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 _____	12/19/2013

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 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 observations, resident interviews (Residents #108 and 142), interview with a contracted plumber, staff interviews and review of facility records/policy, the facility failed to use an infrared thermometer per manufacturer's instructions, for approximately 30 days, to identify unsafe water temperatures in 9 of 20 sampled resident bathrooms that exceeded 116 degrees Fahrenheit (Rooms 132, 130, 133, 135, 144, 154, 157, 118 and 115). The findings included: Review of the facility policy, undated "Water Temps: Test and log the hot water temperatures" recorded in part, "Ensure patient room water temperatures are between 105 degrees and 115 degrees Fahrenheit (or as specified by state requirements)." Review of the manufacturer guide on the facility's gun-style infrared thermometer read in part that the distance-to-spot ratio for the infrared thermometer was 8:1 (one inch from the water source would provide the temperature of up to an eight inch circumference).	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 Deficiency Corrected 1. Upon notification of alleged water termperature concern, the plumber was contacted and all rooms were checked for compliance. The mixing valve was adjusted and rooms 132, 130, 133, 135, 144, 154, 157, 118, and 115 were in compliance with company policy and state regulations. 2. Temperatures were taken throughout the night by the Interim Maintenance Director/Plumber/Unit Nurses with no further issues and documented. 3. To further insure consistent appropriate water temperature, the mixing valve	12/23/13

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

Electronically Signed | 01/15/2014

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F 323	Continued From page 1 During an initial facility tour on 12/16/13 the hot water at the sink in resident bathrooms was identified too hot to touch after approximately 3 to 5 seconds. The surveyor's thermometer was used and identified the following: · 3:20 PM, room 132, hot water was 121.2 degrees Fahrenheit (° F) · 3:39 PM, room 130, hot water was 120.5° F · 4:04 PM, room 133, hot water was 120.8° F · 4:13 PM, room 135, hot water was 121.4° F · 4:36 PM, room 144, hot water was 118.0° F · 4:41 PM, room 154, hot water was 120.7° F · 4:47 PM, room 157, hot water was 118.3° F · 4:53 PM, room 118, hot water was 118.7° F · 5:00 PM, room 115, hot water was 118.3° F Resident #108, identified as alert and oriented, stated in an interview on 12/16/13 at 4:30 PM that the water at the sink in the bathroom (room 132) did run hot and required the addition of cold water to get the water to a comfortable temperature. Resident #108 had not reported this to staff. An interview with the interim maintenance director (IMD) on 12/16/13 at 4:39 PM revealed he served in this role for the past week since the previous maintenance director left the position on 12/11/13. The IMD said he was responsible for monitoring water temperatures; the facility had two hot water tanks which supplied water to resident bathrooms, shower rooms and the kitchen. He further stated that there was one mixing valve which mixed water between the pipes for both tanks. The IMD stated he monitored water temperatures twice weekly, routinely between 08:00 - 09:00 AM by checking the water temperatures of each water tank, mixing valve, kitchen (dish machine and sinks),	F 323	cartridge was cleaned and rebuilt with new gasket and washers. After installation of rebuilt cartridge, hot water was turned on in 8 resident rooms. This gave a draw to the mixing valve enabling accurate setting of the temperature. Completion Date 12-23-13. 4. To further aid in the prevention of the occurrences of the alleged deficiency, water temps will be checked by the Maintenance Director and/or Assistant Maintenance Director in 5 random rooms on a daily basis during the week. On weekends, the temperature will be checked by a Charge Nurse in 5 random rooms. Additionally the mixing valve will be put on a routine preventative maintenance plan which will consist of quarterly cleaning and rebuilding of the cartridge. Any trends will be reporte to the Quality Assurance Committee for 3 months and at random intervals thereafter.	

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six resident rooms (three rooms on each side of the facility) and two shower rooms. He stated he adjusted the mixing valve water temperature as needed to keep the water in resident bathrooms and shower rooms between 106 - 111°F. He stated that he last checked water temperatures on 12/09/13 and found water temperatures in resident rooms and shower rooms ranged between 106 - 111°F. The IMD stated he currently used a gun-style infrared thermometer for temperature monitoring as instructed by the prior maintenance director since about a month ago. He also stated he had not received training on how to use this thermometer, he did not have manufacturer instructions regarding its use and he was unaware of the distance-to-spot ratio when using the infrared thermometer.

