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 04/20/2018

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 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		5/4/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/04/2018

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F 655	Continued From page 1 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to initiate a baseline care plan for smoking for 1 of 4 residents reviewed for smoking (Resident #1). The findings included: Resident #1 was admitted to the facility on 03/13/18 with diagnoses of diabetes, osteomyelitis, and amputation of left great toe, peripheral vascular disease, tobacco use, and depression. Review of the Smoking Risk Data collection tool dated 03/13/18 revealed Resident #1 could smoke independently. Review of the Near Miss facility incident report dated 03/16/18 at 7:00 PM revealed Resident #1 was observed in the smoking area with his left leg wound dressing on fire. The Nurse Aide was able to extinguish the fire. Review of the care plan revealed a smoking care plan was initiated for Resident #1 on 03/17/18. The care plan revealed Resident #1 was an unsafe smoker: at risk for injury related to unsafe smoking status due to having episode of non-compliant with facility smoking policy and continuous attempts to smoke without supervision.	F 655		

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F 655	Continued From page 2 An interview conducted on 04/19/18 at 10:09 AM with the MDS Nurse revealed when a resident was admitted to the facility the admitting nurse should initiate a baseline care plan for smoking if the resident was a smoker. She stated a care plan for smoking for Resident #1 should have been initiated on the day he was admitted and not after he had an incident of unsafe smoking. An interview conducted with the Director of Nursing on 04/20/18 at 9:13 AM revealed it was her expectation for all new residents that smoke have a baseline care plan on admission for smoking.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 656		5/4/18

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F 656	Continued From page 3	F 656		

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.
(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 review and staff and resident interviews, the facility failed to develop a comprehensive care plan for 1 of 4 residents reviewed for smoking (Resident #2).

Findings included:

Resident #2 was admitted on 11/28/17 with diagnoses that included cerebral infarction, dementia, amnesia, psychosis, history of falling, and mental disorder.

The quarterly Minimum Data Set (MDS) dated 3/6/18 was coded as Resident #2 having cognitive impairment and requiring supervision for bed mobility, transfers, eating, and toileting.

A review of care plan dated 12/7/17 and created

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F 656	Continued From page 4 by the MDS Coordinator revealed Resident #2 was a smoker. There was no documentation identifying if Resident #2 needed supervision. A review of a smoking assessment dated 3/23/18 for Resident #2 revealed she had fallen several times while receiving care in the facility and was not safe to smoke without supervision. An interview on 4/18/18 at 11:59am with Resident #2 revealed she had not received education on the smoking policy and had not signed a contract to smoke independently. During an interview on 4/19/18 at 10:09am the MDS Coordinator revealed Resident #2 required supervision for smoking and the care plan should have reflected the need for supervision. An interview with the Director of Nursing (DON) on 4/20/18 at 9:53am revealed it was her expectation for Resident #2 to have a smoking care plan and for it to be labeled supervised if supervision was needed.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 689		5/4/18

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facility failed to supervise a resident assessed as needing supervision and a smoking apron while smoking and failed to implement interventions to prevent the resident from having smoking materials in his possession for 1 of 4 resident's reviewed for smoking (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 03/13/18 with diagnoses of diabetes, peripheral vascular disease, and depression.

Review of the admission Minimum Data Set dated 03/20/18 revealed Resident #1 was cognitively intact and used tobacco.

Review of the Smoking Risk Data Collection Tool dated 03/13/18 revealed Resident #1 was assessed to be able to smoke independently, unsupervised in the designated smoking area.

Review of the facility "Near Miss" incident report dated 03/16/18 at 7:00 PM revealed Resident #1 was observed by Nurse Aide #3 (NA) in the smoking area with his left lower leg dressing on fire. NA #3 was able to extinguish the fire and Resident #1 was assessed by Nurse #1 to have no injuries related to the incident. The immediate action taken was: The resident was instructed he would need to be supervised and wear a smoking apron from now on while smoking.

Review of the care plan dated 03/16/18 revealed Resident #1 was an unsafe smoker and was at risk for injury related to unsafe smoking status due to having episodes of non-compliance with the facility smoking policy and continuous attempts to go out and smoke unsupervised. The

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goal was for Resident #1 to smoke safely at the designated times, in designated area with supervision of staff and have no smoking injuries through the next review. The interventions included: Residents, family members, responsible parties will be instructed and reminded as indicated that any smoking materials (cigarettes, cigars, matches, lighters) are to be turned in to facility staff for management and dispensing. Smoking apron will be worn for safety as needed. Smoking will be supervised by staff members as needed.

Review of the nurse's notes revealed the following:
- 03/16/18 9:40 PM Resident #1 was observed with a lighter and a pack of cigarettes at 8:00 PM. As per the resident, his family brought them to him. The lighter and cigarettes were taken and placed with his other cigarettes under supervision of the staff.
-03/18/18 11:30 PM Resident #1 was caught smoking outside unsupervised. His room was searched and three empty boxes were found in his room. The Director of Nursing (DON) was made aware of the situation.
-03/19/18 6:30 AM Resident #1 was caught for the second time this shift in the courtyard smoking unsupervised. The DON was made aware of the situation.
-03/22/18 5:31 PM The DON and Assistant Director of Nursing (ADON) searched Resident #1's room with resident's permission. No cigarettes or lighters found. Resident #1 was advised that if he had any cigarettes or lighters that he needed to give them to us, he stated that he did not have any, we checked resident and wheelchair with his permission, no cigarettes or lighters found. Resident was placed on 1:1

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supervision.
-04/05/18 5:25 AM Resident was observed coming from outside courtyard/smoking area unattended. This writer reminded resident that he is not to go smoke without supervision, due to previous incident.
-04/06/18 10:08 AM Resident #1 was in the DON office and his wife was called and notified that Resident #1 was found 04/05/18 morning and this morning smoking unsupervised.

