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 _____	C 08/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH ROAD 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 160 SS=B	483.10(f)(10)(v) CONVEYANCE OF PERSONAL FUNDS UPON DEATH (v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on resident trust account review and staff interviews the facility failed to convey funds within 30 days for 2 of 3 sampled residents that expired. (Residents #69 and #141) The findings included: 1. Resident #141 was admitted to the facility 09/12/12 and expired on 04/05/17. Review of the resident trust account of Resident #141 noted the final fund amount of $706.51 was not sent to the Clerk of Courts until 08/03/17. On 08/11/17 at 10:00 AM the Business Office Manager explained the delay in conveyance of funds for Resident #141 was due to a delay in reversal of funds from the corporate level. On 08/11/17 at 4:00 PM the Administrator stated he expected resident funds to be conveyed within 30 days of expiration. 2. Resident #69 was admitted to the facility 10/28/15 and expired on 04/2717. Review of the resident trust account of Resident #69 noted the final fund amount of .27 was not sent to the Clerk of Courts. On 08/11/17 at 10:00 AM the Business Office Manager stated it was her understanding	F 160	This plan of correction (POC) constitutes the facility's written allegation of compliance for the deficiencies cited. Preparation and / or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections prepared and / or executed solely because it is required by the federal and state law. Corrective action has been accomplished for the alleged deficient practice in regards to the delay in conveyance of funds involving resident #141 and #69. The facility Business Office Manager immediately released the funds to the estate of each above noted resident on 8/11/17. On 8/17/17, the facility Business Office Manager completed an audit of RFMS	9/9/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 9/5/17

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

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F 160	Continued From page 1 that fund amounts less than $50.00 were not conveyed to the Clerk of Courts when a resident expired. The Business Office Manager stated she had not encountered this before and was not sure what to do with the monies remaining in an account when a resident had less than $50.00 at the time of expiration. On 08/11/17 at 4:00 PM the Administrator stated he expected all monies to be conveyed within 30 days of expiration, regardless of the final balance in the resident trust account.	F 160	to ensure all other accounts were in compliance. The audit resulted in all accounts being in compliance in regards to conveyance of funds. To ensure the facility remains in substantial compliance, the facility Business Office Manager will complete an audit tool weekly for 6 months. The audit tool will be completed to ensure accounts of expired and/or discharged patients are closed within 30 days of discharge or the patient expiring. The facility Business office Manager will bring the results of the audit tool to the monthly QA meeting for 6 months to ensure compliance. On August 28, 2017 the facility Administrator reeducated the Business Office Manager on the facility's policy on "Resident Trust Fund". The Administrator will be The person responsible for implementing The acceptable plan of correction.	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, resident, and family interviews the facility failed to promote dignity by not washing a resident's hair before sending the resident out of the facility to a physician's appointment for 1 of 4 residents reviewed for dignity (Resident #84). The findings included: Resident #84 was admitted to the facility 06/22/17 with diagnoses which included cognitive communication deficit, muscle weakness, and 2 fractured thoracic vertebrae. A care plan dated 06/23/17 described Resident #84 with an activities of daily living self-care	F 241		

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F 241	Continued From page 2 deficit related to impaired balance, limited mobility, and pain. The care plan goal specified the resident would improve current level of function through the 90 day review date. Interventions included the resident was totally dependent on 1 staff member for showering. An admission Minimum Data Set (MDS) dated 06/29/17 indicated the resident was moderately cognitively impaired. The MDS specified Resident #84 required extensive staff assistance for dressing and was totally dependent on staff for bathing. The resident's mood assessment indicated the resident was minimally depressed. The MDS assessment documented the resident did refuse care 1 to 3 days of the assessment period. Review of a note written by the Social Worker and dated 08/08/17 specified Resident #84's cognition was moderately impaired. The note further specified the resident had stated sometimes she felt bad about herself. An observation on 08/09/17 at 8:59 AM revealed Resident #84 was sitting in a wheelchair in her room. Her hair looked wet. A closer observation revealed the resident's hair was found to be greasy. At 4:30 PM on 08/09/17, the resident was observed sitting in a wheelchair in her room with her nightclothes on. Her hair continued to appear greasy in appearance. At this time, the resident stated she would get a shower the following day. On 08/10/17 at 12:00 PM Resident #84 was observed sitting in her room in a wheelchair. She stated she just got back from an appointment	F 241	F 241 It is the facility policy that all residents receive personal care and grooming daily. Corrective actions have been taken for the alleged deficient practices as described related to resident #84 during the survey process. It was noted that resident #84 was observed 8/9/17-8/11/17 with greasy hair. Resident #84 went out to a doctor's appointment in the current condition. Because all residents receiving personal care are potentially affected by deficiency F241, on 8/13/17 the Director of Nursing and supervisors completed a 100% audit on resident's preference of shower / bath and hair care. After completion of the resident preference audit, the facility shower schedule has been revised and resident #84 was added	9/9/17

