DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 06/24/2016

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of the medical record, the facility failed to promote the dignity of 1 of 7 sampled residents as evidenced by providing nail care prior to the resident's participation in dining and group activities (Resident #39). The findings included: Resident #39 was re-admitted to the facility on 12/31/15. Diagnoses included cerebral infarction (stroke) with left hemiparesis. A quarterly Minimum Data Set dated 04/06/16 assessed Resident #39 with intact cognition and required extensive to total staff assistance with personal hygiene and bathing. Review of the April 2016 care plan and Kardex (documentation to nurse aides of nursing care required) revealed Resident #39 had a self-care performance deficit regarding activities of daily living (ADL) which required nursing staff to check his nail length/cleanliness and trim/clean as necessary. Resident #39 was observed in his room and interviewed on 06/21/16 at 09:43 AM. His fingernails to both hands were observed to	F 241	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. Immediate correction was achieved for the alleged deficient practice as follows: On 6/23/2016 resident #39 finger nails were cleaned and trimmed by the certified nursing assistant. Resident was interviewed and agreed to have nail care/handwashing prior to meals and activities In order to identify other residents who may be affected by this alleged deficient practice does not recur includes: On 6/23/16 the nursing staff conducted an	7/21/16

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

Administrator 7/25/16

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 241	Continued From page 1 extend approximately one-quarter inch beyond the nail bed with brown matter underneath the fingernails of his right hand. Resident #39 stated during this observation "My fingernails need to be cleaned and trimmed, if I want it done, I have to tell them." Resident #39 was also observed with his fingernails the same length and with brown matter underneath the nails of his right hand during the following group activities: · 06/22/16 12:49 PM in the main dining room at a table with 2 other residents · 06/22/16 4:01 PM while outside in the smoking area at a table with 2 other residents · 06/23/16 2:40 PM in the main lobby area awaiting the start of a group activity with other residents present · 06/23/16 2:59 PM in a group activity (bingo) During a follow up interview on 06/22/16 at 12:49 PM, Resident #39 stated that he wanted to have his nails cleaned, and that he did not like it when his nails were dirty. He further stated that his nails got soiled a lot because he was a smoker and that in order to have nail care provided, he had to ask. He stated "If I don't ask it doesn't get done." During an interview on 06/23/16 at 2:59 PM, Nurse Aide (NA) #1 stated that Resident #39 required extensive to total staff assistance with ADL and required nail care as needed. NA #1 further stated that whenever a resident needed nail care, it should be provided. NA #1 stated she provided morning care to Resident #39 that morning (06/23/16), but that she did not look at his nails. NA #1 stated that she was his assigned NA on 6/21/16 (Tuesday) on the 7A - 3 P shfit and that she washed his hands during morning care that day, but because he smoked, his nails got	F 241	audit on current residents to ensure that residents fingernails were cleaned and trimmed. Nail care was provided for residents that were identified needing nail care. Residents will receive nail care during scheduled shower days and as requested and /or needed prior to meals and activities. Measures initiated to ensure that the alleged deficient practice does not recur include: In- service and re-education began on 6/23/16, for the nursing Staff, by the Director of Nursing and /or Assistant director of Nursing, regarding provision of nail care and resident has a choice and a right to have fingernails cleaned and trimmed as requested, with each bath or shower, prior to meals and activities, and as needed. Newly hired clinical staff will receive education during	

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F 241	Continued From page 2 dirty frequently. Resident #39 was observed in a bingo activity at the time of the interview and NA #1 confirmed that he had dark matter underneath the fingernails of his right hand and that his nails needed to be trimmed. NA #1 asked Resident #39 if he wanted his nails cleaned and trimmed and he stated "Yes." During an interview on 06/23/16 at 03:15 PM, the Director of Nursing (DON) stated she expected nail care to be provided to residents with showers, baths and as needed; whenever the staff saw that nail care was needed. During the interview, the DON observed the nails of Resident #39 while he participated in bingo and confirmed that he needed his nails cleaned and trimmed to promote his dignity. The DON stated that because Resident #39 was a smoker and smoked with his right hand, he nails got dirty frequently from smoking and from putting his hands in the ashtray. During an interview on 06/23/16 at 04:36 PM NA #4 stated that she gave Resident #39 a bed bath the night before (06/22/16) but that she did not offer him nail care. NA #4 stated that she washed his hands during the care, but that she did not clean or trim nails. She further stated that nail care should be provided with showers/baths, but that she did not notice that Resident #39 nails were dirty and she did not ask him if he wanted nail care.	F 241	orientation regarding the facility's protocol on cleaning and trimming of nails. The Unit manager and the Hall nurse will observe ten residents per week x4 weeks, then 10 residents monthly for 3 months to ensure residents' fingernails are clean and trimmed. Ongoing monitor implemented to ensure that the alleged deficient practice does not recur include: The DON will review the findings of weekly monitoring by the Unit Managers and the Hall Nurses. This information will be summarized and the findings will be presented as a part of the facility's Quality Assurance meeting. This will continue until compliance is achieved and maintained for three consecutive months.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;	F 242	On 7/12/16 resident #23 was interviewed by his QIS Ambassador to ensure his choices are met in regards to shower / bath with frequency and time resident chooses to	7/21/16

