| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| AVANTE AT CHARLOTTE | 4801 RANDOLPH RD CHARLOTTE, NC 28211 |

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| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT *is not met as evidenced* by:<br>Based on observations, record review and staff interviews the facility staff failed to turn and reposition a resident with a stage 3 pressure ulcer on her coccyx in one (1) of three (3) sampled residents. Resident (#159)<br><br>The findings are:<br><br>A review of an undated facility document titled "Turn Clock" revealed a schedule for resident positioning and turning. The document stated from 12-2 AM/PM resident should be positioned on their back; from 2-4 AM/PM resident should be positioned on their right (R) side; from 4-6 AM/PM resident should be on their left (L) side; from 6-8 AM/PM resident should be positioned on their back; from 8-10 AM/PM resident should be positioned on their right (R) side and from 10-12 AM/PM the resident should be positioned on their left (L) side.<br><br>Resident #159 was re-admitted to the facility on 8/26/11 with diagnoses including a stroke, | F 314 | 1. Deficiency corrected. The resident was repositioned.<br>2. All CNA's were in-serviced on turning and repositioning.<br>3. Nursing administration (or designee) will randomly spot-check the turning and repositioning of at least three residents weekly. Any areas of concern will be addressed and corrections implemented as appropriate to ensure compliance is achieved.<br>4. The trends and results from the audits will be reviewed at the monthly Quality Assurance Committee Meeting to maintain compliance and evaluate effectiveness for at least a three month period of time until the requirements of #3 are met.<br><br>RECEIVED<br>SEP 13 2011<br>BY: | SEP 30 2011 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Abbott — TITLE: Administrator — (X6) DATE: 9/12/11

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 314 | Continued From page 1<br>diabetes, urinary tract infection, methicillin-resistant Staphylococcus aureus (MRSA), Clostridium Difficile colitis (C-Diff colitis) and a stage 3 sacral decubitus ulcer.<br><br>The initial admission Minimum Data Set (MDS) dated 8/19/11 indicated severe impairment in short and long term memory and severe impairment in cognition for daily decision making. The resident was totally dependent on staff for turning and positioning and activities of daily living.<br><br>A review of a plan of care dated 8/26/11 revealed a problem for alteration in skin related to moisture and incontinence, decreased activity, impaired mobility and nutritional risk. The goals stated pressure ulcer will show signs of healing and pressure ulcer risk will be minimized with interventions listed in part to turn and reposition resident every two (2) hours.<br><br>A review of a physician's order dated 8/29/11 stated to cleanse wound to coccyx with normal saline, apply Santyl ointment to area, cover with moistened saline gauze then apply a retention dressing. Change daily and as needed if excessive drainage.<br><br>A review of a skin condition assessment dated 8/26/11 revealed an open area stage 3 with some necrotic areas on the resident's coccyx.<br><br>A review of a kardex on 8/31/11 at 4:46 PM indicated resident was incontinent of bowel and bladder, skin care to coccyx and turn every two (2) hours. | F 314 | | |

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| F 314 | Continued From page 2<br>During continuous observations on 9/1/11 from 8:15 AM until 10:36 AM Resident #159 was observed lying on her back in bed and with her head turned slightly to her left and the head of her bed was elevated approximately 45 degrees. Both side rails were down and an air mattress was on her bed at a normal pressure setting. A medication nurse was observed further down the hallway at a medication cart but no staff was observed entering the resident's room during the continuous observations.<br><br>On 9/1/11 at 10:47 AM Licensed Nurse (LN) #4 entered the resident's room with medications in her hand.<br><br>On 9/1/11 at 11:15 AM Nurse Aide (NA) #2 entered the resident's room with towels and washcloths in her hands.<br><br>During an interview on 8/31/11 at 4:44 PM with NA #3 he stated he was aware the resident had a wound and they turned her every two (2) hours when she was in bed. He explained the nurse aides go to the kardex at the nurse's station to find out what care they should provide to each resident.<br><br>During an interview on 8/31/11 at 4:48 PM with LN #4 she confirmed a kardex was located at the nurse's station and the nurse aides should look at it to provide care specific to each resident and if they required to be turned and repositioned on a schedule.<br><br>During an interview with NA #2 on 9/1/11 at 11:42 AM she stated she had been very busy this morning and was working her way up the hall | F 314 | | |