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F 241	Continued From page 3 outside the facility and her family member went with her. The resident's hair still appeared greasy and was flat on her head. At 2:13 PM on 08/10/17 Resident #84 was observed in the therapy room with other residents and therapist. She was dressed nicely but her hair continued to appear very greasy and flat on her head. An interview was conducted on 08/10/17 at 4:34 PM via phone with the family member that assisted Resident #84 to the outside appointment. The family member stated she was very disappointed with Resident #84's appearance when she went to the doctor today. She stated the resident's hair was dirty. The family member further stated while in the doctor's office the resident reported to her that she did not like her hair and felt bad about herself. The family member stated Resident #84 did have communication problems related to mental deficits and would sometimes say no when asked if she wanted care. The family member added the resident always liked a shower. She also stated the resident never allowed her hair to get dirty when she lived at home before coming to the facility. An observation on 08/11/17 at 8:25 AM, Resident #84 was lying in her bed. The resident's hair looked wet and greasy. An interview with Nurse Aide (NA) #1 on 08/11/17 at 8:47 AM revealed Resident #84 should have gotten a shower on the evening of 08/10/17 per the shower schedule. The NA added she was assigned to Resident #84 on the day shift of 08/10/17. The resident was already dressed by the 11:00 PM to 7:00 AM staff when she came to	F 241	to the beauty shop schedule weekly per family preference. The following corrective actions were implemented to prevent this deficient practice from re occurring: The resident preference sheet will be completed by the Social Worker / Nursing Staff upon admission. The DON or Nursing Supervisor will audit accuracy of showers 3x a week for 3 months and then weekly thereafter. Nursing staff was educated on the new shower schedule. All new nursing staff will be educated on this process during new hire orientation. The Director of Nursing will analyze the audits /reviews for patterns and trends and report in the QA meeting x 3 months to evaluate the Effectiveness of the plan and will make needed Adjustment based on outcomes / trends Identified The Administrator will be The person responsible for implementing The acceptable plan of correction.	

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F 241	Continued From page 4 work yesterday. NA #1 stated the resident's hair was greasy yesterday before going to the doctor's office. The NA further stated she did not know why the resident's hair was greasy. An interview was conducted with the Assistant Director of Nursing (ADON) on 08/11/17 at 9:06 AM. The ADON stated the resident should be getting her hair washed and a shower on Monday and Tuesday evenings. After observing the resident, the ADON reported on 08/11/17 at 9:14 AM, the resident was getting a shower at that time and her hair was to be washed. An observation on 08/11/17 at 3:04 PM revealed Resident #84 was in the activity room participating in the monthly birthday party the facility provided for all residents with a birthday in August. The resident's hair appeared fluffy and clean and she was dressed in nice clothes. An interview was conducted with Resident #84 on 08/11/17 at 3:25 PM. The resident stated it made her feel bad to have her hair dirty. An interview was conducted with the Director of Nursing (DON) on 08/11/17 at 4:12 PM. The DON stated it made her sad to know a resident did not feel good about herself because her hair as not clean. The DON added this would be rectified.	F 241		
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	F 253	Corrective action has been accomplished for the alleged deficient practice in regards to the damaged and unpainted areas on residents walls (Rooms 108,111,115,118,140), resident (Room 110) and supply room doors that would not fully close, dirty raised commodes (Rooms 111,120,136), gaps between conduit and ceiling frame in the supply room, missing, improperly seated and damaged ceiling tile(s) in the supply room, penetrations in ceiling tiles in the supply room and the ceiling vent in the supply room that was ajar permitting penetration to the roof space.	9/9/17