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F 242	Continued From page 3 interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, resident, and staff interviews the facility failed to provide 1 of 3 sampled residents who were reviewed for choices with the number of showers they preferred each week (Resident #23). The findings included: Resident #23 was admitted to the facility on 12/31/15 with diagnoses which included diabetes, high cholesterol and high blood pressure. The admission Minimum Data Set (MDS) dated for 01/08/16 indicated Resident #23 had no short or long term memory problems. The MDS indicated Resident #23 required extensive assistance with bed mobility, transfers, hygiene and bathing. The MDS further indicated it was "somewhat important" for Resident #23 to choose between a tub bath, bed bath, shower or sponge bath. During an initial interview on 06/21/16 at 8:36 AM with Resident #23, he stated his understanding was that he was to receive two showers each week which was fine for him, but he usually got a bed bath instead and he prefers a shower. Review of the documented showers in the facilities computer shower/bed bath tracking system and review of the handwritten documentation in the shower books from 02/28/16 to 06/24/16 indicated Resident #23 received only one shower or no showers during the following weeks: · 02/28/16 - 03/05/16 · 03/06/16 - 03/12/16	F 242	receive them. Staff were made aware of resident #23 choice for showers/bath and information included on shower list. On 7/13/16 and 7/14/16, the Interdisciplinary team interviewed current alert / oriented residents to ensure that shower / bathing choices are being met. The IDT will discuss bathing/ shower preferences with family members during care plan conference, for residents that are unable to make choices. Showers will be offered twice a week if resident/family does not request differently. By 7/ 21/ 16 education was provided by the Director of Nursing and/or the Assistant Director for the Nursing staff regarding providing residents showers/ bath as scheduled per resident choice and documented in the shower book.	

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F 242	Continued From page 4 · 03/20/16 - 03/26/16 · 03/27/16 - 04/02/16 · 04/10/16 - 04/16/16 · 04/17/16 - 04/23/16 · 05/15/16 - 05/21/16 During a follow-up interview on 06/22/16 at 4:25 PM with Resident #23, he stated he was scheduled to receive two showers a week but was not been receiving them every week. Resident #23 further indicated the nurse aide (NA) comes in his room to give him a sponge bath instead of a shower and he did not know why. Resident #23 stated he did not ask why he was not receiving an shower as he preferred because he didn't want to "fuss with anyone" as he tries to "get along with everybody." During an interview with Nurse Aide #1 (NA #1) on 06/23/16 at 9:09 AM, NA #1 stated if it was a shower day and there were only 3 nursing assistants working together sometimes a resident received a complete bed bath instead of a shower because of the lack of time. NA #1 also stated Resident #23 "never refuses to take a shower but sometimes due to lack of staff he has to get a bed bath." During an interview with NA #3 on 06/24/16 at 9:20 AM, NA #3 indicated Resident #23 needed complete assistance with a shower except his face, which he prefers to wash himself. NA #3 also indicated Resident #23 had "never refused a shower" when they had been offered to him. During an interview with the Director of Nurses on 06/24/16 at 12:10 PM, she stated her expectation was for staff to offer choices to the residents and if a resident wanted 2 showers a week or a shower every day that would be provided for that resident. The DON further stated she expected the staff to provide showers and not bed baths if that was the choice of the resident.	F 242	Upon admission, residents with decisional capacity are afforded the opportunity to make the staff aware if they would prefer to have a shower or a bed bath, shift received and frequency. Upon admission, for residents without decisional capacity, the choices regarding shower / bed bath, shift received and frequency will be discussed with the responsible party. For new admissions, during the 72 hour care planning meeting, the resident's' desires for shower/ bed bath, shift received and frequency are reviewed. Residents are asked during the Facility's QIS questionnaire if they would like to make changes in their bathing or shower schedule. This information is also reviewed with resident and / or responsible party during care plan meetings. The hall nurse and the unit managers	