Review of temperature logs with the IMD revealed documentation of temperature monitoring for 12/9/13 (ranged 106-111°F), no documentation for November 2013 and daily monitoring for October 2013 (no concerns were noted). There was no further documentation available for review of facility water temperature monitoring. The IMD stated he could not locate any further documentation of temperature monitoring because the prior maintenance director documented water temperatures using a personal computer and took this computer with him, thus the water temperatures were no longer available to the facility.

Resident #142, identified as alert and oriented, stated in an interview on 12/16/13 at 4:41 PM that when she washed her hands at the bathroom sink (room 154) she added cold water at times

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because the hot water was too hot. Resident #142 had not reported this to staff.

Observation of water temperature monitoring by the IMD occurred on 12/16/13. The IMD was initially observed to use a gun-style infrared thermometer held approximately 13.5 inches away from the water source (identified as his routine practice). Additionally, a digital thermometer held directly in the water stream (for a check) was used, but was not the routine practice. On 12/16/13 at 5:45 PM, the gun-style infrared thermometer revealed a temperature of 30°F when held approximately one inch from an ice/water bath and a fluctuating temperature of 35-37°F when held approximately 13.5 inches away from the ice/water bath. The IMD was unaware if the infrared thermometer could be adjusted with calibration to 32°F. The digital thermometer revealed a temperature of 32°F when placed in an ice/water bath. The following rooms were identified with temperatures above 116°F during the IMD water temperature monitoring:

· 5:04 PM, room 157, infrared thermometer (13.5 inches away) - 114°F; digital (in water stream) - 119.8°F; 5:59 PM (second check) infrared thermometer (1 inch away) - 124.5°F; digital (in water stream) - 122.6°F
· 5:07 PM, room 154, infrared - 122°F; digital - 123.5°F; 6:00 PM infrared 129°F, digital 121°F
· 5:10 PM, room 147, infrared - 113°F; digital - 121.5°F; 6:03 PM infrared 113°F, digital 118.8°F
· 5:15 PM, room 135, infrared 108°F; digital 119.2°F; 6:10 PM infrared 112°F, digital 117.4°F
· 5:23 PM, room 132, infrared 111°F, digital 116.8°F; 6:16 PM infrared 105, digital 112°F

An interview with the administrator on 12/16/13 at

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7:16 PM revealed she was unaware of any current problems with water temperatures. She stated that the facility's prior practice was daily water temperature monitoring until the previous maintenance director came on board at which time he advised the current IMD to conduct water temperature monitoring twice weekly. The administrator stated she was aware when this practice changed, but her expectation and that of the corporate office, was daily water temperature monitoring. The administrator also stated that she was aware that a gun-style infrared thermometer was being used for water temperature monitoring, but was unaware of the correct technique. The administrator further stated she was informed by the corporate office that the gun-style infrared thermometer was not a corporate approved thermometer for facility water temperature checks due to the ambient temperatures that affected its accuracy. The administrator also stated there was no additional documentation of water temperatures available for review, as the previous maintenance director took the computer documentation with him when he left. Additionally, the administrator stated that she has contacted a plumber to check the water temperatures and that water temperatures would be monitored throughout the night before any residents received a bath the next morning.

An interview with the facility's contracted plumber occurred on 12/16/13 at 8:33 PM and revealed that he installed a mixing valve in the facility about 18 months ago and the mixing valve cartridge was last changed in August 2013. He stated the valve cartridge should be changed every 60-90 days due to calcium build-up and to maintain the effectiveness of the mixing valve. He also stated that a periodic increase in water

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F 323	Continued From page 5 temperatures would occur when water was being used in more that one location in the facility and could remain high if a valve (swinging valve) in one of the pipes was stuck. During this interview the IMD was present and stated he was aware that the valve cartridge in the mixing valve required replacing every 60-90 days, but he had not made this repair yet as he had only been in the role of IMD for the about 1 week.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and physician interview, the facility failed to implement planned interventions to prevent weight loss for 1 of 5 residents (Resident #91). Findings included: Resident #91 was admitted to the facility on 03/15/12 with diagnoses including a history of cerebrovascular disease with hemiplegia,	F 325	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 conslusions 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 _____	12/19/13