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F 253	Continued From page 5 by: Based on observations and staff interviews, the facility failed to repair or paint walls, repair a resident door that would not fully close, or clean raised commode seats for 8 of 40 occupied or available resident rooms (Rooms 108, 110, 111, 115, 118, 120, 136 and 140), and penetrations in a suspended ceiling for 1 of 1 storage rooms adjacent to a resident room. The findings included: 1. Observation on 8/8/17 at 11:11AM of Room 140 revealed dirty vinyl baseboard and gouged wall. Observation on 8/8/17 at 3:37PM of Room 120 revealed in the bathroom a raised commode seat with rust and soiling on the metal frame. Observation on 8/8/17 at 4:11PM of Room 110 revealed the door to this room did not shut completely when pulled closed, sticking in the door jamb and thus preventing its complete closure. Observation on 8/9/17 at 9:04AM of Room 136 revealed in the bathroom a raised commode with brown matter under the commode seat and visible from the door going to the bathroom. Observation on 8/9/17 at 10:18AM of Room 118 revealed marred wall and spots that were spackled and unsanded areas, needing paint, along the wall behind resident beds. Observation on 8/9/17 at 10:30 AM of Room 108 revealed deep gashes in wallboard behind a resident's bed, with penetrations along the	F 253	An audit was conducted by the facility Maintenance Director on 8/16/17 to ensure all other remaining resident room walls are not damaged and are properly repaired and painted. These rooms meet substantial compliance. An audit was conducted by the facility Maintenance Director on 8/14/17 to ensure all other facility doors fully close. Facility doors meet substantial compliance. An audit was conducted by the facility Maintenance Director on 8/23/17 to ensure all raised commode s were clean and free from rust. All raised commodes are clean and free from rust	

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F 253	Continued From page 6 baseboard. Observation on 8/9/17 at 11:40AM of Room 111 revealed in the bathroom black staining at the base of the commode and an unpainted spot on the wall where a two roll tissue dispenser was once attached. Observation on 8/10/17 at 2:50PM of Room 115 revealed wall was punched in behind a resident's bed in the same size and shape of the bed's headboard. Interview on 8/11/17 at 3:28PM with the Director of Facility Services revealed an East Wing renovation (rooms in the 150s) which included resident rooms is completed and the second phase of the project will rooms on the West Wing in the 130s and rooms 114 and 115 are currently underway. He stated the start of the third phase of the project to complete the rest of the resident rooms was unknown as the corporate office controlled the budget and the timeline. He stated that life safety issues were addressed first regardless of project timelines. He stated the facility used a computer program for staff to document facility repair issues which he checked three to four times a day. He stated this program converted these reports into emails which he could open on his cell phone, permitting him to prioritize what required his attention. He stated when staff entered the concern into the computer, they could document whether it was a major or minor issue to help gauge how quickly to fix the concern. He stated there was nothing in the queue requiring his attention. He stated he usually addressed facility concerns with 24 hours. He stated that doors that would stick in the door jambs or did not close required attention, with him	F 253	An audit was conducted by the facility Maintenance Director on 8/18/17 to ensure all ceiling tiles and ceiling vents were in place and free from any damage. Facility ceiling tiles and ceiling vents are in compliance. To ensure the facility remains in substantial compliance, the facility Maintenance Director will complete audit tools weekly for 2 months then monthly thereafter for 6 months. Audit tools will be completed to ensure dry wall is in place, not damaged, free from holes and painted, facility doors close freely, raised commodes are clean and free from rust and that ceiling tiles and ceiling vents are in place, not damaged and free of penetrations. The facility Maintenance Director will bring the completed audit tools to the monthly QA meeting monthly for 8 months to ensure compliance.	

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F 253	Continued From page 7 fixing one recently. He started that there were no ceiling tiles requiring his attention. He stated he expected staff to enter facility concerns into the computer system or to tell him in person. He stated he provided an orientation to new staff to tell them about life safety issues that could cause harm to employees or residents. He stated that wall condition issues like holes or penetration could be addressed in a day and scrapes were addressed on a weekly basis. He stated that resident equipment, including commode seats, were cleaned by housekeeping staff and any broken or damaged equipment required reporting and this too could be put into the computer system. He stated that any floor staining under the commodes was addressed by housekeeping and if they were not successful then they would get him to lift the commode bowl to clean the stain. Observation on 8/11/17 from 3:30PM to 4:00PM, a tour of the facility with the Director of Facility Services revealed findings of the noted resident rooms similar to observations from 8/8/17 through 8/10/17. Interview on 8/12/17 at 10:19AM with the Administrator revealed his expectation for staff to report facility concerns by using the computer system. He stated that breaks in ceilings and walls should be noted by staff and reported in the computer. 2. Observation on 8/8/17 at 11:21AM revealed the door the supply room, located between the East Wing nursing station and resident Room 155, was ajar. Inside the supply room, a tile in the suspending ceiling was not seated in the ceiling frame, permitting penetration to the roof space. A second ceiling tile had a brown stain consistent with a water leak. A ceiling vent was	F 253	The facility Maintenance Director will re-educate facility staff on the Direct Supply TELS work order system to ensure that staff members know the proper system the facility utilizes to generate work orders. The Administrator will be The person responsible for implementing The acceptable plan of correction.	