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F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to repair loosened faucets in 6 of 25 bathrooms, failed to repair a loosened ceramic sink that separated from the wall in 1 of 25 bathrooms, and failed to repair a loosened plastic power outlet cover in 1 of 25 bathrooms. The findings included: 1. a. The following observations were related to loosened faucets identified in residents' bathrooms: Observation of room 136 on 06/22/16 at 4:23 PM revealed the left handle of the bathroom faucet was loosened and wiggled when it was used. However, the faucet panel was intact and fit properly to the sink. This was observed again on 06/23/16 at 2:37 PM and on 06/24/16 at 9:46 AM. On 06/22/16 from 4:25 PM to 4:49 PM, the whole faucet panels for the bathroom in rooms 138, 139, 143, 118, and 120 were observed as loosened and failed to attach properly to the sink. The faucet panel shifted from side to side easily when it was used. This was observed again on 06/23/16 from 2:40 PM to 3:03 PM and on 06/24/16 from 9:48 AM to 10:14 AM. In an interview with Resident #78 on 06/24/16 at 10:04 AM, she stated that the bathroom faucet had been in disrepair for over a week. It bothered her as the loosened faucet would shift whenever she used it. She would like to have it fixed as	F 253	will provide the Director of Nursing and/or Assistant director daily documentation of showers/bed baths given. Each month the Director of Nursing will review the documentation of 10 residents to validate that the residents when appropriate were afforded the opportunity to receive shower/ bed bath as desired and as scheduled. A summary of the above findings will be presented as a part of the facility's monthly Quality Assurance Meeting. This will continue until substantial compliance is achieved and maintained for three consecutive months. F 253 On 6/30/16, the Facility Maintenance Director identified the loose sink, faucets and outlet cover that had been	7/21/16 7/21/16

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F 253	Continued From page 6 soon as possible. b. The following observations were related to a loosened ceramic sink identified in a resident's bathroom: On 06/22/16 at 4:23 PM, the sink for room 136 was observed as loosened and failed to attach properly to the wall. The whole sink separated from the wall easily. This was observed again on 06/23/16 at 2:37 PM and on 06/24/16 at 9:46 AM. c. The following observations were related to facility's failure to repair a loosened bathroom plastic power outlet cover: Observation of the bathroom in room 139 on 06/22/16 at 4:28 PM revealed the plastic power outlet cover was loosened and wiggled when the switch was being used. One of the screws used to secure the plastic power outlet cover was missing and the other one was loosened. This was observed again on 06/23/16 at 2:44 PM and on 06/24/16 at 9:53 AM. The Maintenance Manager was on a walking tour with the surveyor to residents' rooms identified with maintenance issues on 06/24/16 at 10:33 AM. An interview was conducted after the tour. He stated the maintenance department consisted of himself and an assistant. He worked according to a priority of resident safety first, resident quality of life, and then the work orders. He normally made rounds and checked for new work orders at least once daily. According to the Maintenance Manager, the above identified faucets were in disrepair as his assistant was on medical leave since last week and he had other recent maintenance concerns with higher priority. He added that facility's communication system for work orders was effective. He had no problems staying informed regarding facility's maintenance needs. In an interview conducted on 06/24/16 at 11:50	F 253	noted during survey as being out of compliance. Repairs on these noted areas immediately took place. All noted areas were repaired and back in proper working order on 7/1/16. On 7/1/16, the facility Maintenance Director conducted an audit of sinks faucets and outlet covers within the facility . Areas identified in need of repair were corrected on 7/1/16. The facility Maintenance director will conduct an auditof sinks, faucets, and outlet covers weekly for 4 weeks. Any areas of concern will be corrected when identified. The facility staff will utilize the TELs system to notify the maintenance director when repairs are needed. The Maintenance director and or assistant will monitor the TELS system daily to identify repair needs. The Maintenance	

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F 253	Continued From page 7 AM, the Administrator stated that it was his expectation for all areas of the facility to be in appropriate repair. It was the facility's responsibility to maintain a safe/clean living environment and to ensure everything was in working/operating condition.	F 253	director will report during morning meeting at least 5 times a week, concerns that have been reported and corrected.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	The Administrator and/or the Maintenance director will analyze the audits and requests to identify patterns/trends and will adjust plan as needed and discuss during monthly QA for 3 months for continued compliance. F 278 Corrective action has been accomplished for the alleged deficient practice in regards to accurate coding of PASRR status for Resident #59. The MDS assessment dated 6/06/16, had not been transmitted, so therefore it was reopened and coded accurately to reflect a Level 2 PASSR. The MDS was transmitted to the state successfully and accepted on 6/23/16. Current facility residents have the potential to be affected by the alleged deficient practice. The MDS coordinator completed an audit on 6/23/16, for current facility residents, to validate that residents with a Level 2 PASSR were coded correctly on the MDS. Assessments identified as inaccurate were modified and transmitted to the state and accepted on 6/24/16.	7/21/16 7/21/16

