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 07/27/2018

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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to assess the ability of a resident to self-administer medications (Aspercreme with lidocaine and Pepcid complete) were kept at the bedside for 1 of 1 residents (Resident #17) reviewed for self-administration of medications. Findings Included: Resident #17 was admitted to the facility on 10/26/17. Diagnoses included cerebral infarction, noncompliance with other medical treatments and regimen, major depressive disorder severe with psychotic mechanism, hypertension and type 2 diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) dated 4/26/18 revealed that Resident #17 was cognitively intact. Resident #17 had adequate hearing, clear speech and able to understand and make herself understood. Resident #17 required total assistances with toilet use and personal hygiene and limited assistance with bed mobility. Review of the care plans revealed that Resident #17 was not care planned to self-administer medications. An observation on 7/24/18 at 10:20am revealed that Resident #17 had a tube of aspercreme with	F 554	• On 07/26/18 Resident #17 was found to have over the counter cream containing a tube of Aspercreame with lidocaine and a container of Pepcid Complete Tablets at the bedside without an order for administration. All medications were immediately removed from the bedside. The NP was notified, and an order was obtained for the resident to self-administer medications. A self-administration assessment was also completed. Resident #17 was noted to be able to self-administer medications appropriately. Resident #17 care plan was updated to include may self-administer medications. 08/02/18 Resident #17 responsible party (son) was contacted and educated on the facilities resident self-administration guidelines. Resident #17 responsible party (son) agreed the facility will supply all the resident's medications. • All residents with a desire to self-administer medications have the potential to be affected by the alleged deficient practice. • On 07/26/2018 Education was initiated by the DON and designee for nurses to immediately remove any medication found at the bedside. On 07/30/2018 the ADON completed an audit of all current residents with orders to	8/24/18

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

Electronically Signed | 08/16/2018

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 07/27/2018

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 554	Continued From page 1 lidocaine and a container of Pepcid complete tablets on her bedside table. Review of the electronic medical record (all active orders) on 7/25/18 at 8:56am revealed that Resident #17 does not have an order to self-administer medications or to keep at the bedside. Further review of Resident #17's medical record revealed an active order for pepcid tablet 20mg two times a day for GERD (gastroesophageal reflux disease). Review of Resident #17's MAR (medication administration record) revealed the order for pepcid was given consistently. Review of the electronic medical record (assessments) on 7/25/18 at 8:58am revealed that there was no self-administration assessment completed for Resident #17. An observation and interview on 7/26/18 at 8:33am with Resident #17 revealed the aspercreme with lidocaine and the Pepcid remained on the bedside table. Resident #17 stated she doesn't apply the aspercreme herself. She stated her son came every night and applied the cream to her right knee and she only took the Pepcid 2-3 times a week after lunch. Resident #17 stated that she had the aspercreme and pepcid since she was admitted to the facility. Resident #17 further stated that she used the Pepcid for heartburn relief. An interview on 7/26/18 at 11:44am with Resident #17's primary nurse revealed that she was unaware of the medications at bedside. The nurse revealed that residents that self-administer medications would need a doctor's order and an assessment completed.	F 554	self-administer medications to update self-administer assessment, care plan, and MD/NP order. 08/06/18 All nurses have been educated on the facilities guidelines for resident to self-administer medications including any resident requesting for medication to be kept at the bedside must have a self-administer assessment completed by a nurse, a MD/NP order to self-administer medication, and a care plan developed for self-administer medications. On 08/06/18 All current resident rooms were checked for medications at bedside with none found. All staff will be educated by 08/24/18 to notify the charge nurse of any medications seen at bedside. A memo will be sent to all residents and responsible parties on the resident self-administer guidelines by 08/24/18. • SW to complete an audit of all current residents to determine if a resident has a desire to self-administer medications. Based upon the SW audit any resident with a desire to self-administer medications will have a self-administer assessment completed by 08/ 24/18. MD/NP order will be obtained for medications to be self-administered, and resident care plan developed for self-administer medications. Self-Administer Assessment will be added to new admission paperwork. Residents and/or responsible parties upon admission will be educated by nurse on self-administer protocols. • 08/20/18, DON and/or designee will randomly audit 30 resident rooms for medications at the bed side daily times	