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F 253	Continued From page 8	F 253		

ajar, permitting penetration to the roof space. Around metal electric conduit leading to an electrical panel, gaps between the conduit and the ceiling frame approximately 3 inches in width permitted penetrations to the roof space.

Observation on 8/8/17 at 12:28PM revealed the door to the supply room door was ajar. Inside the supply room, ceiling penetrations were similar to those observed on 8/8/17 at 11:21AM.

Observation on 8/11/17 at 7:13AM revealed the door to the supply room door was ajar. Inside the supply room, ceiling penetrations were similar to those observed on 8/8/17 at 11:21AM with an additional missing ceiling tile in the corner of room by the door measuring approximately 6 inches by 8 inches, permitting penetration to the roof space.

Interview on 8/11/17 at 3:28PM with the Director of Facility Services revealed that life safety issues were addressed first regardless of project timelines. He stated the facility used a computer program for staff to document facility repair issues which he checked three to four times a day. He stated this program converted these reports into emails which he could open on his cell phone, permitting him to prioritize what required his attention. He stated when staff entered the concern into the computer, they could document whether it was a major or minor issue to help gauge how quickly to fix the concern. He stated there was nothing in the queue requiring his attention. He stated he usually addressed facility concerns with 24 hours. He stated that doors that would stick in the door jambs or did not close required attention, with him fixing one recently. He started that there were no ceiling

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F 253	Continued From page 9 tiles requiring his attention. He stated he expected staff to enter facility concerns into the computer system or to tell him in person. He stated he provided an orientation to new staff to tell them about life safety issues that could cause harm to employees or residents. He stated that wall condition issues like holes or penetration could be addressed in a day and scrapes were addressed on a weekly basis. Observation on 8/11/17 at 3:55PM during a tour of the facility with the Director of Facility Services revealed the door to the supply room was ajar. Observations of the supply room ceiling were similar to those on 8/8/17 and 8/11/17. Interview on 8/11/17 at 3:55PM with the Director of Facility Services revealed the hinge on the door needed to be tightened and missing ceiling tiles, gaps around those not seated in the ceiling frame and the penetrations around the electrical conduit needed to be repaired. Interview on 8/12/17 at 10:19AM with the Administrator revealed his expectation for staff to report facility concerns by using the computer system. He stated that breaks in ceilings and walls should be noted by staff and reported in the computer.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (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	F 272	Corrective action has been taken for the alleged deficient practice. A modification to the comprehensive triggered CAA MDS assessment for resident #47 was completed on 8/28/17 to ensure documentation of analysis of findings such as labs with a description of the problem, contributing factors and risk factors related to nutrition and end stage renal disease.	9/9/17

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F 272	Continued From page 10 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. 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	F 272	To ensure that no other residents are affected by the alleged deficient practice, an audit of the Nutrition Care Area Assessment for all residents has been completed as of 8/31/17. In order to ensure that the facility stays in compliance, the facility RN / MDS nurse will conduct an audit of the Nutrition Care Area Assessment Comprehensive Assessment monthly for 3 months. Continuation upon recommendation of the QA committee. Clinical staff that may complete the nutritional CAA have been in serviced to complete an analysis of findings to include	

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F 272	Continued From page 11 shifts. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to nutrition for 1 of 1 sampled resident who received dialysis (Resident #47). The findings included: Resident #47 was admitted to the facility on 04/13/13 with diagnoses which included end stage renal disease. Review of Resident #47's annual Minimum Data Set (MDS) dated 02/04/17 revealed Resident #47 received dialysis treatment and did not require a therapeutic diet. The MDS indicated Nutrition was among the areas that triggered for further analysis. Review of Resident #47's Nutrition Care Area Assessment (CAA) dated 02/09/17 revealed no documentation of findings with a description of the problem, contributing factors and risk factors related to nutrition and end stage renal disease. The CAA indicated Resident #47 consumed 92% of a regular diet and had a high body mass index of 34.9676, and received dialysis. The CAA indicate a referral to another discipline was warranted and documented referral to the medical doctor and registered dietician as needed. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan.	F 272	a description of the problem, contributing factors and risk factors related to nutrition. Comprehensive assessments completed each month will be monitored by the facility RN /MDS nurse or Registered Dietician. The comprehensive assessments will be reviewed during the monthly QA meeting x 3 months to ensure documentation of a complete analysis of findings to include a description of the problems, contributing factors and risk factors related to nutrition. The Administrator will be The person responsible for implementing The acceptable plan of correction.	