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| F 314 | Continued From page 3<br>bathing and assisting other resident's with their morning care. She explained she was behind with her morning work schedule and she was aware the resident was supposed to be turned every two (2) hours but she had been trying to catch up and had not gotten to the resident yet. She further verified she was assigned to the resident's care this morning but she had not turned or repositioned resident this morning prior to entering her room at 11:15 AM.<br><br>During an interview on 9/1/11 at 2:28 PM with LN #4 she stated she turned the resident to her right (R) side when she entered her room this morning and gave her medications at 10:47 AM. She explained staff was supposed to use the Turn Clock as the turning schedule so that the resident was turned and repositioned every two hours. She verified a copy of the turning schedule was located in the medication administration record on the medication cart for the nurses to use and the nurse aides could get a smaller copy from the wound care nurse to carry with them. LN # 4 verified the Turn Clock indicated the resident should have been on her right side between 8-10 am instead of on her back or left (L) side. LN # 4 further stated she thought the nurse aides used the turn clock schedule but was not sure.<br><br>During an interview with LN #1 on 9/1/11 at 3:22 PM she stated the nurse Aides were supposed to turn the resident every two hours. She also verified the Turn Clock was supposed to be used by staff as the turning schedule. She stated it was her expectation that staff should have turned the resident every two (2) hours according to the schedule. | F 314 | | |

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| F 314 | Continued From page 4<br>During an interview on 9/1/11 at 3:47 PM with the Director of Nurses (DON) she stated it was her expectation that any resident who had a pressure ulcer should be turned and repositioned to keep them off the area. She stated resident's who have bony prominence's may need to be turned more frequently than every two hours but they should be turned and repositioned at a minimum of every two (2) hours. | F 314 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to implement a system to identify expired milkshakes and facility staff failed to secure an open bag of bologna stored in the freezer.<br><br>The findings are:<br><br>1. During the initial tour of the kitchen on 8/29/11 at 9:58 AM two (2) cardboard boxes of Mighty Shakes were observed on the shelves in the walk in cooler. According to manufacturer's recommendations they indicated that once the | F 371 | 1. Deficiency corrected. The Dining Services Manager immediately discarded all nourishments without an individual expiration date, as well as the unsecured bag of bologna.<br>2. All dining services personnel will be in-serviced on the labeling of expiration dates on nourishments and the appropriate storage of frozen foods.<br>3. The Dining Services Manager (or his designee) will audit the expiration dates of at least five nourishments at least one day/week. Also, the Dining Services Manager (or his designee) will audit the storage of all frozen foods at least one day/week. Any areas of concern will be addressed and corrections implemented as appropriate to ensure compliance is achieved.<br>4. The trends and results from the audits will be reviewed at the monthly Quality Assurance Committee Meeting to maintain compliance and evaluate effectiveness for at least a three month period of time until the requirements of #3 are met. | SEP 30 2011 |

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| F 371 | Continued From page 5 | F 371 | | |

milkshakes were thawed, they were good for fourteen (14) days. The individual cartons of Mighty Shakes stored for use did not indicate when they expired and/or when they had been thawed.

During an observation at the west wing nursing station on 8/29/11 at 10:10 AM, two (2) individual cartons of Mighty Shakes were sitting on the counter. Each carton was labeled with a resident name, room number and was dated 8/29/11.

During an observation on 9/1/11 at 10:10 AM one (1) individual carton of Mighty Shakes was delivered by dietary staffon to the west wing nursing station. The carton had a label on the outside with a resident's name, room number and was dated 9/1/11.

During an interview on 8/29/11 at 9:59 AM with the Dietary Manager (DM) he stated the dietary staff put labels on the outside of the Mighty Shakes with the resident name, room number and the date the Mighty Shake was to be delivered to the resident. He further confirmed the individual cartons of Mighty Shakes were not labeled with an expiration date.