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F 278	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) accurately to reflect the Level 2 Preadmission Screening and Resident Review (PASRR) status for 1 of 1 sampled resident identified as a Level 2 PASRR resident (Resident #59). The findings included: Resident #59 was admitted to the facility on 06/01/2015 with multiple diagnoses including psychosis disorder and depression. A review of Resident #59's annual Minimum Data Set (MDS) assessment dated 06/06/2016 indicated Resident #59 was not evaluated by the state Level 2 PASRR process to have a serious mental illness and/or mental retardation or a related condition in Section A. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. Review of Resident #59's medical records revealed she was admitted to the facility as a Level 2 PASRR evaluated resident. An interview was conducted with MDS Coordinator on 06/23/16 at 4:54 PM. She stated it was her mistake to not code Resident #59 as a Level 2 PASRR on the resident's annual MDS of 06/06/16. She acknowledged Resident #59 was evaluated by Level 2 PASRR prior to her admission to the facility. She stated that Level 2 PASRR usually initiated by the discharging hospital. She explained it was her carelessness that lead to the error in the resident's most recent annual MDS.	F 278	Measures put into place to ensure the alleged deficient practice does not recur include: The Social Worker or Admissions Director will notify the MDS coordinator when a resident has a Level 2 PASSR, to assure accurate coding on the MDS. The Director of Nursing (DON) will review MDS comprehensive assessments weekly for 4 weeks to validate that the MDS assessment is coded accurately to reflect the Level 2 PASSR. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 312 F 312 SS=D	Continued From page 9 483.25(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, staff interviews and review of the medical record, the facility failed to provide nail care to Resident #39 for 1 of 3 sampled residents reviewed for activities of daily living. The findings included: Resident #39 was re-admitted to the facility on 12/31/15. Diagnoses included tobacco use, diabetes mellitus type 2, general muscle weakness, cerebral infarction (stroke), left hemiparesis, and cervical cord compression with spasms. A quarterly Minimum Data Set dated 04/06/16 assessed Resident #39 with intact cognition and required extensive to total staff assistance with personal hygiene and bathing. Review of the April 2016 care plan and Kardex (documentation to nurse aides of nursing care required) revealed Resident #39 had a self-care performance deficit regarding activities of daily living (ADL) which required nursing staff to check his nail length/cleanliness and trim/clean as necessary.	F 312 F 312	**Immediate correction was achieved for the alleged deficient practice as follows:** On 6/23/2016 resident #39 finger nails were cleaned and trimmed by the certified nursing assistant. Resident was interviewed and agreed to have nail care/handwashing prior to meals and activities **In order to identify other residents who may be affected by this alleged deficient practice does not recur includes:** On 6/23/16 the nursing staff conducted an audit on current residents to ensure that residents fingernails were cleaned and trimmed. Nail care was provided for residents that were identified needing nail care. Residents will receive nail care during scheduled shower days and as requested and /or needed prior to meals and activities.	7/21/16

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F 312	Continued From page 10 Resident #39 was observed in his room and interviewed on 06/21/16 at 09:43 AM. His fingernails to both hands were observed to extend approximately one-quarter inch beyond the nail bed with brown matter underneath the fingernails of his right hand. Resident #39 stated during this observation "My fingernails need to be cleaned and trimmed, if I want it done, I have to tell them." Resident #39 was also observed with his fingernails the same length and with brown matter underneath the nails of his right hand as follows: · 06/21/16 at 8:05 PM · 06/21/16 at 9:21 PM · 06/22/16 12:49 PM · 06/22/16 4:01 PM · 06/23/16 2:40 PM · 06/23/16 2:59 PM During a follow up interview on 06/22/16 at 12:49 PM, Resident #39 stated that he wanted to have his nails cleaned, and that he did not like it when his nails were dirty. He further stated that his nails got soiled a lot because he was a smoker and that in order to have nail care provided, he had to ask. He stated "If I don't ask it doesn't get done." During an interview on 06/23/16 at 02:59 PM, Nurse Aide (NA) #1 stated that Resident #39 required extensive to total staff assistance with ADL and required nail care as needed. NA #1 further stated that whenever a resident needed nail care, it should be provided. NA #1 stated she provided morning care to Resident #39 that morning (06/23/16), but that she did not look at his nails. NA #1 stated that she was his assigned NA on 06/21/16 (Tuesday) on the 7A - 3 P shift	F 312	**Measures initiated to ensure that the alleged deficient practice does not recur include:** In- service and re-education began on 6/23/16, for the nursing Staff, by the Director of Nursing and /or Assistant Director of Nursing, regarding provision of nail care and resident has a choice and a right to have fingernails cleaned and trimmed as requested, with each bath or shower, prior to meals and activities, and as needed. Newly hired clinical staff will receive education during orientation regarding the facility's protocol on cleaning and trimming of nails. The Unit manager and the Hall nurse will observe ten residents per week x4 weeks, then 10 residents monthly for 3 months to ensure residents' fingernails are clean and trimmed.	

