## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE  CHARLOTTE, NO. 28204  STREET ADDRESS, CITY, STATE, ZIF CODE 2616 BAST STH STREET CHARLOTTE, NO. 28204  PHISH TAG  FROM INITIAL COMMENTS  On October 24, 2018. The Division of Health Service Regualtion, Nursing Home Licensure and Cartification conducted a revisit (paper follow up). The facility was found to be in compliance effective October 3, 2018.  F 667 Care Plan Timing and Revision  OFFICE) (i) Prepared by an interdisciplinary team, that includes but is not limited to—  (ii) Prepared by an interdisciplinary team, that includes but is not limited to— (ii) A nurse aide with responsibility for the resident. (iii) Prepared by an interdisciplinary team, that includes but is not limited to— (ii) A nurse aide with responsibility for the resident. (iii) Prepared by an interdisciplinary team, that includes but is not limited to— (iii) A prepared by an interdisciplinary team, that includes a provide the comprehensive care plan to the resident and the resident and the resident are 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 on the resident and the development of the resident and the resident record if the residents are plan.  (iii) Chi or appropriate staff or professionals in disciplines as determined by the residents. (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:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE  COMPLETE CARE AT CHARLOTTE  DIVIDIGATION OF CONSECTION  (EACH DEFOCIONY MUST BE PRECEDED BY FULL REQUIRED TAKE)  (EACH DEFOCIONY MUST BE PRECEDED BY FULL REQUIRED TO THE APPROPRIATE DIVIDIGATION)  FOOD  INITIAL COMMENTS  FOOD  ON October 24, 2018, The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted a revisit (pager follow up). The facility was found to be in compliance effective October 9, 2018.  F657 Care Plan Timing and Revision  OFFICIAL OCTOPERS SHEET COMPLETE OF THE APPROPRIATE DIVIDIGATION OF TH			345201					_	
CAMPLETE CARE AT CHARLOTTE  (X4.) D. SUMMARY STATEMENT OF DEFICIENCIES  SEACH DEPICENCY MUST BE PRECIDED BY PULL RECOULATIONY OR LSC IDEMIFTING INFORMATION)  F 000  INITIAL COMMENTS  On October 24, 2018, The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted a revisit (paper follow up). The facility was found to be in compliance effective October 8, 2018.  F 657  Care Plan Timing and Revision CFR(s), 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 side with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the exitent 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 residents care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident, (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This RECUIREMENT is not met as evidenced by:	NAME OF PI	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE	1 10/	24/2010	
FREETIX TAG    CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)   TAG									
On October 24, 2018, The Division of Health Service Regualtion, Nursing Home Licensure and Certification conducted a revisit (paper follow up). The facility was found to be in compliance effective October 8, 2018. F 657 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  \$483.21(b)(2) A 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's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterfy review assessmentss. This REQUIREMENT is not met as evidenced by:	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
Service Regualtion, Nursing Home Licensure and Certification conducted a revisit (paper follow up). The facility was found to be in compiliance effective October 8, 2018.  F 657 Care Plan Timing and Revision  F 657 SS=D  CFR(s): 483.21(b)(2)(i)-(iii)  \$483.21(b) Comprehensive Care Plans \$483.21(b)(2) A comprehensive care plan must bee  (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 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:	F 000	INITIAL COMMENTS		FO	000				
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	AROPATORY	DIDECTOR'S OF PROVINCE	SLIDDLIED DEDDESENTATIVES SIGNATUD	<u> </u>		TITI E		(X6) DATE	

Electronically Signed 10/30/2018

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(	(X3) DATE SURVEY COMPLETED	
		245004	D WING			R-C	
		345201	B. WING _			10/24/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
COMPLET	E CARE AT CHARLOTT	E		2616 EAST 5TH STREET			
				CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT		
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