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 07/27/2018

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 554	Continued From page 2 An interview on 7/26/18 at 12:10pm with the DON (director of nursing) revealed that residents who desire to self-administer medications would need a doctor's order and an assessment completed. The DON stated that her expectation would be for a doctor's order to be in place, the resident to be assessed and the care plan developed. An interview on 7/26/18 at 12:13pm with the Administrator revealed that his expectation regarding self-administration of medication would be that staff speak with the residents who desired to self-administer medications, obtain a physician's order, and complete the required assessment.	F 554	one-week, weekly times 4 weeks, and monthly times 3 months. Results of these audits will be reviewed in the 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 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide side rails to accommodate bed mobility for 3 of 3 sampled residents who used side rails (Residents #42, #69 and #85). The findings included: 1. Resident #42 was admitted to the facility on 10/19/16 with diagnoses which included seizures, restless leg syndrome and hypertension.	F 558	• It was identified that residents #41,69, and 85 had their bed rails removed while having a current need and ability to use the bedrails. Upon identification of the desire and/or need to have bedrails after their removal, each resident was evaluated by the therapy department to determine their appropriateness to have the rails. Due to the results of the evaluations deeming the rails requests appropriate , beneficial to residents and	8/24/18

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 07/27/2018

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 558	Continued From page 3 Review of Resident #42's annual Minimum Data Set (MDS) dated 10/21/17 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #42 required the extensive assistance of two persons with bed mobility. Review of Resident #42's side rail assessment screen dated 02/15/18 revealed the East Unit Manager documented Resident #42 used side rails for positioning and support. The assessment concluded Resident #42 would not utilize side rails. Review of Resident #42's quarterly Minimum Data Set (MDS) dated 05/28/18 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #42 required the extensive assistance of one person with bed mobility. Review of Resident #42's care plan initiated 11/11/16 revealed interventions for a physical functioning deficit included bed mobility assistance. Observation on 07/24/18 at 11:08 AM revealed Resident #42 in bed without side rails. Interview with Resident #42 on 07/24/18 at 11:09 AM revealed he used side rails to position independently until the facility removed them last week. Resident #42 explained he did not know the reason for the removal and needed the side rails. Resident #42 reported he now had to wait for a nurse aide to assist with repositioning. Resident #42 moved his arms to demonstrate his reach and strength of grasp.	F 558	were not a entrapment risk resident #41, 69, and 85's bed rails were replaced on 7/27/18. • All residents that had their bed rails removed during the process to ensure resident safety have the potential to be affected by this alleged deficient practice. • All residents whom had their bed rails removed will be evaluated by the therapy department to determine their appropriateness for the proper use of bedrails and their necessity for bed mobility and positioning. These residents will be evaluated by 8/17/18 and those deemed appropriate, the rails will be reinstalled by maintenance by 8/24/18 • Resident evaluations outcomes will be documented on the QI form entitled Bed Rail Appropriateness as well as weather the rails were replaced. If deemed inappropriate to return rails, the explanation will also be documented on the QI form. All residents that were evaluated by the therapy department will be monitored by Administrator or Designee to ensure rails remain in place and if any changes to bed rail appropriateness have occurred. The monitoring will be documented on the Bed Rail Monitoring tool and will be conducted daily x5, weekly x4, and monthly x3. 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.	

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 07/27/2018

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 558	Continued From page 4	F 558		

Interview with Nurse Aide (NA) #1 on 07/25/18 at 8:44 AM revealed Resident #42 used side rails for bed mobility. NA #1 explained Resident #42 required 2 persons for repositioning without the side rails. NA #1 reported the side rails were removed on Friday (7/20/18) and did not know the reason for the removal.

Interview with Nurse #1 on 07/25/18 at 3:55 PM revealed Resident #42 used side rails for bed mobility. Nurse #1 reported Resident #42 "has been upset ever since (the removal)." Nurse #1 explained she did not know the reason the side rails were removed but Resident #42 required more physical assistance without the side rails.

Interview with NA #2 on 07/26/18 at 8:40 AM revealed Resident #42 used the side rails to independently reposition in bed.

Interview with the East Unit Manager on 07/26/18 at 10:56 AM revealed she was not involved in the decision to remove Resident #42's side rails. The East Unit Manager reported Resident #42 used side rail infrequently for repositioning.

Interview with the Director of Rehabilitation on 07/26/18 at 11:02 AM revealed the therapy department did not participate in the side rail assessment. The Director of Rehabilitation reported Resident #42 used side rails to initiate turning and for bed mobility.

Interview with the Director of Nursing (DON) on 07/26/18 at 11:06 AM revealed residents received side rail assessments upon admission and annually. The DON reported Resident #42's side rails were removed to ascertain the need for side

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 07/27/2018

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 558	Continued From page 5	F 558		

rails. The DON reported Resident #42 did not receive an assessment prior to the removal. The DON explained nurses on the unit should assess and report a need for side rails. The DON was not aware Resident #42 desired and used side rails.

Interview with the Administrator on 07/26/18 at 11;13 AM revealed he expected assessments to be conducted prior to side rail removal. The Administrator explained he expected side rails to be provided when needed for bed mobility.

A second interview was conducted with the DON on 07/26/18 at 3:59 PM. The DON explained the removal of Resident #42's side rails was a delayed response to the 02/15/18 assessment. The DON reported the delay was due to personnel changes in the maintenance department.

