was a little "fuzzy." Resident #98 did not receive facial grooming on 10/3/12.

On 10/4/12 at 8:31 AM Resident #98 had multiple dark blond colored hairs ranging from approximately ¼ - ½ inch in length around her bilateral cheeks and around her chin. Resident #98 stated, "I have some whiskers and could use a shave."

An interview with Nurse #2 on 10/4/12 at 9:20 AM revealed Resident #98 needed to be shaved and would be shaved immediately.

An interview with the Director of Nursing (DON) on 10/4/12 at 1:42 PM revealed shaving was to be performed with morning care on an as needed basis. The DON explained her expectation was for NA #1 to have shaved the Resident when she realized the Resident required to be shaved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 312	Continued From page 2 2. Resident #65 was admitted March 2008 with diagnoses of Dementia. A Minimum Data Set (MDS) dated 7/17/12 indicated Resident #65 was cognitively impaired and required total assistance with personal hygiene. A plan of care dated 9/21/12 for activities of daily living indicated Resident # 65 had self care deficits related to limited mobility and disease process. An intervention for personal hygiene noted the resident required total assist with personal hygiene care. Resident #65 observed on 10/1/12 at 12:27 PM in room, sitting up in bed eating lunch. The Resident was observed to have multiple black hairs to the right and left side of her lip that were ½ inch in length as well as black and grey hairs to the chin. On 10/2/12 at 10:14 AM Resident #65 was observed in bed, sitting up and watching television. Resident #65 was noted with black facial hairs to the bilateral sides of her lips and grey and black hairs to her chin which were approximately ½ inch in length. Interview with staff Nurse #4 on 10/3/12 at 11:55 AM revealed that nursing assistants (NA)s were responsible for morning care which included a bed bath or shower, oral care, incontinence care, nail care for non- diabetic residents and shaving as needed. During an interview on 10/3/12 at 12:16 PM, NA #2 explained she had completed Resident #65's morning care. NA #2 further explained that morning care included a bed bath, nail care, dressing and shaving for both men and women.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 312	Continued From page 3 The NA entered Resident #65's room and stated the Resident did have a couple of facial hairs. The NA further revealed she did not offer or perform shaving on Resident #65. On 10/4/12 at 8:37 AM Resident #65 was observed in bed in her room with multiple black hairs to the left and right sides of her lip and grey and black facial hair approximately ½ inch in length to her chin. An interview with Staff Nurse #2 on 10/4/12 at 9:15 AM revealed shaving was to be done with morning care. Nurse #2 rubbed Resident #65's chin with her fingers and confirmed the Resident should have been shaved. An interview with the Director of Nursing (DON) on 10/4/12 at 1:42 PM revealed shaving was to be performed with morning care on an as needed basis. The DON explained her expectation was for NA #2 to have shaved the Resident when she realized the Resident required to be shaved. 3. Resident #99 was admitted to the facility in September 2011. Diagnosis included dementia with psychotic features, delusional disorder and diabetes mellitus. An annual minimum data set dated 9/14/12 assessed the Resident with impaired cognition, requiring extensive staff assistance with dressing and personal hygiene. Review of the September 2012 care plan revealed Resident #99 required staff assistance for activities of daily living to include nail care with	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 312	Continued From page 4 interventions to check the Resident's nail length, trim and clean her nails with baths and as necessary. Resident #99 was observed on 10/1/12 at 12:45 PM in the main dining room with her lunch meal. Resident #99 was observed at 12:53 PM to use her right hand to pick up lettuce and tomato, put it on her chicken salad sandwich and ate her sandwich with her right hand. The thumb and two middle fingernails of her right hand were observed with dark-colored matter underneath the nail prior to and during the lunch meal. Resident #99 was observed on 10/3/12 at 8:34 AM lying in her bed with the lights turned off. Nurse aide (NA) #3 entered the Resident's room with the breakfast meal. NA #3 repositioned the Resident in bed, set up the breakfast meal tray, informed the Resident of the foods she had to eat, donned the Resident's glasses and exited her room at 8:37 AM. Resident #99 began to feed herself breakfast. NA #3 did not offer hand hygiene or to clean the resident's face prior the the breakfast meal. The thumb nail and two middle fingernails of the Resident's right hand and the two middle finger nails of her left hand were observed with dark-colored matter underneath these nails. On 10/3/12 at 9:50 AM, NA #4 was observed giving Resident #99 a bed bath. During the bed bath, Resident #99 was observed with dark matter underneath the nails of her middle finger and thumb nail and the two middle fingers on her right hand. Resident #99 was assisted out of her room to attend an activity at 10:30 AM without receiving nail care. An interview with NA #4	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 312	Continued From page 5 revealed she did not notice that the nails of Resident #99 were dirty, but that nail care should have been offered during the Resident's total bed bath and as needed. An interview with nurse #2 (nurse supervisor) on 10/3/12 at 10:35 AM revealed that nail care should be offered during morning care, during showers and as needed. Nurse #2 also stated that nail care should be offered immediately if the nails are noted dirty and the resident feeds herself with her hands. Review of the Resident's fingernails during the interview, revealed nurse #2 confirmed that the finger nails of Resident #99 needed to be cleaned. An interview with NA #3 on 10/3/12 at 3:25 PM revealed that she should have washed the face and hands of Resident #99 prior to the breakfast meal on 10/3/12, but once NA #3 realized she had not offered hand hygiene or to wash the Resident's face, Resident #99 had already started feeding herself and NA #3 just did not offer the care. NA #3 further stated that she should have put the lid on the Resident's breakfast meal and offered to wash her face and hands. An interview with the director of nursing (DON) on 10/4/12 at 11:01 AM revealed that resident's finger nails should be monitored and cleaned during showers and as needed. Additionally, the DON stated that hand hygiene should be performed and face care offered to residents prior to meal service.