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F 272	Continued From page 12 Interview with Resident #47 on 08/10/17 at 12:33 PM revealed receipt of a regular diet. Resident #47 explained she did not require dietary restrictions for her renal disease. Interview with the MDS Coordinator on 08/10/17 at 3:50 PM revealed the facility's dietary manager completed the Nutrition CAA. Interview with the facility's dietary district manager on 08/10/17 at 3:53 PM revealed the dietary manager who documented Resident #47's Nutrition CAA no longer worked at the facility. The dietary district manager explained the facility's Registered Dietician conducted a nutrition comprehensive assessment which included an analysis of findings regarding Resident #47's nutrition and renal disease. Telephone interview with the Registered Dietician on 08/10/17 at 4:21 PM revealed she documented by exception should the dialysis dietician or any dietary issue occur. Interview with the Administrator on 08/10/17 at 4:48 PM revealed he expected staff to follow the Resident Assessment Instrument process. The Administrator reported the CAA should contain documentation of descriptions, contributing factors, risk factors and analysis of findings.	F 272	Corrective action has been taken for the alleged deficient practice. A significant correction was completed for resident #7 who can see large print but needed her reading glasses for small print. Resident #7 was coded to not have a visual aid and to have adequate vision due to seeing large and small print. Resident #46 stated he wore glasses for reading but did not need them for completing	9/9/17
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate	F 278		

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F 278	Continued From page 13 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 observations, record review, and staff and resident interviews, the facility failed to accurately assess vision on Minimum Data Set (MDS) assessments for 3 of 3 residents reviewed for vision (Residents # 7, #17, and #46). The findings included: 1. Resident #7 was readmitted to the facility	F 278	tasks. Social Services Director completed the vision test with resident #46, resident #46 did not have reading glasses and resident #46 could see large but not small print. Resident #46 was coded for impaired vision. Resident #17 was seen watching TV and sitting in the dining room and reported that he did not need glasses and see fine otherwise. Resident #17 reported that he had reading glasses to the facility Social Services Director but could not find them. Resident #17 could see large and small print. Resident #17 was coded for adequate vision. All residents have the potential to be effected by the same deficient practice. Audits were completed by the Social Services Director and Designee on	

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F 278	Continued From page 14 05/05/17 with diagnoses which included coronary artery disease, diabetes mellitus, and end state renal disease. A review of a quarterly MDS dated 07/31/17 revealed the vision section, B1000, was marked as vision impaired (sees large print but not regular print in newspapers and books.) Section B1200 which addressed corrective lenses for impaired vision was marked no. The MDS indicated the resident's cognition was intact. An observation of Resident #7 on 08/09/17 at 9:11 AM revealed the resident was sitting on the side of her bed circling large letters in a puzzle book. The resident was not wearing glasses. On 08/11/17 at 8:38 AM Resident #7 was observed sitting on the side of her bed working a word puzzle in a puzzle book. The print in the book was larger than newspaper print. She was not wearing glasses. At this time, the resident stated she could see the words and numbers in the puzzle book but needed glasses for reading. The resident further stated her niece had her reading glasses and she planned to get them so she could read. Resident #7 added otherwise she was just fine with her reading situation at present. An interview with the Social Worker (SW) on 08/11/17 at 12:08 PM revealed she did the vision assessments on the MDS. The SW explained she marked vision as impaired if the resident stated they wore glasses. If they do not have their glasses on at that time, she marked No for corrective lenses. An interview with the MDS Coordinator on	F 278	8/28/17 to interview all residents in regards to their vision. Audits will be completed as of 8/31/17 to ensure all MDS assessments and care plans are accurate in relation to visual aids and vision for all residents. To prevent this alleged deficient practice from reoccurring, the RN or MDS nurse will conduct 10 random audits of section B of the MDS per month times 3 months. A monthly summary of the audits will be presented at the monthly QA meting x3 months. Continuation of audit upon recommendation of the QA committee. The Administrator will be The person responsible for implementing The acceptable plan of correction.	