A second interview with the Rehabilitation Director on 07/27/18 at 9:49 AM revealed a second side rail assessment for Resident #42 determined a need for side rails.

Observation on 07/27/18 at 3:45 PM revealed Resident #42 in bed with 1/3 side rails. Resident #42 reported he repositioned independently with the side rails.

2. Resident #69 was admitted to the facility on 11/17/13 with diagnoses which included cerebral vascular accident with right sided hemiparesis.

Review of Resident #69's significant change (MDS) dated 11/28/17 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #69 required the extensive

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 07/27/2018

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 558	Continued From page 6	F 558		

assistance of one person with bed mobility. The MDS listed functional impairment of the upper and lower extremity's range of motion on one side.

Review of Resident #69's side rail assessment screen dated 02/15/18 revealed the East Unit Manager documented Resident #69 did not use side rails for positioning and support. The assessment concluded Resident #69 would not utilize side rails.

Review of Resident #69's quarterly MDS dated 07/02/18 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #69 required the extensive assistance of one person with bed mobility. The MDS listed functional impairment of the upper and lower extremity's range of motion on one side.

Review of Resident #69's care plan initiated on 11/19/13 revealed side rails maintained current bed mobility level.

Interview with Resident #69 on 07/24/18 at 3:00 PM revealed the facility recently removed side rails from his bed. Resident #69 explained he could only use one arm and needed side rails to move in bed.

Observation of Resident #69's bed on 07/24/18 at 3:10 PM revealed there were no side rails.

Interview with Nurse Aide (NA) #1 on 07/25/18 at 9:16 AM revealed Resident #69 used side rails to independently reposition. NA #1 explained Resident #69 had use of only one arm and hand. NA#1 reported Resident #69 required physical assistance with bed mobility after the side rail

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 07/27/2018

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 558	Continued From page 7	F 558		

removal last week.

Observation on 07/25/18 at 9:35 AM revealed Resident #69 in bed. Resident #69 demonstrated inability to turn. Resident #69 announced he needed help since the removal of the side rails.

Interview with Nurse #1 on 07/25/18 at 4:00 PM revealed Resident #69 used side rails to independently reposition in bed. Nurse #1 explained Resident #69 used his unaffected side to move in bed but could not without the side rails.

Interview with NA #2 on 07/26/18 at 8:41 AM revealed Resident #69 used the side rails to independently reposition in bed.

Interview with Nurse #2 on 07/26/18 at 9:11 AM revealed Resident #69 used side rails to independently reposition in bed.

Interview with the East Unit Manager on 07/26/18 at 10:56 AM revealed she was not involved in the decision to remove Resident #69's side rails. The East Unit Manager reported Resident #69 did not use side rails for repositioning.

Interview with the Director of Rehabilitation on 07/26/18 at 11:02 AM revealed the therapy department did not participate in the side rail assessment. The Director of Rehabilitation reported Resident #69 "definitely required side rails for bed mobility."

Interview with the Director of Nursing (DON) on 07/26/18 at 11:06 AM revealed residents received side rail assessments upon admission and annually. The DON reported Resident #69's side

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 07/27/2018

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 558	Continued From page 8	F 558		

rails were removed to ascertain the need for side rails. The DON reported Resident #69 did not receive an assessment prior to the removal. The DON explained nurses on the unit should assess and report a need for side rails. The DON was not aware Resident #69 desired and used side rails.

Interview with the Administrator on 07/26/18 at 11;13 AM revealed he expected assessments to be conducted prior to side rail removal. The Administrator explained he expected side rails to be provided when needed for bed mobility.

A second interview was conducted with the DON on 07/26/18 at 3:59 PM. The DON explained the removal of Resident #69's side rails was a delayed response to the 02/15/18 assessment. The DON reported the delay was due to personnel changes in the maintenance department.

A second interview with the Rehabilitation Director on 07/27/18 at 9:49 AM revealed a second side rail assessment for Resident #69 determined a need for side rails.

3. Resident #85 was admitted to the facility on 10/20/16.

Review of Resident #85's annual Minimum Data Set (MDS) dated 02/15/18 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #85 required the limited assistance of two persons with bed mobility.

Review of Resident #85's side rail assessment screen dated 02/15/18 revealed the East Unit

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 07/27/2018

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 558	Continued From page 9	F 558		

Manager documented Resident #85 used side rails for positioning and support. The assessment concluded Resident #85 would not utilize side rails.

Review of Resident #85's quarterly MDS dated 07/11/18 revealed an assessment of intact cognition. The MDS indicated Resident #85 required the extensive assistance of one person with bed mobility.

Interview with Nurse Aide (NA) #1 on 07/25/18 at 8:48 AM revealed Resident #85 used side rails for bed mobility. NA #1 reported the side rails were removed on Friday (7/20/18) and did not know the reason for the removal.