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 315	Continued From page 6 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure two (2) of three (3) sampled residents at risk for urinary tract infections were provided appropriate incontinence care. (Resident #4 and #98) The findings include: A facility in-service conducted 9/11/12 entitled " Peri-care/Incontinent " outlined the following: Section entitled: common mistakes- wiping back to front instead of front to back. Section entitled: Procedure - wash the genital area, moving from front to back using a clean area of the washcloth for each stroke. A facility annual in-service date unknown, read in part: when providing peri-care or wiping after a bowel movement, it is especially important to wipe from front to back in order to prevent the introduction of bacteria in the stool into the urethra. Do not wipe in a back and forth motion. 1a. Resident #4 was re-admitted September 2012	F 315	F315 1. Deficiency corrected. The resident was given appropriate care and the CNA was reprimanded. 2. A full-house audit of dependent residents will be completed by the treatment nurse to identify whether dependent residents experienced signs and symptoms of a UTI. Charge nurses will continue ongoing monitoring of dependent residents for signs and symptoms of UTI. All CNA's will be in-serviced on peri/incontinent care for dependent residents and required to complete a return demonstration. 3. Nursing administration (or designee) will implement closer monitoring of CNA compliance with the system for peri/incontinent care by making random observations of care by at least three CNA's weekly on various shifts using an audit tool. Any areas of concern will be addressed and corrections implemented as appropriate to ensure compliance is achieved. Staff will be reprimanded accordingly. 4. The trends and results from the audits will be reviewed at the monthly Quality Assurance Committee Meeting to maintain compliance and evaluate effectiveness for at least a three month period of time until the requirements of #3 are met.	NOV 17 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 315	Continued From page 7 with diagnoses of End Stage Renal Disease. A quarterly Minimum Data Set (MDS) dated 8/16/12 indicated Resident #4 had no cognitive impairment, required extensive assistance with toileting and was incontinent of bowel and bladder. A care plan dated 10/1/12 indicated a focus for Resident #4 regarding the risk for urinary tract infection related to incontinence of bladder. An observation was conducted on 10/3/12 at 11:29 AM of Resident #4's incontinence care. Nursing Assistant (NA) #1 removed Resident #4's incontinent brief and liquid stool oozed from the brief. The NA then turned the Resident on her right side. NA #1 wiped the peri-rectal area from back to front with tissue paper. NA # 1 then assisted the Resident to turn onto her back. She then wiped the perineal area with tissue paper from back to front three times, each time the tissue paper was saturated with fecal matter. NA #1 then placed a wet washcloth in her hand, applied soap and wiped the perineal area from back to front. She continued to wipe the perineal area in this manner three more times, each time she used a new washcloth, until the washcloth was free of fecal matter. NA #1 obtained a new washcloth and rinsed the perineal area from back to front. She continued to rinse the perineal area in this fashion, three more times using a different washcloth for each rinse. An interview with Nurse #2 on 10/3/12 at 12:49 PM revealed NAs were expected to perform peri-care with morning care and as needed. Nurse #2 added the NAs were trained to clean the perineal area from front to back due to the	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 315	Continued From page 8 area being unclean from urine and/or feces. An interview with the Director of Nursing (DON) was conducted on 10/3/12 at 5:03 PM; the DON revealed she would have expected NA #1 to have preformed peri-care as per in-service training. She further added she expected the NA to wipe from front to back and not from back to front when performing perineal care. During an interview with NA #1 on 10/4/12 at 1:05 PM, NA #1 stated she had attended a recent peri-care in-service and was trained to cleanse from front to back. NA #1 explained she should have wiped from front to back instead of wiping from the back to the front when performing perineal care. 1b. Resident #98 was re-admitted April 2011 with diagnoses Anoxic Brain Damage. A quarterly Minimum Data Set (MDS) dated 9/14/12 indicated Resident #98 had cognitive impairment, required total assistance with toileting and was incontinent of bowel and bladder. A plan of care dated 9/21/12 indicated Resident #98 was incontinent of bladder with a goal to prevent/minimize urinary tract infection through an intervention of checking for incontinence, wash, rinse and dry perineum area. On 10/3/12 at 10:28 AM, Resident #98 received a bed bath and incontinence care. Nursing Assistant (NA) #1 turned Resident #98 on her right side. NA #1 placed a washcloth in water	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 315	Continued From page 9 then took tissue paper and wiped the peri-rectal area from the back to the front removing stool from the peri-rectal area. She then turned the Resident onto her back. NA #1 removed the washcloth from the basin, applied soap and washed Resident #98's perineal area from back to front. The NA washed the center and both sides wiping from back to front and using a new washcloth for each area. The NA rinsed the perineal area with a clean washcloth and wiping from back to front. An interview with Nurse #2 on 10/3/12 at 12:49 PM revealed NAs were expected to perform peri-care with morning care and as needed. Nurse #2 added the NAs were trained to clean the perineal area from front to back due to the area being unclean from urine and/or feces. An interview with the Director of Nursing (DON) was conducted on 10/3/12 at 5:03 PM; the DON revealed she would have expected NA #1 to have preformed peri-care as per in-service training. She further added she expected the NA to wipe from front to back and not from back to front when performing perineal care. During an interview with NA #1 on 10/4/12 at 1:05 PM, NA #1 stated she had attended a recent peri-care in-service and was trained to cleanse from front to back. NA #1 explained she should have wiped from front to back instead of wiping from the back to the front when performing perineal care.	