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F 278	Continued From page 15 08/11/17 at 2:24 PM revealed the vision assessment was done incorrectly. She explained corrective lenses should have been marked yes instead of no if the resident had glasses. The MDS Coordinator further stated it did not matter if the resident was wearing them at the time of the vision assessment. An interview with the Director of Nursing on 08/11/17 at 4:32 PM revealed she expected all MDS assessments to be done correctly. 2. Resident #17 was readmitted to the facility 10/04/16 with diagnoses which included diabetes mellitus and congestive heart failure. A review of a quarterly MDS dated 06/08/17 revealed the vision section, B1000, was marked as vision impaired (sees large print but not regular print in newspapers and book). Section B1200 which addressed corrective lenses for impaired vision was marked no. The MDS indicated the resident's cognition was moderately impaired. An observation of Resident #17 on 08/08/17 at 2:47 PM revealed the resident was sitting in his wheelchair in his room watching television. He was not wearing glasses. An additional observation on 08/11/17 at 12:01 PM revealed Resident #17 was sitting in his wheelchair in the dining room. He was not wearing glasses. At this time, the resident stated he did need glasses for reading and sees fine otherwise. An interview with the Social Worker (SW) on 08/11/17 at 12:08 PM revealed she did the vision	F 278		

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F 278	Continued From page 16 assessments on the MDS. The SW explained she marked vision as impaired if the resident stated they wore glasses. If they do not have their glasses on at that time, she marked No for corrective lenses. An interview with the MDS Coordinator on 08/11/17 at 2:24 PM revealed the vision assessment was done incorrectly. She explained corrective lenses should have been marked yes instead of no if the resident did have glasses. The MDS Coordinator further stated it did not matter if the resident was wearing them at the time of the vision assessment. An interview with the Director of Nursing on 08/11/17 at 4:32 PM revealed she expected all MDS assessments to be done correctly. 3. Resident #46 was re-admitted to the facility on 1/6/17 with diagnoses including eye nerve atrophy, cataracts and diabetes mellitus (DM) type II with retinopathy. Review of an optometrist note dated 1/12/17 revealed documentation of the resident's eye diagnoses. This note documented Resident #46 as not meeting criteria for treatment of these diagnoses and that he was able to see regular print with an acuity of 20/60 or better. Review of an admission MDS dated 1/13/17 revealed the resident's vision was adequate and corrective lenses were not required. The care area of vision did not trigger on the Care Area Assessment. Review of an optometrist note dated 5/2/17 revealed documentation of the resident's eye	F 278		

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F 278	Continued From page 17 diagnoses. This note documented Resident #46 as not meeting criteria for treatment of these diagnoses and that he was able to see regular print with an acuity of 20/60 or better. Review of Resident #46's most current quarterly Minimum Data Set (MDS) dated 5/9/17 coded him as having moderately intact cognition, impaired vision and having no corrective lenses. Interview on 8/10/17 at 8:30AM of Resident #46 revealed he wore glasses only for reading and had no problems with his vision as it concerned him completing tasks and as having no falls related to his vision. Interview on 8/10/17 at 11:17AM with Resident 46's responsible person revealed the resident used to wear glasses but she was not sure why he stopped wearing them Interview on 8/11/17 at 12:08PM with the Social Worker revealed she was responsible for assessing vision on the MDS. She stated she marked vision as impaired if the resident wore glasses. She stated if the resident said yes to glasses, then she marked vision as impaired. She stated if at the time of the assessment they did not have glasses on, she noted that glasses were not available. Interview on 8/11/17 at 2:24PM with the MDS Coordinator revealed the vision assessment on Resident #46 and other residents was done so incorrectly. She stated corrective lenses should have been marked yes instead of no if they had them. She stated it did not matter if they were wearing them or not at the time of the vision assessment.	F 278		

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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. (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	F 431	Corrective actions have been taken for the alleged deficient practice of improperly storing insulin observed on 8/9/17 on the East wing Medication cart. It is the facility policy as ordered by the pharmacy to store insulin by labeling insulin and dating when opened. Due to potential harm for all residents by the alleged deficient practice on 8/9/17, the Director of Nursing / designee audited all insulins stored in the facility for any unlabeled insulin. The audit resulted in the facility being in compliance. The following actions were taken to prevent this alleged deficient practice from reoccurring: Staff was reeducated on medication storage to include proper storage and discarding of insulin per manufactured / pharmacy recommendations. Education and	9/9/17

