| 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 ______ | R-C 05/16/2018 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>On 05/16/18 the Division of Health Service Regulation Nursing Home Certification Section completed an onsite follow up survey and complaint investigation. The facility remains out of compliance. | F 000 | | |
| {F 700} SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and resident and staff interviews the facility failed to secure loose side rails for 2 of 4 sampled residents (Resident #2, #4). | {F 700} | | |

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

Electronically Signed

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 700} | Continued From page 1 | {F 700} | | |

The findings included:

1. Resident #2 was admitted to the facility on 10/18/2017 with diagnoses that included malignant neoplasm of colon, malignant neoplasm of liver, adult failure to thrive, and muscle weakness.

Review of the quarterly Minimum Data Set (MDS) dated 4/19/2018 revealed that Resident #2 was cognitively intact and required supervision with bed mobility and transfers.

An observation and interview on 5/16/2018 at 10:15am revealed that Resident #2 was lying in bed speaking with family and surveyor. Resident #2 grabbed his left ½ side rail to reposition himself and the rail moved away from the edge of the mattress approximately 4 inches. Resident #2 did not indicate that he verbalized the loose side rail to staff and was not aware of how long the side rail had been loose. Resident #2 stated that he had not had any instance of being stuck in between the side rail and mattress but if the side rail continued to be loose he might get stuck.

An interview was conducted on 5/16/2018 at 2:38pm with the regularly assigned nurse aide (NA) #1 revealed that Resident #2 ½ side rail on the left side were up because the Resident used that rail to get in and out of bed and reposition himself. The NA further indicated that she was not aware of the side rail being loose.

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| {F 700} | Continued From page 2 | {F 700} | | |

An interview was conducted on 5/16/2018 at 2:53pm with the Maintenance Director. The Maintenance Director revealed that the side rails were checked daily. He further stated that if staff identified that a side rail was loose, then a work order would be completed in the computer system. The Maintenance Director revealed that he did not have a work order for Resident #2.

Review of the Side Rail Audit Tool dated May 2018 revealed that the side rails were checked sporadically throughout the building by maintenance. Any identified loose side rail would be tightened by maintenance. The room that Resident #2 resided in was not checked during the audit.

2. Resident #4 was admitted to the facility on 2/27/2018 with diagnoses that included muscle weakness, malignant neoplasm of prostate, depression, and hypertension.

Review of the significant change Minimum Data Set (MDS) dated 4/27/2018 revealed that the resident had moderate cognitive impairment. Resident #4 required extensive assistance with bed mobility and limited assistance with transfers.

An observation was made on 5/16/2018 at 12:37pm revealed that both ½ side rails to Resident #4s bed were loose. Further observation revealed that the ½ side rails were grabbed, the side rails moved approximately 5 inches from the edge of the mattress.

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| {F 700} | Continued From page 3<br>An interview was conducted on 5/16/2018 at 2:40pm with the nurse aide (NA) #1 revealed that Resident #4 ½ side rails were used for bed mobility. Resident #4 used the rails to roll from side to side. The NA further indicated that she was not aware of the side rail being loose and had not reported the issue to maintenance.<br><br>An interview was conducted on 5/16/2018 at 2:53pm with the Maintenance Director. The Maintenance Director revealed that side rails were checked daily. He further stated that if staff identified that a side rail was loose, then a work order would be completed in the computer system. The Maintenance Director revealed that he did not have a work order for Resident #4.<br><br>Review of the Side Rail Audit Tool dated May 2018 revealed that the side rails were checked sporadically throughout the building by maintenance. Any identified loose side rail would be tightened by maintenance. The room that Resident #4 resided in was not checked during the audit.<br><br>An interview with the Interim Director of Nursing (DON) on 5/16/2018 at 3:15pm revealed that she expected staff to complete a work order so that Maintenance would be aware of any issue that needed to be fixed.<br>An interview with the Administrator on 5/16/2018 at 4:50pm revealed that he expected side rails to be tight and properly secured on the resident's beds. | {F 700} | | |
| F 867 | QAPI/QAA Improvement Activities | F 867 | | |

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| F 867 SS=D | Continued From page 4<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview 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 2018. This was for one recited deficiency which was originally cited in April 2018 during a complaint investigation and was subsequently recited in May 2018 on an on-site follow up survey and complaint investigation. The deficiency was in the area of bed rails. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program.<br><br>The findings included:<br><br>This tag is cross referenced to:<br><br>F700 Bed Rails: Based on observations, record review and resident and staff interviews the facility failed to secure loose side rails for 2 of 4 sampled residents (Resident #2, #4).<br><br>An interview on 5/16/2018 at 4:50pm with the | F 867 | | |

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| F 867 | Continued From page 5 Administrator revealed that he checked with his maintenance director daily regarding side rails and side rails being properly secured to the resident's beds. The Administrator revealed that he was not certain where the system failed, why the side rails were still loose and continued to be an issue. | F 867 | | |