F 315		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 469	Continued From page 10 control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and review of facility records, the facility failed to maintain an effective pest control program. The findings are: Review of the facility's pest control service provider contract, undated, recorded in part, "All resident rooms will be inspected and/or treated on a monthly basis. If a room is not vacated at the time our service specialist is on site, such room will be serviced on the following month." On 10/2/12 at 9:55 AM, housekeeping staff #1 was observed to use his foot and shoe to kill a large brownish, black bug with two antennea crawling near the East Unit nurse's station. On 10/2/12 at 10:15 AM, Resident #84 stated that the facility had a problem with bugs. An observation occurred on 10/3/12 at 3:50 PM in room 147 with nurse #1 present. A small and a medium-sized brownish, black bug (both identified as German cockroaches) were observed crawling on the floor at the foot of bed B. Resident #84 was in bed B, in a low bed. Nurse #1 used a paper towel to kill one bug, but was unable to reach the second bug, which crawled underneath the Resident's bed. Nurse #1	F 469	F469 1. Deficiency corrected. The resident was temporarily transferred to another room, the sighted pests were killed and the pest control contractor provided an intense extermination treatment. 2. A full-house audit was completed to identify whether any pests were cited in resident rooms. All-staff will be in-serviced on how to appropriately log and report sightings of pests. Maintenance staff will be in-serviced on implementing a standing rotation for pest control treatment in each room at least once per quarter, in addition to routine interior and exterior services. 3. Environmental services staff will be responsible for making rounds in each resident's room at least once per week to observe for pest activity. Any areas of concern will be addressed and corrections implemented as appropriate to ensure compliance is achieved. 4. The trends and results from the audits will be reviewed at the monthly Quality Assurance Committee Meeting to maintain compliance and evaluate effectiveness for at least a three month period of time until the requirements of #3 are met.	NOV 17 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 469	Continued From page 11 left the room to contact maintenance staff. On 10/3/12 at 3:52 PM, nurse #1 returned to the Resident's room and continued talking to Resident #84. At 3:53 PM a third small brownish, black bug (identified as a German cockroach) was observed crawling on the wall next to the window. Nurse #1 got another paper towel and killed the bug that was crawling on the wall. The nurse stated she was unaware of any pest activity in room 147 in the past. On 10/3/12 at 3:54 PM, maintenance staff #1 entered room 147 with a can of bug spray. Maintenance staff #1 looked around the Resident's room moved a plastic bag that contained a pair of the Resident's shoes; a spider was observed to crawl across the floor. Maintenance staff pulled the Resident's night stand away from the wall and further observation revealed a large brownish, black bug with two antennea was adhered to the back of the night stand. Additionally, approximately 24 live small brownish, black bugs were noted on the floor behind the night stand. The large brownish, black with two anntenea crawled across the floor and was killed by maintenance staff #1. He also sprayed the floor area behind the night stand to kill the remaining small bugs that were observed. On 10/3/12 at 3:55 PM the maintenance director entered room 147 and stated that pest control services were provided monthly and as needed. The maintenance director stated that the pest control service provider serviced the exterior of the facility on 10/1/12, but did not service room 147. The maintenance director stated he was not aware that there was a concentration of bugs in room 147. He further stated that the pest control	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 469	Continued From page 12 service provider serviced the facility routinely and if additional pests were cited, he would call the service provider back. Staff documented pest citings in a log book kept at the receptionist desk and this book was used by the service provider to identify which specific rooms needed to be treated. Review of the pest citings log book revealed room 147 was last documented as having roaches on 7/17/12 and was treated on 7/25/12. Pest control services were also provided twice in August and September 2012, but not for room 147. On 10/3/12 at 5:25 PM an interview with the administrator revealed pest control services were provided on 10/1/12 to the exterior of the facility and specific rooms were baited, but did not include room 147. On 10/4/12 at 8:17 AM, an interview with housekeeping staff #1 revealed that he observed a spider and an "American cockroach" in the facility that week, and killed an "American cockroach" near the East Unit nurses station yesterday morning (10/3/12), but he forgot to document these citings in the log book that is kept at the receptionist desk. He further stated that he sees bugs in room 147 at least weekly and has informed his supervisor, the maintenance director, but he does not always document these citings in the log book. On 10/4/12 at 8:20 AM, maintenance staff #1 stated that when pest citings occur, he records this in the log book at receptionist desk. He denied seeing pests in room 147 in the past and was not aware of pest activity in that room. Maintenance staff #1 stated citings of pest activity	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 469	Continued From page 13	F 469		