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F 431	Continued From page 19 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 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 label 3 insulin pens with a prescription label and remove 1 insulin pen opened more than 28 days per manufacturer's recommendation from 1 of 3 medication carts, East Wing medication cart, reviewed for medication storage. The findings included: Review of the package insert from the manufacturer's website for the insulin Humalog KwikPen revealed under storage recommendations to throw the pen away after 28 days of use. 1. a. Observation on 8/9/17 at 2:30 PM of the East Wing medication cart revealed a plastic storage box containing numerous residents' insulin pens and vials, including the following insulin pen devices: One opened Novolog Flexpen, 100 units/1ml, 3 ml prefilled, manufacturer's expiration date of 11/2018 with no prescription label and not in a	F 431	implementation of nurse daily insulin audit sheet to be completed by oncoming and off going nurse each shift to assist with compliance of storage. DON/Nursing Supervisor will audit storage of medication / insulin 3x a week for 4 weeks and then weekly thereafter for 2 months. The Director of Nursing will analyze the audits /reviews for patterns and trends and report in the QA meeting x 3 months to evaluate the Effectiveness of the plan and will make needed Adjustment based on outcomes / trends Identified The Administrator will be The person responsible for implementing The acceptable plan of correction.	

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F 431	Continued From page 20 labeled bag. An unused Novolog Flexpen, 100 units/1ml, 3 ml prefilled, manufacturer's expiration date of 11/2019 with no prescription label and not in a labeled bag. One opened Lantus pen, 100 units/1ml, 3 ml prefilled, manufacturer's expiration date of 8/2019 with no prescription label and not in a labeled bag. 1. b. One Humalog KwikPen, 100ml/1ml, 3ml prefilled, manufacturer's expiration date of 12/2019, with a printed prescription label and a penned date of opening on 7/5/17 (or opened for 35 days by the observation date). Taped to the lid of the plastic box that held resident's insulin vials and pens was a copy of the Insulin Expiration Day Count chart. Interview on 8/9/17 at 2:30 PM with Nurse #1 revealed nurses were expected to write on insulin pens when they were opened and nurses referred to a reference taped to the inside of the plastic box that held resident's insulin. She stated nurses were expected to label pens with the resident's names. She stated some insulin pens came from the contract pharmacy in a box of 12 and the box itself had a prescription label. She stated the Lantus pen was probably a "stock pen" and did not come from the pharmacy with a label. She stated that sometimes insulin came from the pharmacy in a zipper-type bag with a pharmacy label and they would sometimes get separated from the pens. Observation on 8/9/17 at 2:30 PM revealed the Unit Manager removing from the medication room refrigerator a box of 12 Novolog insulin pens, a	F 431		

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F 431	Continued From page 21	F 431		

prescription label with a resident's name (currently at the facility) affixed to the box but no labels affixed to individual pens.

Interview on 8/9/17 at 4:54 PM with the Assistant Director of Nursing and Director of Nursing (ADON and DON) revealed insulin was kept in the refrigerator until opened and once opened, nurses were expected to monitor that it was not used past the number of days, once opened, as recommended by the manufacturer. The DON stated insulins were kept in a plastic box in the medication cart and nurses were expected to write the date opened on the vial or pen to know how long it could be used once opened. The DON stated she expected that insulin was labeled with resident names and individual insulin pens should have resident name stickers put on them by the contract pharmacy. She stated nurses were not permitted to share pens among the residents. The DON stated she did not know what residents would have used the unlabeled insulin pens, mentioning that one resident was recently discharged and the pens might have belonged to him as she did not get insulin pens for him when his medications were sent back to the contract pharmacy. The DON stated when pens came out of a box of pens, the facility had stickers for nurses to write resident names on them. The DON stated a contract pharmacy technician came out and checked medication carts and she would expect them to pick up on these issues during their checks.