Interview with Resident #85 on 07/25/18 at 9:23 AM revealed the facility removed her side rails last Friday (07/20/18). Resident #85 explained she used the side rails and did not understand the reason for the removal.

Observation of Resident #85's bed on 07/25/18 at 9:30 AM revealed no side rails.

Interview with Nurse #1 on 07/25/18 at 4:05 PM revealed Resident #85 used side rails for bed mobility at times but not always

Interview with NA #2 on 07/26/18 at 8:40 AM revealed Resident #85 used the side rails to independently reposition in bed.

Interview with the East Unit Manager on 07/26/18 at 10:56 AM revealed she was not involved in the decision to remove Resident #85's side rails. The East Unit Manager reported Resident #85 used side rail infrequently for repositioning.

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 07/27/2018

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 558	Continued From page 10 Interview with the Director of Rehabilitation on 07/26/18 at 11:02 AM revealed the therapy department did not participate in the side rail assessment. Interview with the Director of Nursing (DON) on 07/26/18 at 11:06 AM revealed residents received side rail assessments upon admission and annually. The DON reported Resident #85's side rails were removed to ascertain the need for side rails. The DON reported Resident #85 did not receive an assessment prior to the removal. The DON explained nurses on the unit should assess and report a need for side rails. The DON was not aware Resident #85 desired and used side rails. Interview with the Administrator on 07/26/18 at 11;13 AM revealed he expected assessments to be conducted prior to side rail removal. The Administrator explained he expected side rails to be provided when needed for bed mobility. A second interview was conducted with the DON on 07/26/18 at 3:59 PM. The DON explained the removal of Resident #85's side rails was a delayed response to the 02/15/18 assessment. The DON reported the delay was due to personnel changes in the maintenance department. A second interview with the Rehabilitation Director on 07/27/18 at 9:49 AM revealed a second side rail assessment for Resident #85 determined a need for side rails.	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		8/24/18

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 07/27/2018

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 657	Continued From page 11 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to revise pressure sore interventions and update the care plan for 1 of 3 sampled residents with pressure sores (Resident #71). The findings included: Resident #71 was admitted to the facility on	F 657	• It was identified that resident #71's wound care interventions were not present on the resident's care plan. Once identified, resident's care plan was updated by MDS Coordinator on 8/16/18 to ensure all wound care interventions were present and care plan is accurate to the care being delivered to resident. • All residents being treated for wounds	

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 07/27/2018

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 657	Continued From page 12 08/05/17 with diagnoses which included dementia, diabetes mellitus and chronic ischemic heart disease. Review of Resident #71's annual Minimum Data Set (MDS) dated 02/20/18 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #69 was always incontinent of bladder and bowel with no pressure sores. Review of Resident #71's Pressure Sore Care Area Assessment dated 03/07/18 revealed a risk for pressure sore development with the decision to proceed to care plan. Review of Resident #71's care plan initiated on 05/24/17 revealed interventions to prevent pressure sores included weekly skin inspections, pressure reducing wheel chair cushion and mattress, and application of barrier cream after incontinent episodes. Review of Resident #71's quarterly MDS dated 04/18/18 revealed no pressure sores. Review of readmission nursing note dated 05/23/18 revealed Resident #71 acquired one Stage 3 and one Stage 4 pressure sores during a hospital stay. The physician ordered an air mattress, wound consultation, wound treatment, vitamin and nutritional supplements. Review of Resident #71's quarterly MDS dated 07/04/18 revealed an assessment of moderately impaired cognition and the presence of one Stage 3 and one Stage 4 pressure sore. Review of Resident #71's care plan revealed	F 657	and receiving wound care have the potential to be affected by this alleged deficient practice. • 100% of care plans for residents receiving wound care will be audited to ensure proper interventions are in place and properly documented on the individual care plan. This audit will be conducted by the Administrator or designee and will be completed by 8/24/18. Any discrepancies noted will be documented on the Care Plan audit form and addressed by the MDS department. Facility review process updated to ensure care plans are reviewed for residents with wounds during weekly At-Risk meeting and care plans are updated at that time. • After the completion of the initial audit, care plans will be audited by the Administrator or designee to ensure they will continue to be accurate to the resident's current condition. These audits will be conducted daily x5, weekly x4, and monthly x3. 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.	

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 07/27/2018

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 657	Continued From page 13	F 657		

there was no documentation of pressure sore location or interventions to treat the pressure sores. The care plan listed the same interventions as 05/24/17. The most recent revision dated 08/16/17 regarded resolution of deep tissue injury on the right ischium.