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F 325	Continued From page 6 dementia and a stage 4 pressure ulcer to his coccyx. The most recent Minimum Data Set (MDS) dated 10/23/13 documented the Resident with severely impaired cognition for daily decision making and requiring total assistance for all activities of daily living including 1 person assistance for eating. The MDS noted his height as 64 inches and his weight as 94 pounds (lbs.) with a nutritional approach of a mechanically altered diet. Review of Resident #91's care plan, revised on 12/16/13, revealed the presence of a coccyx wound with interventions including educating the family on the importance of good nutrition. Another problem noted the Resident receiving a mechanically altered diet with interventions including monitoring of weights, serving the diet as ordered, staff assistance with feeding and the registered dietician (RD) evaluating and making diet change recommendations as needed. Review of Resident #91's medical record revealed an order dated 01/03/13 to add large portions to his diet secondary to weight loss. A review of weights taken for Resident #91 revealed his weight to be 102.2 lbs. on 06/21/13. Another diet order dated 06/28/13 directed a pureed diet. Another diet order dated 07/09/13 directed restorative aides to feed the Resident. Review of an RD note dated 08/29/13 and 09/19/13 revealed a recommendation to continue the Resident's ordered diet and other nutritional interventions due to a low body mass index (BMI) of 17.5 and for wound healing. Another RD note dated 10/04/13 revealed a weekly weight of 98.6 lbs. with no significant weight change noted, meal intake of 75 to 100% of large portion meals, meal	F 325	F325 Deficiency Corrected 1. Resident #91 was immediately given additional pureed food based on diet order and tray ticket. 2. Dietary Manager conducted an audit of all tray tickets for diet orders that read large portions. The audit was completed and showed all tray cards were appropriate and accurate. No other corrective action was needed. Completion Date 12/19/13. 3. Dietary Manager in serviced all dietary staff and dining room personnel to read tray cards accordingly, follow menu extension pertaining to portion sizes and a portion control chart was implemented. Completion Date 12/19/13. 4. Dietary Manager and/or Designee will conduct one random tray audit 1 time a week for 4 weeks to insure trays match tray cards and report results to Quality Assurance Committee for 3 months and then results of audits will be reviewed for any trends and recommendations during Quality Assurance Committee meetings for 3 months and then randomly thereafter.	

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intake adequate to meet his needs and to continue the ordered diet and nutritional interventions to promote weight gain and wound healing. A weekly weight meeting note dated 12/09/13 revealed the Resident's weight to be 95 lbs., down 0.4 lbs. in 7 days, meal intake of 75 to 100% and being fed by staff. Review of meal intake records from 11/19/13 to 12/17/13 revealed Resident #91 eating 75 to 100% of all meals.

Upon review of Resident #91's weights for the period 06/21/13 to 12/6/13, the Resident's weight loss was calculated at 7.2 lbs. or a 7% loss.

On 12/18/13 at 1:29 PM, Resident #91 was observed seated in a gerichair in the main dining room. A plate of food was observed next him with one scoop of pureed cheeseburger, one scoop of mashed potato and one scoop of pureed green beans. Review of the tray card next to the plate with the Resident ' s name revealed the phrase "large portions" in the note section. Dietary Aide (DA) #1 was observed plating food at the steam table in the main dining room.

On 12/18/13 at 1:29 PM, DA #1 was interviewed. When asked to plate large portions of a pureed diet, DA #1 replied there was no more pureed food on the steam table but stated it would be two scoops of each food item on the menu. DA #1 was asked to inspect the plate of food served to Resident #91 and she replied that it was not large portions. DA #1 stated the Resident did not eat all that much. DA #1 was asked to inspect the tray card with the Resident's name and she replied it stated large portions.

On 12/18/13 at 1:30 PM, the Dietary Manager (DM) was asked to inspect Resident #91's lunch

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plate in the main dining room. He replied the plate did not have large portions and the tray card documented large portions. He stated two scoops of each food item would be an acceptable serving size for large portions. The DM stated the DA plating food at the steam table was not qualified to determine portion size based on past observations of meal intake, but DAs were expected to provide the portion as ordered and noted on the tray card.

On 12/18/13 at 2:35 PM, Resident #91 was observed in his room being weighed with a lift scale by NA#1 and NA#2, with the first shift nursing supervisor (Nurse #1) present. After the scale was zeroed and the sling attached to the scale, the Resident was raised off his gerichair and was free hanging without any contact with other objects. The digital screen of the lift scale read 80.4 lbs. Resident #91 was placed in bed by NA #1 and NA #2. The percentage of weight loss from the weight of 95 lbs., documented on 12/06/13, to the weight of 80.4 lbs. during this observation was calculated at 15.37% loss.

On 12/18/13 at 2:40 PM Nurse #1 was interviewed. She stated the weight obtained was accurate and significant, which would be communicated to the physician and the RD.

On 12/18/13 at 4:00 PM the RD was interviewed. She stated she wrote orders for diets and Resident #91's portions were increased due to increasing appetite need for additional calories. The RD stated she would never put anyone on large portions if they were not eating well. She stated her next step would be to make sure dietary staff was serving food correctly and follow up on his most recent weight.

