STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(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 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		5/21/18

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

Electronically Signed | 05/17/2018

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 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews and observation the facility staff failed to notify medical staff regarding a change in bowel function for 1 of 1 sampled residents with diarrhea (Resident #6). Findings included: Resident #6 was admitted 12/31/2015 with diagnoses that included fecal impaction and abdominal pain. Review of Resident #6's bowel records revealed the resident had large loose stools for 18 of 25 days from April 1-25, 2018. Review of Resident #6's medication orders documented Imodium A-D tablet 2milligrams (mgs) give 1 tablet by mouth every 6 hours as needed for diarrhea. Review of the Medication Administration Record (MAR) for April 2018 documented Resident #6 had not received any Imodium for diarrhea. There was no documentation on the MAR that the resident had refused this medication during April 2018.	F 580	1.) Resident #6 was immediately provided peri care, NP notified of change in condition, and Charge Nurse offered resident medication for watery stools. 2.) All residents with a change of condition have the potential to be affected by the alleged deficient practice. 3.) 5/15/18, ALL Nursing staff was educated by DON or designee on immediate Notification of Change in Resident Health Status Policy. Education included notifying Physician, NP or PA, and legal representative or family of any accident resulting in injury requiring potential for physician intervention, acute illness or significant change in resident's physical, mental, or psychosocial status, significant changes in treatment, transfer/discharge from the facility, or death. Unlicensed staff will be educated to notify licensed staff, charge nurse, or nursing supervisor immediately of any change in resident physical, mental, or psychosocial status by 5/21/18.	

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F 580	Continued From page 2 On 04/24/2018 at 9:19 AM Resident #6 said he had diarrhea most of the time. He stated he takes no medication for it since he took Imodium and it had not helped. Observation on 04/24/2018 at 1:20 PM of incontinence care for Resident #6 revealed he had a large amount brown watery stool that soaked the bed and drained onto the floor creating a large puddle of brown watery fluid. Interview with Resident #6 on 04/24/2018 at 1:20 PM revealed this usually happened at about this time of the day and again about 10:00 PM. He stated sometimes it happens more often. He stated it was watery stool. Interview on 04/24/2018 at 2:34 PM with the Nurse Practitioner (NP) revealed nothing had come to her regarding Resident #6 having a change or acute problem from the nursing staff. She stated she was not aware he was having liquid diarrhea every day now. Interview on 04/24/2018 at 4:34 PM with Nurse Aide (NA) #1 revealed Resident #6 had diarrhea all the time. Interview on 04/24/2018 at 5:02 PM with NA #2 revealed Resident #6 had liquid diarrhea. He sometimes can tell you it is coming. Interview on 04/25/2018 at 10:21 AM with the Director of Nursing (DON) revealed no concerns had been brought to her about Resident #6's diarrhea. Interview on 04/25/2018 at 10:38 AM with the	F 580	4.) DON or designee will audit 24 hr reports, Incident Reports, and MD/NP provider communication book to ensure resident change of condition is reported to the physician, NP or PA, and family member daily times one-week, weekly times one month, and monthly times 3 months. Results of these audits will be reviewed in Quality Assurance Committee Meeting monthly for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 580	Continued From page 3	F 580		

Assistant Director of Nursing (ADON) revealed no concerns had been brought to her about Resident #6's diarrhea.

Interview on 04/25/2018 at 2:15 pm with the Medical Director revealed the NP was there daily and handled the daily resident concerns. He was not aware of Resident #6's diarrhea. He stated to check the provider communication book and it would be there if there was a concern about his diarrhea.

Review of the provider communication book for March and April 2018 revealed there was no concern documented for the provider regarding Resident #6's watery stool or diarrhea.

Interview on 04/25/2018 at 2:55 PM with Nurse #1 revealed she was not aware that Resident #6 had diarrhea or she would have offered the Imodium that Resident #6 had ordered for diarrhea.

Interview on 04/25/2018 at 3:32 PM with Nurse #2 (Unit Manager) on Resident #6's hall revealed No one told her the resident was having diarrhea or she would have offered the resident Imodium. She stated she expected the nurse aide to let her know if Resident #6 had diarrhea.

Interview on 04/25/2018 at 4:27 PM with the Nurse #2 revealed she had attended the 04/11/2018 Interdisciplinary (IDT) meeting regarding Resident #6's care. She stated she had not talked to the NP recently because she didn't know about how "watery" his diarrhea was. She stated after review of his bowel record for March and Aril 2018 he had been having loose stools for over a month. She stated she should

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F 580	Continued From page 4 have been notified of the liquid watery stools which seemed chronic by review of Resident #6's bowel records for the past two months. Interview on 04/25/2018 at 4:59 PM with the DON revealed she was not aware of the liquid watery stools Resident #6 had. She stated it was her expectation that the NAs would notify the nurse if there was a change with the resident and the nurse would notify the NP or doctor or provider on call.	F 580		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 6 of the past 25 days reviewed (4/10/18, 4/13/18, 4/14/18, 4/17/18, 4/21/18, and 4/22/18). A record review of the daily staff schedules dated 4/1/18 through 4/25/18 revealed there was no RN	F 727	1.) A record review of the Daily Nursing Staffing Postings and Daily Assignment Sheets revealed no RN including the ADON was scheduled in the facility for at least 8 consecutive hours per day. The Staffing Coordinator was not aware she could include the ADON hours on the Daily Nursing Staffing Postings and Daily	5/22/18