Interview on 8/10/17 at 2:42 PM with the contract Pharmacist revealed insulin pens should be labeled and could not be interchanged among residents, each resident requiring their own individually labeled pens for their own use. He

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F 431	Continued From page 22 stated the contract pharmacy had a technician who came to the facility quarterly or every other month to check the medication carts. Telephone interview on 8/10/17 at 3:30 PM with the contract pharmacy General Manager revealed insulin pens were dispensed in zipper-type bags with labeled affixed on the outside of the bags. She stated the pens should have an auxiliary label with the resident's name as an identifier. She stated that one insulin pen was sent at a time to the facility. She stated if a Humalog insulin pen was stored at room temperature for more than 28 days it should be discarded. An interview on 8/11/17 at 2:45 PM with the Administrator revealed he expected staff to ensure insulin pens had a prescription label affixed to them and not to use them, once opened, past the number of days recommended by the pharmacy or the manufacturer.	F 431		
F 520 SS=E	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	F 520	In service education was provided on 8/31/17 to the interdisciplinary team by the Regional Clinical Consultant regarding the facility QAA program which includes developing, implementing, monitoring and maintaining interventions to promote quality of care and quality of life.	9/9/17

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F 520	Continued From page 23 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 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 and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in August of 2014. This was for three recited deficiencies which were originally cited in July of 2014 on a complaint investigation and on the current recertification survey. The deficiencies were in the areas of neglect, choices and activities of daily living. The continued failure of the facility during two federal surveys of record	F 520	The facility will diligently follow the facility's policy and procedure of the QA process to prevent a repeat deficiency from reoccurring. The Administrator, Director of Nursing, Maintenance Director and Social Worker will analyze the audits and requests to identify patterns / trends and will adjust plan as needed and discuss during monthly QA meeting x 6 months for continued compliance. Following each monthly QA meeting, The meeting minutes will be reviewed By the Regional Vice President of Operations and the Regional Clinical Consultant to assure compliance For addressing of the plan of Correction deficiency. The Administrator will be The person responsible for implementing The acceptable plan of correction.	

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 _____	C 08/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT CHARLOTTE	4801 RANDOLPH ROAD 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 520	Continued From page 24	F 520		

show a pattern of the facility's inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross referred to:

1 a. F 241: Dignity: Based on observations, record review, and staff, resident, and family interviews the facility failed to promote dignity by not washing a resident's hair before sending the resident out of the facility to a physician's appointment for 1 of 4 residents reviewed for dignity (Resident #84).

The facility was recited for F241 for failing to promote dignity by sending a resident to a doctor's appointment with dirty hair. F241 was originally cited during the June 24, 2016 recertification survey for not promoting dignity by not providing nail care before dining.

b. F253: Maintenance and Housekeeping: Based on observations and staff interviews, the facility failed to repair or paint walls, repair a resident door that would not fully close, clean raised commode seats for 8 of 40 occupied or available resident rooms (Rooms 108, 110, 111, 115, 118, 120, 136 and 140), and penetrations in a suspended ceiling for 1 of 1 storage rooms adjacent to a resident room.

During the recertification survey of June 2016 the facility was cited for F253 for failure to repair a loosened ceramic sink that separated from the wall, loosened faucets in 6 of 25 bathrooms, and a loosened plastic power outlet cover. On the current recertification survey the facility was again recited for failure to paint walls, repair resident

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F 520	Continued From page 25 doors, commode seats and suspended ceiling. c. F278: Accuracy of Minimum Data Set: Based on observations, record review, and staff and resident interviews, the facility failed to accurately assess vision on Minimum Data Set (MDS) assessments for 3 of 3 residents reviewed for vision (Residents # 7, #17, and #46). During the recertification survey of June 2016 the facility was cited for failure to code the level 2 preadmission screening and resident review status. On the current recertification survey the facility was recited for failure to code vision accurately. d. F431: Drug Labeling and Storage: Based on observation, record review and staff interviews, the facility failed to label 3 insulin pens with a prescription label and remove 1 insulin pen opened more than 28 days per manufacturer's recommendation from 1 of 3 medication carts, East Wing medication cart, reviewed for medication storage. During the recertification survey of June 2016 the facility was cited for failure accurately reconcile narcotic medication. On the current recertification the facility failed to remove expired and unlabeled medications from medication carts and medication storage rooms. During an interview on 08/12/17 at 10:36 AM, the Administrator explained over the past year, the facility's administrative staff had completely changed. He stated the Director of Nursing and	F 520		

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F 520	Continued From page 26 Assistant Director of Nursing had been replaced more than once. All other management positions including the Unit Managers, Dietary Manager, Housekeeping and Laundry Supervisor, and Social Worker had been replaced this year. The Administrator stated he felt a good management team was in place now and felt this would make a difference in the outcome of repeat deficiencies.	F 520		