normally occurred when it rained, particularly "American cockroaches" and occasionally "German cockroaches". Maintenance staff #1 also confirmed that he thought the bugs noted in room 147 on 10/3/12 looked like the "German cockroaches and American cockroaches" he saw in the facility in the past.

On 10/4/12 at 8:33 AM, a follow-up interview with the maintenance director revealed that staff may report pest activity to him, but staff should document this in the log book. He did not remember staff reporting recent pest activity to him regarding room 147.

On 10/4/12 at 8:45 AM a telephone interview with the pest control service provider revealed that he was not aware pest activity related to German cockroaches to the level as seen in room 147 on 10/3/12 and had not treated that room during the recent monthly visits. He stated that pest activity to this level was a problem that needed to be addressed. He further stated that he provided monthly inspections of residents rooms during pest service visits, but if patient care was being performed in a resident's room, he did not spend a great deal of time in that room. During service visits he concentrated around the air conditioning (ac) units because the facility reported citings of American cockroaches. He added that he thought that the American cockroaches were coming into the facility from the ac units.

On 10/4/12 9:40 AM an interview with housekeeping staff #2 revealed that in the last few months, she observed "American cockroaches" in room 147 and Resident #84 also reported this activity to her. She further stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING _____ B. WING _____	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH RD CHARLOTTE, NC 28211

(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 469	Continued From page 14 she reports this to her supervisor, the maintenance director, or the nurse on the hall.	F 469		