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 11/13/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	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 staff interview, review of facility records and the medical record, the facility failed to implement interventions per the care plan for 1 of 3 sampled residents reviewed for fall risks. (Resident #1) The findings included: Resident #1 was admitted to the facility 09/4/13 from the hospital. Diagnoses included Parkinson's disease, syncope and collapse, Orthostatic hypertension, dementia, abnormal gait and contusion of knee. A care plan dated 09/4/13 recorded Resident #1 was at high risk for falls due to a history of falls, hypotensive episodes, decreased balance and ability to transfer and gait problems. The goal of the care plan was to minimize the Resident's risk from falls and fall related injuries with interventions which included ensure appropriate footwear is worn when ambulating or mobilizing in wheel chair and observe for unsafe actions and intervene. An admission minimum data set dated 09/11/13	F 323	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 D.F.R. 405.1907_____ F323 1. Resident #1 discharged 10/11/13 home with family. 2. Director of Nursing and/or Unit Supervisors completed an audit of all ambulatory residents care planned to insure that measurable objectives and individualized interventions to minimize residents at risk for falls and fall related injuries are in place. The audit was completed and showed care plans were appropriate and	12/6/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy S Oetsinger — TITLE: Administrator — (X6) DATE: 12/6/13

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.

Black Mountain DHSR Received DEC 09 2013 by: PAM

original signature 12-3-13 mh

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F 323	Continued From page 1 assessed Resident #1 with mildly impaired cognition, requiring limited assistance with locomotion on the unit and sustaining a fall in the last 30 days. Fall risk screens dated 09/04/13, 09/12/13 and 09/18/13 assessed Resident #1 at moderate risk for falls due to a history of falls, required assistance with toileting and predisposing diseases. Nurse progress notes from 09/15/13 to 09/29/13 documented Resident #1 was observed by staff to ambulate independently in her room and in the hallway without staff assistance. The nurse progress notes described Resident #1 with slow but steady gait and non-compliant with the use of a walker/cane when ambulating in her room. Review of the incident report dated 09/29/13 revealed Resident #1 was found on the floor at 08:30 AM on 09/29/13 on her left side next to her bed. Resident #1 sustained a skin tear to her left wrist. The incident report recorded that Resident #1 was not wearing footwear at the time of fall. The incident report also indicated that Resident #1 was observed at 08:28 AM in her room seated calmly on her bed in it's lowest position. An X-ray of her wrist was ordered and completed on 09/30/13 and was negative for a fracture. An interview with nursing assistant #1 (NA #1) occurred on 11/13/13 at 3:22 PM. NA #1 stated that Resident #1 was confused at times, was at risk for falls and required frequent reminders to use her call bell, sit down or use her walker when she was in her room. NA #1 stated she often observed Resident #1 ambulate in her room by herself. On 09/30/13 NA #1 observed Resident	F 323	accurate. No other corrective action was needed. Completion Date 12/6/13. 3. Director of Nursing and/or Unit Supervisors in-serviced all staff on the 4P's regarding positioning, personal needs, pain, and placement. The DON and/or Unit Supervisors also in-serviced staff on review of all Residents' care plans and insure all interventions are in place when providing care to residents. Completion Date 12/6/13. 4. Director of Nursing and/or Unit Supervisors will conduct 3 random audits per week of the care plans to validate interventions on care plans are in place. 3 audits per week x 3 months and then results of audits will be reviewed for any trends and recommendations during Quality Assurance Committee meetings.	12/6/13

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F 323	Continued From page 2 #1 in her room at 07:15 AM, 08:28 AM and 08:30 AM dressed and wearing knee high stockings without shoes. NA #1 stated she did not offer to assist Resident #1 with putting on her shoes that morning, because she did not think the Resident would get up from her bed. NA #1 heard Resident #1 scream around 08:30 AM on 09/30/13 and found her on the floor next to her bed. Interview with NA #2 occurred on 11/13/13 at 3:44 PM. NA #2 stated that Resident #1 was at risk for falls and wore tennis shoes because it was safer for the Resident to have on shoes. Staff had to assist Resident #1 with putting on and tying her shoes. NA #1 also stated that at times Resident #1 required frequent monitoring because she would often ambulate slowly in her room independently. An interview with nurse #1 occurred on 11/13/13 at 4:22 PM and revealed Resident #1 was confused at times and required reminders to user her call bell to ask staff for assistance. At times Resident #1 was observed to toilet herself without staff assistance. Staff monitored her frequently because she walked around her room alone. Nurse #1 stated staff had to ensure she wore appropriate footwear, non-skid socks or non-slip shoes, for her safety. Nurse #1 stated on 09/30/13 Resident #1 sustained a fall in her room. The Resident said her feet got tangled up. Nurse #1 stated Resident #1 was not wearing appropriate footwear at the time of the fall. An interview with the director of nursing (DoN) occurred on 11/13/13 at 5:30 PM. The interview revealed that Resident #1 had a previous admission to the facility in which the Resident used her call bell, so staff had the same	F 323		

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F 323	Continued From page 3 expectation that during this readmission Resident #1 would use her call bell for assistance. The DoN stated in hindsight there were things staff could have done differently, but at the time of her fall, staff did not anticipate that Resident #1 would attempt to ambulate without assistance.	F 323		