Review of the wound physician's note dated 07/19/18 revealed a Stage 3 pressure sore on the coccyx and a Stage 4 pressure sore on the right foot. The wound physician described Resident #71's wounds as improved with continuance of calcium alginate with dry dressing daily to both foot and coccyx ulcers.

Observation on 07/25/18 at 8:49 AM revealed Resident #71 used an air mattress with both heels offloaded.

Interview with the MDS Coordinator on 07/27/18 at 2:43 PM revealed the MDS nurse who updated the care plan was not available for interview. The MDS Coordinator reported Resident #71's care plan should include the Stage 3 and Stage 4 pressure sores, a measurable goal and current interventions. The MDS Coordinator explained the wound nurse could revise care plan for wound care and treatment.

Telephone interview with the wound nurse on 07/27/18 at 3:04 PM revealed she recommended interventions such as limitation of Resident #71's length of time seated in a chair but did not update or revise care plans.

Interview with the Director of Nursing (DON) on 07/27/18 at 3:08 PM revealed Resident #71's care plan required update and revisions. The DON reported she expected Resident #71's care

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 07/27/2018

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 657	Continued From page 14 plan to accurately reflect interventions required for pressure sores.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of the medical record, the facility failed to provide toe support to a resident with decreased range of motion and contractures for 1 of 3 sampled residents reviewed for limited range of motion (Resident #32). The findings included: Resident #32 was admitted to the facility on 12/13/14 and re-admitted after a hospitalization on 2/21/18. Diagnoses included paraplegia, abnormal posture, bilateral foot/ankle	F 688	• It was identified that resident #32 to have a toe support missing from one of her ankle splints which are necessary for resident due to her decreased range of motion and contractures. Replacement foot support provided to resident on 7/26/18 and splits were determined by the Therapy Director to be in proper working order for the needs of the resident. • 100% of residents utilizing splits or any other device for range of motion or contractors were audited by 8/17/18 to ensure that all residents have the	8/24/18

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 07/27/2018

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 688	Continued From page 15 contractures and foot drop, among others. Review of the October 2017 care plan and Care Area Assessment for Resident #32 identified she required assistance from staff with physical functioning and was at risk for continued decline in physical functioning and possible worsening contractures due to limited mobility. A physician's order dated 10/05/17 recorded "Patient will have bilateral ankle splints applied to wear 4 hours and removed 4 hours during 24 hour period every shift." Medical record review revealed Resident #32 was referred to physical therapy (PT) on 4/23/18 due to complaints of pain in the buttocks area, muscle spasms, plantar flexion contractures of bilateral (B) ankles/feet and decreased ROM. The goal included to increase LE ROM/strength. A quarterly minimum data set dated 5/11/18 assessed Resident #32 with clear speech, able to understand/understood, intact cognition, required extensive/total staff assistance with dressing/mobility and limited range of motion (ROM) to bilateral lower extremities (BLE). Resident #32 was discontinued from PT services on 6/12/18 and placed on a functional maintenance program (restorative nursing program) to continue ROM exercises to maintain joint mobility and stretching with emphasis on feet/ankles and the use of orthotics (boots). Approaches included to perform passive ROM and stretching exercises to BLE in bed, stretching bilateral ankles/feet prior to application of multi podus boots (MPB) with toe support. Nursing staff were to apply bilateral MPB with toe support 4 to	F 688	necessary equipment that is in proper working order in order address their range of motion and/or contractures. This audit will be conducted by the Therapy Manager and recorded on the Splint Audit QI tool and any missing or malfunctioning pieces will be replaced or fixed at that time. • 100% In-service to be provided to Rehab and nursing staff to communicate missing, broken, or misplaced equipment to their immediate supervisor so equipment can be fixed or replaced, and/or an alternative can be determined. This education is to be completed by 8/24/2018. • After initial audit, resident with splints will be audited by the Administrator or designee for proper location of equipment and equipment in good working order. These audits will be recorded on the Splint monitoring tool. The monitoring will be completed daily x5, weekly x4, and monthly x3. 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.	

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 07/27/2018

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 688	Continued From page 16	F 688		

6 hours daily to aide in positioning and alignment of her feet/ankles.

Resident #32 was observed in her room in bed on 07/25/18 at 09:59 AM. MPB were observed laying on top of her wardrobe. Resident #32 stated she received the MPB during a recent hospitalization earlier that year, but now the piece that provided toe support was missing. She stated "I have been asking therapy to help me get this fixed and they say different things like, we are working on it, we don't have the parts to fix it, or we can't fix your boots. I have been waiting for this for a while." Resident #32 further stated she reported the missing toe support to the administrator, therapy and to nursing staff several weeks ago.