An interview conducted on 04/18/18 at 3:31 PM with Nurse #1 revealed he admitted Resident #1 on 03/13/18 and assessed him as a safe smoker. He stated on 03/16/18 Resident #1 set his left lower leg wound dressing on fire while he was outside smoking and the NA was able to extinguish the fire. Nurse #1 stated he did a head to assessment on Resident #1 right after the incident and found no injuries but informed him he would be have to be supervised and wear a smoking apron when he smoked from now on due to the incident. He stated he did another smoking assessment and Resident #1 was assessed as a non-safe smoker, who had to be supervised and wear a smoking apron when he went out to smoke. Nurse #1 further stated he caught Resident #1 several times with cigarettes and lighters in his room and smoking unsupervised after the incident on 03/16/18 and reported it to the Assistant Director of Nursing and the Director of Nursing.

An interview conducted on 04/20/18 at 9:13 AM with the Director of Nursing (DON) revealed her first day at the facility was 03/19/18 and she was informed of the smoking incident with Resident #1 on 03/22/18 by the Social Worker at the morning meeting because he wanted to be able

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F 689	Continued From page 8 to smoke unsupervised again. She stated she and the Assistant Director of Nursing met with Resident #1, searched his room for cigarettes and lighters and placed him on 1:1 supervision due to the incident that occurred on 03/16/18 and the continued documented behavior of smoking unsupervised and having smoking materials in his room after the incident. She stated he remained on 1:1 supervision for approximately two weeks and she met with him and his Responsible Party and discussed the need for him to follow the smoking policy or they would have to find other placement for him. She stated they both agreed to adhere to the smoking policy. The DON stated there were no further interventions implemented after the 1:1 supervision on 03/22/18 even after he was caught smoking several times unsupervised after the 1:1 supervision had ended. She stated interventions should have been implemented to check his room every shift for cigarettes and lighters so he could not go out and smoke unsupervised.	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident	F 700		5/4/18

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representative and obtain informed consent prior to installation.

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews the facility failed to secure loose side rails for 2 of 4 sampled residents (Resident #5, #8).

The findings included:

1. Resident #5 was admitted to the facility on 09/18/06 with current diagnoses of high blood pressure, non-Alzheimer's dementia, hemiplegia, seizure disorder, anxiety, and depression.

Review of the annual Minimum Data Set dated 03/11/18 revealed Resident #5 was moderately cognitively impaired and required extensive assistance with bed mobility and transfers.

An observation made on 04/19/18 at 10:52 AM of Resident #5's right ½ side rail revealed Resident #5 grabbed the rail to pull up in bed and the rail moved away from the edge of the mattress approximately 6 inches.

An interview conducted on 04/19/18 at 2:00 PM with Nurse Aide (NA) #1 revealed she was Resident #5's NA and she had not noticed his right ½ side rail being loose. She stated she would have notified the Maintenance Director if

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she had noticed it was loose.

An interview conducted on 04/19/18 at 2:15 PM with the Maintenance Director revealed staff notified him of maintenance issues and needed repairs when they arose. He stated he did not conduct routine audits of side rails and relied on the nurse's and NAs to notify him if a side rail was loose. He stated staff had not notified him of Resident #5's side rail being loose.

On 04/19/18 at 2:25 PM the Maintenance Director and the Administrator were accompanied to Resident #5's room and examined the right side rail. They confirmed the side was loose and needed to be tightened. The Administrator stated Resident #5 would shake the side rail at times and that could have made it loose. They stated they would need to check the side rails more often.

2. Resident #8 was admitted to the facility on 10/18/16 with diagnoses of high blood pressure, dementia, seizure disorder, and depression.

Review of the quarterly Minimum Data Set dated 01/24/18 revealed Resident #8 was moderately cognitively impaired and required extensive assistance with bed mobility and transfers.

An observation made on 04/19/18 at 11:00 AM of Resident #8's right ½ side rail revealed the rail moved away from the edge of the mattress approximately 6 inches.

An interview conducted on 04/19/18 at 11:05 AM with Nurse Aide (NA) #2 revealed she was Resident #8's NA and she had not noticed his right ½ side rail being loose. She stated she

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F 700	Continued From page 11 would have notified the Maintenance Director if she had noticed it was loose. An interview conducted on 04/19/18 at 2:15 PM with the Maintenance Director revealed staff notified him of maintenance issues and needed repairs when they arose. He stated he did not conduct routine audits of side rails and relied on the nurse's and NAs to notify him if a side rail was loose. He stated staff had not notified him of Resident #8's side rail being loose. On 04/19/18 at 2:30 PM the Maintenance Director and the Administrator were accompanied to Resident #8's room and examined the right side rail. They confirmed the side was loose and needed to be tightened. They stated they would need to check the side rails more often.	F 700		
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's	F 838		5/4/18

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resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

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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 838	Continued From page 13 §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for the resident population competently during day to day operations and in an emergency situation. The findings included: Review of the facility assessment revealed it did not contain the facility's resident population, both the number of resident's and the facility's resident capacity, the care required by the resident population, staff competencies, physical environment, and cultural, ethnic, and religious factors that may affect resident's care. It also did not contain the facility's resources such as services provided, personnel, and contracts with third parties, and managing resident records. An interview conducted on 04/20/18 at 10:42 AM with the Administrator revealed the prior Director of Nursing (DON) had been working on the Facility Assessment and she did not complete it before she resigned a couple of months ago. He stated he knew it wasn't completed and should have gotten it completed after the DON resigned.	F 838		