During an interview on 9/1/11 at 10:02 AM with Licensed Nurse (LN) # 7 she stated she thought there was an expiration date under the label with the resident ' s name and room number. She removed the label and stated she could not find an expiration date on the carton.

During an interview on 9/1/11 at 10:15 AM with Nurse Aide (NA) #4 he stated he was not sure what the expiration date was on the carton of

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| F 371 | Continued From page 6<br>Mighty Shakes but he thought it might be the date printed on the label with the resident's name and room number.<br><br>During an interview on 9/1/11 at 1:50 PM the Dietary Manager stated he was aware of the manufacturer's recommendations that Mighty Shakes expire fourteen (14) days after they were removed from the freezer and they should be labeled so that staff know what date they expire. He stated it was his expectaion that staff should discard the Mighty Shakes if they had expired.<br><br>2. During the initial tour of the kitchen on 8/29/11 at 8:23 AM a cardboard box was observed sitting on a shelf in the freezer with ice crystals on top and the top flaps loosely closed. The box contained a plastic bag of frozen bologna and was open to air.<br><br>During an interview on 8/29/11 at 8:42 AM with the Dietary Manager (DM) he stated the bologna was used this past weekend and was used routinely for residents who requested sandwiches. He further stated the bologna would have been served later today for any resident who requested it. He stated that it was his expectation that staff should have sealed the plastic bag containing the bologna after it was used and it should have not been left open to air. | F 371 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS | F 441 | | |

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| F 441 | Continued From page 7<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | 1. Deficiency corrected. The resident's room was disinfected. The urinary catheter bag was repositioned.<br>2. All CNA's will be in-serviced on how to appropriately doff gloves after providing incontinent care. All nursing staff will be in-serviced on how to appropriately position urinary catheter bags.<br>3. Nursing management (or designee) will be responsible for at least three observations per week of the gloving techniques of CNA's after providing incontinent care. Nursing management (or designee) will be responsible for at least three random spot-checks of the placement of catheter bags weekly. Any areas of concern will be addressed and corrections implemented as appropriate to ensure compliance is achieved.<br>4. The trends and results from the audits will be reviewed at the monthly Quality Assurance Committee Meeting to maintain compliance and evaluate effectiveness for at least a three month period of time until the requirements of #3 are met. | SEP 30 2011 |

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| F 441 | Continued From page 8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review, the facility failed to remove gloves after providing incontinent care for one (1) of three (3) sampled residents (Resident #159) and failed to position a urinary catheter bag off the floor for one (1) of the three (3) residents with indwelling urinary catheters (Resident #42).<br><br>The findings are:<br><br>A review of a facility policy titled "Personal Protective Equipment - Using Gloves" and dated June 2005 stated to use gloves to prevent the spread of infection. The policy further stated to remove gloves before removing the mask and gown and discard them into the designated waste receptacle inside the room.<br><br>A review of an undated facility procedure titled "Perineal Care" stated to remove disposable gloves, discard into designated container and wash hands after the completion of incontinence care.<br><br>1. Resident #159 was re-admitted to the facility on 8/26/11 with diagnoses including a stroke, diabetes, urinary tract infection, methicillin-resistant Staphylococcus aureus (MRSA), Clostridium Difficile colitis (C-Diff colitis) and a stage III sacral decubitus ulcer.<br><br>The initial admission Minimum Data Set (MDS) dated 8/19/11 indicated severe impairment in short and long term memory and severe impairment in cognition for daily decision making. The resident was totally dependent on staff for | F 441 | | |

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| F 441 | Continued From page 9 | F 441 | | |

activities of daily living and was always incontinent of bladder and bowel.

A review of monthly physician's orders dated 8/26/11 through 8/31/11 revealed orders for C-Diff precautions.