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F 312	Continued From page 11 and that she washed his hands during morning care that day, but because he smoked, his nails got dirty frequently. Resident #39 was observed in a bingo activity at the time of the interview and NA #1 confirmed that he had dark matter underneath the fingernails of his right hand and that his nails needed to be trimmed. NA #1 asked Resident #39 if he wanted his nails cleaned and trimmed and he stated "Yes." During an interview on 06/23/16 at 03:15 PM, the Director of Nursing (DON) stated she expected nail care to be provided to residents with showers, baths and as needed; whenever the staff saw that nail care was needed. The DON stated that she identified this problem when she came started a quality improvement plan in December 2015, conducted staff in-services on 12/03/15, conducted some random checks and some monitoring. The DON further stated that she had not conducted any monitoring of residents nails thus far in June 2016. During the interview, the DON observed the nails of Resident #39 and confirmed that he needed his nails cleaned and trimmed. The DON stated that because Resident #39 was a smoker and smoked with his right hand, he nails got dirty frequently from smoking and from putting his hands in the ashtray. During an interview on 06/23/16 at 04:36 PM NA #4 stated that she gave Resident #39 a bed bath the night before (06/22/16) but that she did not offer him nail care. NA #4 stated that she washed his hands during the care, but that she did not clean or trim nails. She further stated that nail care should be provided with showers/baths, but that she did not notice that Resident #39 nails were dirty and she did not ask him if he wanted	F 312	**Ongoing monitor implemented to ensure that the alleged deficient practice does not recur include:** The DON will review the findings of weekly monitoring by the Unit Managers and the Hall Nurses. This information will be summarized and the findings will be presented as a part of the facility's Quality Assurance meeting. This will Continue until compliance is achieved and maintained for three consecutive months.	

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F 312	Continued From page 12 nail care.	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to have an environment free of hazards by maintaining hot water temperature at 120 Fahrenheit (F) for 14 of the 33 rooms and 1 of the 1 shower room observed. (Rooms #130, #132, #133, # 134, # 135, # 136, # 137, #138, # 139, # 140, # 141, # 142, # 143, # 145, and the shower room). The findings included: On 06/21/2016 at 4:57 PM, the Maintenance Manager was conducting a routine check for residents' bathroom hot water temperature along with the surveyor. Of the 33 bathrooms being checked, the following bathrooms hot water temperatures were found to be at 120 F. (Rooms #130, #132, #133, # 134, # 135, # 136, # 137, #138, # 139, # 140, # 141, # 142, # 143, and # 145). The rest of the bathrooms were within normal limits of 105 F - 115F. Of the 1 shower room observed, the hot water temperature was also observed at 120 F. In an interview on 06/21/2016 at 5:41 PM, the Maintenance Manager stated the once daily hot	F 323	On 6/21/16, deficiency identified and addressed. Facility Maintenance Director adjusted the facility's mixing valve that controls the hot / cold water supply in the facility. On 6/21/16, Water temperatures were taken by the facility Maintenance Director to ensure the water temperatures in resident rooms and the one shower room were between 105 – 115 degrees Fahrenheit. All tested areas in compliance with our policy. The facility Maintenance Director or Maintenance Assistant will test water temperatures at least once daily, 5 times a week for one month then once daily, 5 times a week thereafter. Any areas of concern will be addressed and corrections	7/21/16

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F 323	Continued From page 13 water temperature check for residents' bathroom was normally conducted by his assistant who had been on medical leave since last week. He had worked for the facility for about 6 weeks. According to the Maintenance Manager, he had perceived that the upper limits of hot water temperature for residents' bathrooms were supposed to be at 120 F. He added that the facility had multiple water heaters; the hot water that was observed at 120 F was supplied by the same water heater. He stated that the facility used to have 2 shower rooms. Only one shower room was operating as the other was under renovation. Review of facility temperature logs for the past 6 months revealed that the above residents' bathrooms hot water was maintained at 120 F. No hot water temperature logs for shower room were available for review. On 06/21/2016 at 6:05 PM, the Maintenance Manager stated that he had adjusted the hot water temperature for the above identified bathrooms and shower room to 112 F about 15 minutes ago. On 06/21/2016 at 6:49 PM, the Maintenance Manager re-tested the hot water temperature for room #137 and the shower room. The hot water temperature for both bathrooms were at 110 F. Review of facility incident report indicated that no incidents related to hot water injuries had been reported since April 1st, 2016. An interview was conducted with the Administrator on 06/24/2016 at 11:50 AM. He stated that the hot water temperature for residents' bathroom and shower room must be consistent with the facility policy and maintained at the temperature ranges of 105 F to 115 F. He pointed out that the recent transition in maintenance department might have compromised its effectiveness.	F 323	implemented as appropriate to ensure compliance with the standard is achieved and maintained. The Maintenance director and/or the Administrator will review the results of the audits to identify patterns/ trends and will be reviewed at the monthly and quarterly QA meetings to maintain compliance.	