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F 325	Continued From page 9 On 12/19/13 at 8:31 AM the wound treatment nurse (Nurse #2) was interviewed. Nurse #2 stated in the past Resident #91 had a weight loss issue and the weight loss team decided to place him on restorative dining. She stated the Resident has end stage dementia with muscle wasting and a family member reported to her the Resident's overall decline in the past two years. Nurse #2 stated the Resident's weight on 12/18/13 surprised her and weight loss was significant for someone with a stage 4 pressure ulcer. On 12/19/13 at 9:11 AM NA #2 was interviewed. She stated familiarity with Resident #91's care needs and his need for assistance with feeding. She stated he ate real well, usually 100% of his meals. She stated the portions usually served to Resident #91 at meals looked like one scoop of each pureed item and she had not noticed any additional scoops of food or bowls on his tray. On 12/19/13 at 12:36 PM the physician was interviewed by phone. He stated ordering large portions for a resident may work as a nutritional intervention if they were eating well and the larger portions should be offered with each meal. The physician stated weight loss in a resident was not always very clear if due to illness or an infection.	F 325		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance;	F 363		12/19/13

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F 363	Continued From page 10 and be followed. This REQUIREMENT is not met as evidenced by: Based on observations of the lunch meal tray line, review of the facility menu and staff interviews, the facility failed to serve 25 of 29 residents in the main dining (MDR) room spinach and sweet potatoes (Residents #79, 113, 1, 45, 124, 90, 76, 26, 60, 42, 20, 114, 39, 88, 57, 70, 111, 8, 103, 21, 54, 112, 59, 105, and 65) and 3 of 29 residents in the MDR pureed spinach and pureed sweet potatoes (Residents #77, 58, 123) in one-half cup portions according to the menu for 1 of 2 lunch tray line observations. The findings included: An observation of 29 residents eating lunch in the MDR occurred on 12/16/13 at 12:12 PM. The lunch meal tray line was observed and included sweet potatoes and spinach (both regular and pureed consistency) each served from a one-third cup serving utensil. Review of the menu revealed residents receiving sweet potatoes or spinach, regular or pureed consistency, were to receive a one-half cup portion of each vegetable. Dietary aide #2 (DA #2) was observed in the MDR from 12:16 PM to 12:25 PM to plate/serve one-third cup portion of sweet potatoes and one-third cup portion of spinach (regular consistency) for Residents #79, 113, 1, 45, 124, 90, 76, 26, 60, 42, 20, 114, 39, 88, 57, 70, 111, 8, 103, 21, 54, 112, 59, 105, and 65 instead of a one-half cup portion according to the menu. Additionally, DA #2 also plated/served in the MDR one-third cup portion of pureed sweet potatoes	F 363	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 _____ F363 Deficiency Corrected 1. All residents were provided additional servings per patient preference. 2. Dietary Manager conducted an inventory of all scoops and there were sufficient scoops in the kitchen. Dietary Manager ordered additional scoops to have on hand. The inventory was completed and showed all scoops were available. No other corrective action was needed. Completion Date 12/19/13. 3. Dietary Manager in serviced all dietary staff and dining room personnel to read tray cards accordingly, follow menu extension pertaining to portion sizes and a portion control chart was implemented. Completion Date 12/19/13. 4. Dietary Manager and/or Designee will conduct 2 random audits per week for 4 weeks to check on scoop accuracy and report results to Quality Assurance Committee for 3 months and then results	

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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 363	Continued From page 11 and one-third cup portion of spinach for Residents #77, 58, and 123 instead of a one-half cup portion according to the menu. An interview on 12/16/13 at 12:25 PM with DA #2 revealed she was trained to use the menu spreadsheet to know which serving utensils to use when plating foods for each meal service, but she did not use the spreadsheet routinely. An interview with the consultant registered dietitian (RD) occurred on 12/18/13 at 4:41 PM and revealed that she expected dietary staff to use the menu spreadsheet as a resource for serving menu items and correct portions. The RD further stated that if a resident received food portions less than the menu required, this could provide the resident with fewer calories than expected and could affect the resident's nutritional status. An interview with the certified dietary manager (CDM) occurred on 12/19/13 at 11:25 AM and revealed that he tried to monitor the tray line daily for accurate portions, but at times he had to multi-task and did not get to conduct monitoring of the tray line for portions. The CDM further stated that staff was trained to use the menu spreadsheet for correct portions.	F 363	of audits will be reviewed for any trends and recommendations during Quality Assurance Committee meetings.	