During an observation of incontinence care on 9/1/11 at 11:25 AM Nurse Aide (NA) #2 entered the resident's room, washed her hands, and put on a gown and gloves. NA #2 bathed the resident's upper body and then opened the resident's brief that was saturated with urine and stool. A dressing on the resident's coccyx was partially off the skin and stool was inside the dressing and on the open wound. A pad underneath the resident was also saturated with a yellow/brown substance and the bottom sheet on the bed had a large wet ring under the resident. NA #2 cleaned the resident and with her soiled gloves still on, placed the soiled linens in one plastic bag and trash into a second trash bag. NA #2 still with her soiled gloves still on put clean clothes on the resident, opened the door to the bathroom and carried the resident's bath basin inside to empty it in the sink and rinse it out. NA #2 came back out of the bathroom, touched the resident's overbed table, picked up a roll of plastic bags and took one bag off the roll to put the resident's bath basin inside. She then went into the bathroom with her soiled gloves still on and removed her gown and gloves and washed her hands.

During an interview on 9/1/11 at 11:42 AM with NA #2 she stated should have changed her gloves after handling soiled linens and before she touched any other items in the resident's room

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| F 441 | Continued From page 10<br>but she just forgot to do it.<br><br>During an interview on 9/1/11 at 3:22 PM with Licensed Nurse (LN) #1 she stated it was her expectation that staff were supposed to change their gloves when they were soiled during incontinence care and after incontinence care was completed.<br><br>During an interview on 9/1/11 at 3:47 PM with the Director of Nurses (DON) she stated it was her expectation that once gloves were soiled during incontinence care the staff should go ahead and change them. She further stated staff should not touch clean surfaces in the resident's room with their soiled gloves still on.<br><br>2. Resident #42 was readmitted to the facility on 5/31/11 with diagnoses which included a Stage 3 pressure ulcer and suprapubic catheter secondary to urethral stricture. Resident #42's most recent quarterly Minimum Data Set dated 8/1/11 listed an indwelling catheter. The care plan dated 6/23/11 documented a risk for urinary tract infections related to bowel incontinence and presence of the suprapubic catheter. There were no specific documented interventions related to the catheter.<br><br>Review of the facility's undated Infection Control Procedures for catheter bags revealed tubing and | F 441 | | |

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| F 441 | Continued From page 11<br>catheter bags were to be off the floor.<br><br>Observations revealed Resident #42 in a low bed with the catheter bag with privacy cover on the floor on 8/29/11 at 11:58 AM and 12:25 PM; on 8/30/11 at 8:40 AM and 10:30 AM and on 8/31/11 at 8:54 AM and 9:29 AM.<br><br>Further observation on 8/31/11 at 9:34 AM revealed Nursing Assistant (NA) #1 raised Resident #42's bed to give a bed bath. The catheter bag was off the floor during the bed bath. NA #1 lowered the bed to the lowest position and left the room at 10:12 AM with the catheter bag on the floor.<br><br>Interview on 8/31/11 at 10:20 AM with NA #1 revealed Resident #42's catheter bag should not be on the floor. NA #1 explained Resident #42's low bed caused the catheter bag to be on the floor. NA #1 reported the catheter bag could not be raised off the floor. NA #1 attempted unsuccessfully to adjust the catheter bag off of the floor.<br><br>Interview on 8/31/11 at 10:20 AM with Licensed Nurse (LN) #5 revealed catheter bags were to be off the floor. Upon observation of Resident #42's catheter bag on the floor, LN #5 adjusted the straps, lifted the mattress and inserted the straps through a slit on the bed frame. The catheter bag lifted off the floor. LN #5 reported she did not notice the catheter bag placement when she gave medications and made nursing rounds.<br><br>Interview on 8/31/11 at 10:28 am with LN #1, nursing supervisor, revealed the catheter bag should be off the floor. She explained the low | F 441 | | |

| 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 _____ | 09/02/2011 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 441 | Continued From page 12<br>bed frame contained slits for catheter bag adjustment.<br><br>Interview on 8/31/11 at 12:40 PM with the Director of Nursing (DON) revealed she expected catheter bags to be off the floor. Upon observation of the bag and tubing on the floor during this interview, the DON indicated the catheter bag on the floor was not correct. | F 441 | | |