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F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews the facility failed to provide sufficient staff to provide assistance with personal hygiene and grooming for 2 of 3 residents (Residents #35, #23) and to respond to calls lights for 1 of 2 residents (Resident #1). Findings included: Review of the staffing sheets 05/01/2015-06/24/2016 revealed 3 evening shifts with 2 nurse aides working and 1 shift with 2.5 nurse aides working. Average census for these shifts was 60 residents.	F 353	Corrective action has been accomplished for the alleged deficient practice in regards to sufficient staffing to meet the resident needs related to provision of personal hygiene and response to call lights. A) On 6/23/2016 resident #39 finger nails were cleaned and trimmed by the certified nursing assistant .Resident #39 was interviewed and agreed to have nail care/handwashing prior to meals and activities. B) On 7/12/16 resident #23 was interviewed by his QIS Ambassador to ensure his choices are met in regards to shower / bath with frequency and time resident chooses to receive them. Staff were made aware of resident #23 choice for showers/bath and information included on shower list. C) Resident # 1 was assisted into bed by facility certified nursing assistant on 6/21/16 at approximately 9:15pm.The Administrator interviewed the resident on 7/14/16 regarding resident choice for bedtime and informed nursing staff regarding resident wishes. Current facility residents have the potential to be affected by the alleged deficient practice A) On 6/23/16 the nursing staff conducted an audit on current residents to ensure that residents' fingernails were cleaned and trimmed. Nail care was provided for residents that were identified needing nail care. Residents will receive nail care during scheduled shower days and as requested and /or needed prior to meals and activities. B) On 7/14/16, the Interdisciplinary team interviewed current alert / oriented residents to ensure that shower / bathing choices are being met. The IDT will discuss bathing/shower preferences with family members during care plan	7/21/16

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F 353	Continued From page 15 Review of Resident Council minutes dated 6/10/2016 revealed there was an occasional wait on evening shift for call bells to be answered. Residents stated the facility is "short staffed". Resident Council minutes 05/16/2016 specified call bells second shift not always answered in a timely manner. Two resident stated their showers were not given as scheduled. Resident council minutes 03/14/2016 documented 3 residents reported call lights at night not answered in timely manner. Resident Council minutes 02/08/2016 documented 2 residents that would like to get up earlier. Resident Council minutes 01/11/2016 documented that 2 residents stated they were not getting showers and 1 resident reported calls bells were not being answered in a timely manner on 1st and 2nd shift. Interview on 06/21/2016 4:45:19 PM Nurse Aide (NA) #4 stated that at times she had not been able to give residents showers because of a lack of supplies and not enough staff. She stated she had reported this to the nurse supervisor and they tell us that housekeeping has been told to leave us supplies but still it ' s not always available. Interview on 06/21/2016 8:40 PM NA #4 stated she had half of the 57 residents now. She stated that "you do the best you can do". Interview on 06/21/2016 8:35 PM a family member of Resident #1 stated that there were not enough nurse aides on evenings. Last night they were late putting her family member to bed. She stated for the past couple of months it has not been good with staffing. She stated there were a lot of staff that had quit recently. She was waiting now for her family member to be put in bed.	F 353	conference, for residents that are unable to make choices. Showers will be offered twice a week if resident/family does not request differently. C) The DON and/or the ADON provided in service education for nursing staff beginning on 6/27/16, regarding answering call lights timely to meet resident needs. Measures put into place to ensure the alleged deficient practice does not recur include: The DON and/or ADON provided in service education for the nursing staff beginning 6/27/16, regarding provision of care for dependent residents, resident choices and answering call lights. The Unit manager and the Hall nurse will observe ten residents per week x4 weeks, Then 10 residents monthly for 3 months to ensure residents' fingernails are clean and trimmed. Upon admission, residents with decisional capacity are afforded the opportunity to make the staff aware if they would prefer to have a shower or a bed bath, shift received and frequency. Upon admission, for residents without decisional capacity, the choices regarding shower / bed bath, shift received an frequency will be discussed with the responsible party .For new admissions, during the 72 hour care planning meeting, the resident's' desires for shower/ bed bath, shift received and frequency are reviewed .Residents are asked during the Facility's QIS questionnaire if they would like to make changes in their bathing or shower schedule. This information is also reviewed with resident and / or responsible party during care plan meetings. The hall nurse and the unit managers will provide the Director of Nursing and/or Assistant director daily documentation of showers/bed baths given. The IDT will conduct call light audits 3 times a week for 4 weeks, then weekly for four months to validate call lights are answered and resident needs are met.	