An interview with the therapy manager occurred on 07/26/18 at 09:27 AM and revealed Resident #32 informed him on Tuesday, 8/17/18 that pieces of her MPB were missing. The therapy manager stated that he and the west unit manager searched her room, but could not locate the toe support to her left MPB. The therapy manager also stated that since Resident #32 was not on therapy case load when the toe support was identified missing, he expected nursing to follow up on locating or replacing this part. The therapy manager then stated that once the toe support was identified as missing, he immediately informed the administrator and reminded the administrator again this week. The therapy manager further stated that when he reminded the administrator this week of the missing toe support, the administrator told him to look again.

The west unit manager (WUM) stated in interview on 07/26/18 at 10:02 AM that Resident #32 told the therapy manager "this week" that she was

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 07/27/2018

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 688	Continued From page 17	F 688		

missing parts to her boots, the therapy manager found the parts and the WUM stated she was not aware that anything else was missing. The WUM also stated that therapy would be responsible for ordering parts to orthotics.

The administrator stated in interview on 07/26/18 at 11:44 AM that he was made aware last week that Resident #32 was missing the toe support for the left MPB, he instructed the therapy manager to look for the missing part. The administrator then stated that he was made aware this week that the toe support was not found and so he instructed the therapy manager to conduct a more thorough search. The administrator stated that he did not consider this a grievance but that he should have which per facility policy required resolution in 5 days.

An interview with nurse aide #3 (NA #3) occurred on 07/26/18 at 01:20 PM which revealed she noticed about 3 weeks ago that the toe support was missing to the left MPB when she applied them and she advised the Resident and reported this to the nurse. NA #3 could not recall the name of the nurse or the day she reported it and stated she did not know what the nurse did with that information.

An interview with the director of nursing on 07/26/18 at 01:30 PM revealed she expected residents to have orthotics applied per physician's order and for nursing staff to report any missing parts for orthotics to the administrator for further direction.

Resident #32 was observed in her wheel chair on the front porch on 07/26/18 at 3:30 PM with bilateral MPB, but without the toe support to the

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 07/27/2018

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 688	Continued From page 18 left MPB. The Resident stated the toe support had still not been found or replaced.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of the medical record, the facility failed to investigate two self-reported falls to determine risk factors to prevent future falls for 1 of 5 sampled residents reviewed for supervision to prevent accidents (Resident #61). The findings included: 1a. Resident #61 was admitted to the facility on 03/07/18. Diagnoses included schizoaffective disorder, cerebral infarction due to embolism of right middle cerebral artery, adjustment disorder with mixed anxiety and depressed mood among others. Review of the March 2018 Care Area Assessment and an April 2018 care plan identified Resident #61 was at risk for falls due to medication, impaired vision and poor balance while seated and with transfers. Approaches included to assess the appropriateness of his wheelchair, foot rests and safety after a fall.	F 689	• Resident #61 reported to the survey team that he sustained two falls and nursing staff failed to investigate the self-reported falls to determine risk factors to prevent future falls. • All residents have the potential to be affected by the alleged deficient practice of not following up. • On 08/06/18 Education was provided to all nurses to investigate all resident statements of a fall and to complete falls incident reports for any resident with witnessed, unwitnessed, or self-reported falls to include risk factors to prevent future falls. On 08/15/18, the Nursing staff were provided with a list of recommendations for interventions to prevent falls. • 08/20/18, DON or designee will audit the risk management reports daily in morning clinical meeting to verify all falls documentation is accurate to include risk factors to prevent future falls. DON or	8/24/18

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 07/27/2018

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 689	Continued From page 19 Review of the nurse's progress notes in the medical record for Resident #61 and review of an incident report, both dated 03/09/18, revealed Resident #61 sustained a fall in the hallway around 10 PM without injury while ambulating independently from his room. He was not wearing non-skid socks at the time of the fall. The fall was witnessed by a nurse who was on the hall administering medications. The incident report revealed Resident #61 self-reported that he removed the non-skid socks staff had applied and stated he needed a larger pair. Resident #61 was given a larger pair of non-skid socks, reminded to wear the socks when ambulating and to use his call bell to request staff assistance. A quarterly minimum data set dated 04/20/18 assessed Resident #61 with clear speech, able to understand/understood, intact cognition, required staff assistance with bed mobility, set up assistance with transfers and unsteady balance with the ability to balance self without staff assistance. The administrator stated in an interview on 07/26/18 at 11:07 AM that Resident #61 fell on 03/09/18 and that there was no other documentation/investigation of a fall since then. The administrator further stated that Resident #61 had a tendency to fall and not advise staff until after the fall. He stated that the facility did not have any other fall investigations for Resident #61 since admssion. Continued review of his medical record revealed a change in condition nurse's progress note dated 06/02/18 written at 3:54 PM by Nurse #5. The progress note recorded Resident #61	F 689	designee will review all falls documentation weekly at the IDT meeting. 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.	

