DEPARTI	FO	FORM APPROVED						
		MEDICAID SERVICES					NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			TE SURVEY MPLETED	
			A. BUILD	JING	3			
		245204					R-C	
		345201	B. WING			0	06/01/2018	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
COMPLET	E CARE AT CHARLOTT	E			2616 EAST 5TH STREET			
					CHARLOTTE, NC 28204			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF COP				
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC	LD BE	COMPLETION DATE	
IAG					DEFICIENCY)			
					-			
F 000				000				
F 000	INITIAL COMMENTS		F	000	0			
		e Division of health Service						
	Regulation, Nursing H							
		ed a revisit. the facility was						
	found to be in complia	ance effective May 22, 2018.						
_ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		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.

PRINTED: 06/15/2018

DEPART	FOF	FORM APPROVED								
		MEDICAID SERVICES					O. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED			
			A. BUILD	JING	·					
		345201	B. WING				R-C			
NAME OF PROVIDER OR SUPPLIER			5. 11.10		STREET ADDRESS, CITY, STATE, ZIP CODE	06/01/2018				
	ROVIDER OR SUFFLIER				2616 EAST 5TH STREET					
COMPLET	E CARE AT CHARLOTT	E								
					CHARLOTTE, NC 28204					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION			
TAG			TAG		CROSS-REFERENCED TO THE APPROF	PRIATE	DATE			
					DEFICIENCY)					
{F 000}	INITIAL COMMENTS	i	{F (000)}					
	On June 1, 2018, the	e Division of Health Service								
	Regulation, Nursing I									
		ed a revisit. The facility was								
	found to be in compli-	ance effective May 22, 2018.								
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		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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