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F 353	Continued From page 16 Interview 06/22/2016 11:49 AM NA #5 stated she worked 3 PM to 11 PM here since April and worked every other weekend. When we have 3 nurse aides it takes longer to answer call bells, than when we have 4 NAs. We answer call bells as quickly as we can, but when we are short staffed it takes longer. She stated she has only worked once when there was only 2 NAs on 3 PM to11 PM shift. She stated she started at 6:00 PM with evening care and finished about 9:00 PM. It just takes longer. We usually have 3 NAs and sometimes 4, not as often 4, but you can get the care done with 3, residents just have to wait longer. Interview 6/22/2016 3:34 PM the Director of Nursing (DON} stated recruitment for new staff we go through corporate office for applications; post vacancies on line for positions; send to DON and I set up interviews. We were fine up to about 2 weeks ago; 4 started in orientation today; 5 nurse aides recently left, 4 on first and 2 part time on second. We post needed staff and let people sign up; 3 people out on medical leave and one on maternity leave and those on medical leave I can't fill. There was only one resident that mentioned concerns to her. She stated they try to meet his needs. Last night there were 3 up to 7:30pm and then there was one hour with just 2 nurse aides for the residents (census 57) and the wound nurse came in for the rest for the shift to help the nurse aides. Second shift this past week was most challenging. I can usually get people to stay over. Two aides had knee surgery and will be back July. I just moved one to 3rd shift from second shift and should have probably waited for the medical leave staff to come back. The nurses are more stable. I have a part time RN who fills	F 353	The Activity director will review with residents monthly during resident council meeting regarding call lights, choices and nail care and will notify the DON regarding concerns that are voiced. The HR director will monitor the applicant flow system at least 5 times a week, to identify potential nursing candidates, and will forward to the DON for potential hire. The clinical management team will continue to assist with resident care to assure continued quality of care for residents. A RN supervisor has been hired for second shift to continue to provide assistance and promote quality care for our residents. The Director of Nursing and/or Administrator will analyze audits/reviews/observations for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 353	Continued From page 17 in. I usually stay late to help in the dining room and see that things get done and I come on the weekends to help out and make sure things are ok. We have an employee meeting the first of each month on payday. My expectation is that the residents are taken care of and they can work in peace. It was the last couple of weeks the staffing got bad. I'm hiring two RNs and have two nurse aides today in orientation. I've been here 7 months and last couple of weeks has been the worst. They can sign up for overtime. A lot do it. Ideal staffing for each shift with a census of 57-60 was 1st shift 6-7 nurse aides; second shift 3-4; 3rd 2-3- most of the time we have that during the week and when we get to weekend and they work every other it ' s 2 on third. The weekend supervisors help with the activities of daily living. There are 3 nurses and a supervisor on the weekends on first shift. Second shift on the weekend there are two nurses and two nurse 7p-7am. Interview on 06/22/2016 4:06 PM Nurse #2 stated he had been here 1 month on 3 PM to 11 PM shift. The usual staffing was 1 nurse and 2 NAs. He stated he's lucky if "I have 3. I personally think we should have at least 4 NAs. Two NAs for 57 res is too heavy a work load, the residents don't get the one on one they need, a lot of the care does not get done. The NAs are rushed to give care and I know residents don't get showers, some are left wet, residents have to wait to get the care they need, we can't get them to bed timely, they have to wait. I help as much as I can by answering call bells and giving patient care, but I also have to pass meds so there is only so much I can do to help the NAs. At the end of the night the NAs are so tired, call bells go unanswered for a while. We get to call bells as quickly as we can, but they have been short a lot	F 353		

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F 353	Continued From page 18 lately and this really does impact patient care." Interview on 06/23/2016 9:00 AM NA #5 stated if it was a shower day and there were only 3 NAs working together sometimes residents didn't get showers because of the lack of time, they got bed baths. Interview on 06/23/2016 2:45 PM NA #6 stated primarily works 7 AM to 3 PM. At times she has had as many as 19 residents to care for. When she has that many, the residents have to wait longer to get the help they need, we get to them as quickly as we can, but it's hard to do everything as quickly when you have so many residents to care for, sometimes the things they want/need gets delayed. She has reported this to management and the Director of Nursing (DON) and was told "to do the best you can".	F 353		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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.	F 431	Corrective action has been accomplished for the alleged deficient practice in regards to the narcotic reconciliation form for Resident #54. The Director of Nursing validated and updated the reconciliation form with the correct amount on 6/23/16. Current facility residents have the potential to be affected by the alleged deficient practice. The Assistant Director of Nursing (ADON) conducted an audit on 6/30/16, of current facility residents receiving narcotic medication, to validate accurate documentation on the narcotic reconciliation form. No issues were identified. The DON and/or the ADON provided in-service education for the licensed nurses beginning on 6/23/16, regarding accurate documentation of narcotics on the narcotic reconciliation form.	7/21/16