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 07/27/2018

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 689	Continued From page 20	F 689		

self-reported an unwitnessed fall and was assessed with left lower leg swelling that was warm to touch with complaints of pain. The progress note also documented Resident #61 was transferred to the ED (emergency department) to rule out DVT (deep vein thrombosis).

Review of an ED discharge summary dated 06/02/18 revealed Resident #61 was treated in the ED for lower leg pain/swelling, peripheral edema and contusion of the left leg.

There was no facility incident report or investigation in the medical record of the self-reported fall of 06/02/18 to determine risk factors to prevent future falls.

An interview with Resident #61 occurred on 07/25/18 at 3:44 PM and revealed he fell recently in the dark in his room and sustained a bruise, but that he could not recall the date of his most recent fall. He stated that he told the nurse when he fell.

An interview with the director of nursing on 07/26/18 at 1:17 PM revealed the facility should have conducted/documented a fall investigation when Resident #61 self-reported a fall on 06/02/18. She confirmed that there was no facility investigation completed for this self-reported fall.

An interview with the administrator on 07/27/18 at 2:00 PM revealed the facility did not conduct a fall investigation for the self-reported fall of 06/02/18 for Resident #61 because the administrator stated the fall was "unwitnessed." The administrator stated Resident #61 was

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 07/27/2018

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 689	Continued From page 21	F 689		

transferred to the hospital, but because staff did not witness the fall, and Resident #61 often reported falls after they occurred, an investigation of the fall did not occur.

A telephone interview occurred on 7/27/18 at 2:01 PM with nurse #5 who advised that Resident #61 reported an unwitnessed fall to her on 06/02/18 which she documented in his medical record and transferred him to the ED for further evaluation, but that she did not complete an investigation report.

1b. Resident #61 was admitted to the facility on 03/07/18. Diagnoses included schizoaffective disorder, cerebral infarction due to embolism of right middle cerebral artery, adjustment disorder with mixed anxiety and depressed mood among others.

Review of the March 2018 Care Area Assessment and an April 2018 care plan identified Resident #61 was at risk for falls due to medication, impaired vision and poor balance while seated and with transfers. Approaches included to assess the appropriateness of his wheelchair, foot rests and safety after a fall.

Review of the nurse's progress notes in the medical record for Resident #61 and review of an incident report, both dated 03/09/18, revealed Resident #61 sustained a fall in the hallway around 10 PM without injury while ambulating independently from his room. He was not wearing non-skid socks at the time of the fall. The fall was witnessed by a nurse who was on the hall administering medications. The incident report revealed Resident #61 self-reported that he removed the non-skid socks staff had applied and

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 07/27/2018

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 689	Continued From page 22	F 689		

stated he needed a larger pair. Resident #61 was given a larger pair of non-skid socks, reminded to wear the socks when ambulating and to use his call bell to request staff assistance.

A quarterly minimum data set dated 04/20/18 assessed Resident #61 with clear speech, able to understand/understood, intact cognition, required staff assistance with bed mobility, set up assistance with transfers and unsteady balance with the ability to balance self without staff assistance.

The administrator stated in an interview on 07/26/18 at 11:07 AM that Resident #61 fell on 03/09/18 and that there was no other documentation/investigation of a fall since then. The administrator further stated that Resident #61 had a tendency to fall and not advise staff until after the fall. He stated that the facility did not have any other fall investigations for Resident #61 since admission.

Review of an ED discharge summary dated 06/08/18 revealed Resident #61 was treated in the ED for contusion of the left knee sustained from a fall.

There was no facility incident report, investigation or documentation of a fall in the medical record of the self-reported fall of 06/08/18 to determine risk factors to prevent future falls.

An interview with Resident #61 occurred on 07/25/18 at 3:44 PM and revealed he fell recently in the dark in his room and sustained a bruise, but that he could not recall the date of his most recent fall. He stated that he told the nurse when he fell.

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 07/27/2018

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 689	Continued From page 23 An interview with the director of nursing (DON) on 07/26/18 at 1:17 PM revealed nursing staff should document all falls in the medical record and because this fall was not documented, she had no way of determining why Resident #61 was transferred to the ED on 06/08/18. The DON stated the facility should have conducted/documented a fall investigation when Resident #61 self-reported a fall to the nurse on 06/08/18. She confirmed that there was no facility investigation completed for this fall. A telephone interview occurred on 07/26/18 at 5:30 PM with Nurse #4 and revealed she could not recall if she was the assigned nurse for Resident #61 on 06/08/18, but that she did recall assessing his left lower leg after he reported to her that he had fallen. She stated the fall was unwitnessed and that the Resident's leg was dark/discolored/warm and he complained of pain. Nurse #4 stated Resident #61 was sent to the ED for further evaluation, but that although she should have, she did not document the fall in his medical record or document an investigation of the fall. An interview with the administrator on 07/27/18 at 2:00 PM revealed the facility did not conduct a fall investigation for the self-reported fall of 06/08/18 for Resident #61 because the administrator stated the fall was "unwitnessed." The administrator stated Resident #61 was transferred to the hospital, but because staff did not witness the fall, and Resident #61 often reported falls after they occurred, an investigation of the fall did not occur.	F 689		
F 842	Resident Records - Identifiable Information	F 842		8/24/18