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F 727	Continued From page 5 scheduled in the facility on 4/14/18, 4/21/18, and 4/22/18. A record review of the time clock report revealed on 4/10/18, the Assistant Director of Nursing (ADON) who was a RN worked 6.5 hours between 1st and 2nd shift; on 4/13/18, the ADON worked 3.75 hours on 1st shift; and on 4/17/18, the ADON worked 5.75 hours between 1st and 2nd shift. An interview on 4/25/18 at 2:40pm with the Staffing Coordinator (SC) revealed she understood the weekend Nurse Supervisor was a RN and had included her for the 8 hour a day requirement. The SC indicated the facility did not have any RNs except the ADON and only had Licensed Practical Nurses (LPN) for scheduling purposes. An interview on 4/25/18 at 4:02pm with the Director of Nursing (DON) revealed she was responsible in collaboration with the Administrator to review the Daily Nurse Staffing form prior to the SC posting in the front lobby. She thought a RN had been scheduled each day and indicated her expectation was for the facility to have a RN each day for at least 8 hours. She revealed supplemental staff were utilized to meet the RN requirement however 2 were out on maternity leave and 1 had quit. An interview on 4/25/18 at 4:05pm with the Administrator revealed he shared the responsibility with the DON to review the Daily Nurse Staffing form and had not gotten around to check the information before posted. He stated he expected the form to be completed accurately and to meet the regulations related to RN staffing	F 727	Assignment Sheets and did not know the licensure status of all nurses. On 4/26/18, The Staffing Coordinator was educated to include the ADON hours and RNs on the Daily Assignment Sheets and Daily Nursing Staffing Posting located in the facility front lobby. Education included to adjust the Daily Nursing Staffing Posting for any days the ADON does not work 8 consecutive hours. The Staffing Coordinator was provided with a list of all current nursing staff licensure listing. 2.) All residents have the potential to be affected by the alleged deficient practice. 3.) Education was provided to the Staffing Coordinator by the DON on 4/26/18 to include the ADON hours on the Daily Staffing Posting located in the facility lobby and update the Daily Nursing Assignment Sheets to include the ADON. The ADON is scheduled to work Monday-Friday for 8 hours per day. The Staffing Coordinator was educated on 5/14/18 to check with Human Resources daily to check hours for RNs including the ADON to ensure the Daily Nursing Staffing Posting is correct for RN coverage for 8 consecutive hours daily and adjust the Daily Nursing Staffing Posting as needed due to changes in RN coverage. Nursing Licensure Listing is maintained by the Human Resource Coordinator. Education was provided to Human Resources Coordinator to notify the Staffing Coordinator of any change in any nurse licensure listing. The Staffing Coordinator was educated on 5/14/18 to	

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F 727	Continued From page 6 daily. The Administrator revealed he had experienced RNs to have more interest in upper level roles and was having a difficult time receiving applicants to work medication carts.	F 727	make sure RN coverage is provided for 8 consecutive hours per day and notify the Administrator, DON or designee if unable to obtain RN coverage for 8 consecutive hours on any day. Administrator, DON or designee will utilize supplemental staffing agencies to meet the RN required hours in addition to interviewing and hiring RN staff. 4.) DON or designee will audit the Daily Nursing Staffing Posting located in the facility lobby and Daily Nursing Assignment Sheets for RN hours daily times one-week, weekly times one month, and monthly times 3 months. Results of these audits will be reviewed in Quality Assurance Committee Meeting monthly for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance (QA) process failed to implement, monitor and revise as needed the action plan developed for a compliant survey of March 2018 in order to achieve and sustain	F 867	1. Facility is to implement and follow procedures for monthly Quality Assessment and Assurance, QAA, program which involve the establishment of a QAA committee to implement,	5/21/18

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F 867	Continued From page 7 compliance. This was for one deficiency cited on a complaint survey. The deficiency was in the area of notification at CFR 483.10. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Committee. The findings include: F 580: Notification: Based on record review, resident and staff interviews and observation the facility staff failed to notify medical staff regarding a change in bowel function for 1 of 1 sampled residents with diarrhea (Resident #6). F 483.10 (Notification): In March 2018 the facility was cited for failing to notify the legal guardian a resident had left the facility. On 04/25/18 at 2:25 PM the Administrator was interviewed and explained the facility met regularly and had developed new systems for ensuring families and physicians were notified of changes in a resident's medical condition. The Administrator stated he believed the facility was in compliance with the regulation.	F 867	monitor and revise as needed the action plans that are developed to ensure continued compliance. Facility is to implement and follow procedures for monthly Quality Assessment and Assurance, QAA, program which involve the added focused review of areas identified to be have repeated deficient practiced noted. This review system will be implemented by the Administrator and will entail a through process evaluation of identified areas to ensure processes are achieving desired goals and identify areas that require modifications to ensure continued compliance. 2. All residents are at risk for being affected by this deficient practice 3. All department head staff provided in-service education regards the requirements for a QAA committee and the purpose and impact of an effective QAA program. This education will also include each departments responsibility as it pertains to the committee. The education is to be completed by 5/21/2018. 4. The Administrator will initiate and regulate QAA program and meeting and adjust meeting frequency to accommodate the needs of the facility. Administrator is to ensure all current action plans are evaluated, by utilized the Action Plan Review and Revision QAA form during QAA meetings. Records will be audited at each meeting to ensure all plans are followed as written and any	

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F 867	Continued From page 8	F 867	corrections will be made at that time.	