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F 431	Continued From page 19 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 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 observations, record review, and staff interviews, the facility failed to accurately reconcile the dose of a narcotic medication for 1 of 3 medication storage areas (2 medication rooms and 1 medication cart). Observation of a medication cart that contained narcotics for west wing on 06/22/16 at 8:14 AM, revealed a 3-ring binder for documentation of narcotic administration was being kept on the cart. Review of the controlled drug receipt/record/disposition form for Resident #54 indicated the resident had a regularly scheduled dose of a liquid antianxiety medication every night at 9:00 PM. The five most recent documented dosages given included the following: · 06/17/16 amt. given 0.25 milliliters (ml) at 9:00PM and 5.75 ml remaining · 06/18/16 amt. given 0.25 ml at 9:00 PM and	F 431	Measures put into place to ensure the alleged deficient practice does not recur include: The DON and/or the ADON provided in-service education for the licensed nurses beginning on 6/23/16, regarding accurate documentation of narcotics on the narcotic reconciliation form. The DON and/or ADON will review5 narcotic reconciliation forms weekly for 4 weeks then 10 monthly for 3 months to validate accurate documentation. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 431	Continued From page 20 5.50 ml remaining · 06/19/16 amt. given 0.25 ml at 9:00 PM and 5.25 ml remaining · 06/20/16 amt. given 0.25 ml at 9:00 PM and 5.00 ml remaining · 06/21/16 amt. given 0.25 ml at 9:00 PM and 5.75 ml remaining During an interview with Nurse #1 (N #1) on 06/22/16 at 9:43 AM, N #1 indicated she was looking at the actual amounts of medication during reconciliation this morning. N #1 further indicated if she had seen the remaining medication amount on the controlled drug form went from 5.00 ml to 5.75 ml she would have caught this mistake. During an interview with the Director of Nursing (DON) on 06/22/16 at 10:25 AM, she stated her expectations were for the nurse administering medications to accurately document the correct dosage of the remaining medication. During an interview with Nurse #2 (N #2) on 06/22/16 at 4:06 PM, N #2 acknowledged he gave the medication on 06/21/16 at 9:00 PM but wrote down the wrong amount. N #2 stated it should have been 4.75 ml, not 5.75 ml as had been documented.	F 431		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520	F 520 Deficiency corrected Corrective action has been accomplished for the alleged deficient practice in regards to the loosened faucets, sink and loosened plastic outlet cover in rooms 136,138,139,143,118 and 120. Repairs were completed on 7/01/16. In service education was provided on 7/01/16, for the Interdisciplinary team (IDT) regarding the facility QAA program which includes developing, implementing, monitoring and maintaining interventions to promote quality of care and quality of life.	7/21/16

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 06/24/2016

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 21 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for one recited deficiency which were originally cited in May of 2015 on the recertification survey and on the current recertification survey. The deficiency was in the area of housekeeping and maintenance services. The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is cross referred to: F253: Housekeeping and Maintenance Services:	F 520	Current facility residents have the potential to be affected by the alleged deficient practice. The facility maintenance director conducted an audit of the facility on 7/01/16, to identify loose faucets, sinks and outlet covers. Repairs for identified loose sinks, faucets and outlet covers were corrected/repaired on 7/01/16. Measures put into place to ensure the alleged deficient practice does not recur include: In service education was provided on 7/01/16, for the Interdisciplinary team (IDT) regarding the facility QAA program which includes developing, implementing, monitoring and maintaining interventions to promote quality of care and quality of life. The facility Maintenance director will conduct an audit of sinks, faucets, and outlet covers weekly for 4 weeks. Any areas of concern will be corrected when identified. The facility staff will utilize the TELs system to notify the maintenance director when repairs are needed. The Maintenance director and or assistant will monitor the TELS system daily to identify repair needs. The Maintenance director will report during morning meeting at least 5 times a week, concerns that have been reported and corrected. The facility will diligently follow the facility's policy and procedure of the QA process to prevent a repeat deficiency from reoccurring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 22 Based on observations, staff and resident interviews the facility failed to repair loosened faucets in 6 of 25 bathrooms, failed to repair loosened ceramic sink that was separated from the wall in 1 of 25 bathrooms, and failed to repair a loosened plastic outlet cover in 1 of 25 bathrooms. During the previous recertification survey of May 2015 the facility failed to keep a resident room and hallway free from strong urine odors. The facility was recited during the recertification and complaint survey of June 24, 2016 for F 253 for failing to repair loosened faucets, a loosened sink separated from the wall and repair a loosened plastic outlet cover in a resident bathrooms. During an interview on 06/24/2016 at 4:00 PM the Administrator stated they have routine Quality Assessment (QA) form. Any incident or accident that they have a concern with that could be focus for the state or facility was addressed and a plan was developed. They do audits and review results in monthly QA meetings. He stated there was no excuse to for a repeat deficiency but the cites addressed different areas of the regulation, an odor and mechanical equipment and the faucets. He stated he was not the administrator last year. It will be a focus of the QA committee and they will address the deficiencies. They will make plans for each and follow up with audits. The audits depend on what the issue concerns. They do routine rounds of facility and document concerns. They replace and/or repair what was needed. They will do daily audits and reduce the number of audits over time. They will take the results of the audits to the QAA committee to discuss and evaluate the results, and revise the plan as needed.	F 520	The Administrator and/or the Maintenance director will analyze the audits and requests to identify patterns/trends and will adjust plan as needed and discuss during monthly QA for 3 months for continued compliance.	