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 07/27/2018

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 842 SS=D	Continued From page 24 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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 07/27/2018

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 842	Continued From page 25 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the medical record, the facility failed to document the medical record for Resident #61 regarding an unwitnessed fall, resident assessment and hospital transfer for 1 of 5 sampled residents reviewed for accidents. The findings included: Resident #61 was admitted to the facility on	F 842	• Resident #61 reported that he self-reported two falls and the nursing staff failed to document in the medical records on an unwitnessed fall, resident assessment, and hospital transfer • All residents have the potential to be affected by the alleged deficient practice. • Falls documentation process was reviewed on 08/15/18 in the weekly IDT meeting. Falls are currently documented	

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 07/27/2018

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 842	Continued From page 26 03/07/18. Diagnoses included schizoaffective disorder, cerebral infarction due to embolism of right middle cerebral artery, adjustment disorder with mixed anxiety and depressed mood among others. Review of the medical record and an incident report, both dated 03/09/18 documented Resident #61 sustained a fall on 03/09/18 without injury. Continued medical record review revealed a nurse's progress note documented Resident #61 reported to nurse #4 that he fell on 06/02/18 and that he was transferred to the ED (emergency department) for further evaluation. There was no other documentation of a fall for Resident #61 in his medical record. A quarterly minimum data set dated 04/20/18 assessed Resident #61 with clear speech, able to understand/understood, intact cognition, required staff assistance with bed mobility, set up assistance with transfers and unsteady balance with the ability to balance self without staff assistance. Review of an ED discharge summary dated 06/08/18 revealed Resident #61 was treated in the ED for contusion of the left knee sustained from a fall. There was no facility incident report, investigation, resident assessment, documentation of a fall or hospital transfer for 06/08/18 in the medical record for Resident #61. An interview with Resident #61 occurred on 07/25/18 at 3:44 PM and revealed he fell recently in the dark in his room and sustained a bruise, but that he could not recall the date of his most recent fall. He stated that he told the nurse when he fell.	F 842	in two separate locations under risk management and incident/accident reports in point click care. Falls documentation process was updated to combine the risk management and incident/accident report documentation to document witnessed, unwitnessed, or self-reported falls under risk management to include the SBAR/Progress note on 08/15/2018. All nurses will be educated on the new process by 08/24/18. • 8/20/18, DON or designee will audit the risk management reports daily in morning clinical meeting to verify all falls documentation is accurate to include SBAR/Progress note and risk factors to prevent future falls. DON or designee will review all falls documentation weekly at the IDT meeting. 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.	

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 07/27/2018

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 842	Continued From page 27	F 842		

The administrator stated in an interview on 07/26/18 at 11:07 AM that Resident #61 fell on 03/09/18 and that there was no other documentation/investigation of a fall since then. The administrator further stated that Resident #61 had a tendency to fall and not advise staff until after the fall. He stated that the facility did not have any other fall investigations for Resident #61 since his admission to the facility.

An interview with the director of nursing (DON) on 07/26/18 at 1:17 PM revealed nursing staff should document all falls, resident assessments and hospital transfers in the medical record. The DON further stated because this fall was not documented in the Resident's medical record, she had no way of determining why Resident #61 was transferred to the ED on 06/08/18.

A telephone interview occurred on 07/26/18 at 5:30 PM with Nurse #4 and revealed she could not recall if she was the assigned nurse for Resident #61 on 06/08/18, but that she did recall assessing his left lower leg after he reported to her that he had fallen. She stated the fall was unwitnessed and that the Resident's leg was dark/discolored/warm and he complained of pain. Nurse #4 stated Resident #61 was sent to the ED by nurse #5 for further evaluation. Nurse #4 stated that although she should have, she did not document the fall, her assessment of his leg, the hospital transfer or an investigation of the fall in his medical record.

A telephone interview occurred on 07/27/18 at 2:01 PM with nurse #5 who stated she was not the assigned nurse for Resident #61 on 06/08/18 when he reported that he fell. She stated nurse

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 07/27/2018

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 842	Continued From page 28 #4 assessed Resident #61 after the fall, but that she helped by calling the physician and obtained a physician's order to transfer Resident #61 to the ED for further evaluation. Nurse #5 further stated that since she was not the assigned nurse, she did not document the fall, the assessment of the resident or the transfer to the hospital in the medical record, but rather expected that the assigned nurse would do that.	F 842		