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AND FLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETE NUME: OF PROVIDER OR SUPPLIER COMPLETE 345201 A BUILDING COMPLETE Rest ADDRESS. CITY, STATE, 2P CODE COMPLETE CODE COMPLETE CARE AT CHARLOTTE STREET ADDRESS. CITY, STATE, 2P CODE STREET ADDRESS. CITY, STATE, 2P CODE COMPLETE CARE OF CORRECTION OF SHOULD BE RESOLUTION OF DEFICIENCIES STREET ADDRESS. CITY, STATE, 2P CODE COMPLETE CARE CORRECTIVE OF SHOULD BE RESOLUTION OF DEFICIENCIES STREET ADDRESS. CITY, STATE, 2P CODE CODE PRETX TAG SUMMAY STATEMENT OF DEFICIENCIES TAGE CORRECTIVE, NO. SHOULD BE RESOLUTION OF USIDE ENTERVINO. INFORMATION PRETX TAGE PRETX RESOLUCIONES FLAN OF CORRECTION RESOLUTION OF USIDE ENTERVINO. INFORMATION PRETX TAGE PRETX RESOLUTION OF USIDE ENTERVINO. INFORMATION PRETX TAGE PRETX RESOLUTION OF USIDE ENTERVINO. INFORMATION PRETX TAGE PRETX RESOLUTION OF USIDE ENTERVINO. INFORMATION DECIDENTIFY OF							
JAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, 21P CODE 203122019 NMME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, 21P CODE 2016 EAST TH STREET CHARLOTTE, NO. 28204 CMMPLET CARE AT CHARLOTTE SUMMARY STATEMENT OF DEPCENCIPS PERCY PERCY PERCY PERCY OP YMM PERCY SUMMARY STATEMENT OF DEPCENCIPS PERCY PERCY <td colspan="2">. ,</td> <td></td> <td>. ,</td> <td></td> <td>COMPLETED</td>	. ,			. ,		COMPLETED	
COMPLETE CARE AT CHARLOTTE 2818 EAST 5TH STREET CHARLOTTE, NC 28204 (M) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES INCOLOR PROVIDENTS PLAN OF CORRECTION (ECAL CORRECTIVE ACTION SHOULD BE PRETX. TAG 00,000 F 684 Quality of Care CFR(s): 483.25 F 684 F 684 4/1/19 SS=D Quality of Care CFR(s): 483.25 F 684 Interment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive cord review, the facility failed to conduct a physical assessment after a fail for 1 of 4 1) It was identified that the facility failed to conduct a physical assessment after a fail for 1 of 1 second review, the facility failed to conduct a physical assessment after a fail for 1 of 1 second review, the facility failed to conduct a physical assessment after a fail for 1 of 4 1) It was identified that the facility failed to conduct a physical assessment after a fail for 2 of 8 sampled residents at fisk for fails (Resident #3). The findings included: Resident #3 as quarterly Minimum Data assessment of intext cognition. The MDS indicated Resident #3's quarterly Minimum Data set (MDS) dated 01/10/19 revealed an assessment with transfers. 3) 100% of runxing staff received education to Fails Cl to and any missing assessments were immediately corrected. 3) 100% of runxing to desident with afail and it hat staff are not to move a resident who a anize and ill givi tivitin reach. Review of Resident #3's quarterly Minimum review afte			345201	B. WING		-	
COMPLETE CARE AT CHARLOTTE CHARLOTTE, NC 28204 (Y4) 0 PREFIX TAG IMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDENT FULL REQUARTORY ON LISC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDENTS FLAT OF CORRECTION (EACH DEFICIENCIES) (PS) (DATE OF DEFICIENCY F 684 Quality of Care CFR(s): 483.25 F 684 F 684 4/1/19 S S=D CFR(s): 483.25 \$ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. This REQUIREMENT is not met as evidenced by: 1) It was identified that the facility failed to conduct a physical assessment after fail or 0 4 sampled resident after fail or 10 4 sampled resident #3's acrepted pain the facility nust ensure that fail are or on one person and type 2 diabetes mellitus. 1) It was identified that the facility failed to conduct a physical assessment after resident assessment after resident assessment were complete. This audit was complete by the DON and recorded on the fails QL tool and any mitisting assessment. Review of Resident #3's care plan dated 12/28/18 revealed interventins to preven	NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRETX TAG IEACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG CEACH CORREPATIVE ACTION SHOULD BE CROSS REFERENCED to THE APPROPRIATE COMMETION DEFICIENCY F 684 Quality of Care CFR(5): 483.25 F 684 F 684 4/1/19 S 483.25 Quality of Care Classify residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 1). It was identified that the facility failed to conduct a physical assessment after a statistical assessment after a fall for 1 of 4 sampled resident at risk for fails (Resident #3). 1). It was identified that the facility failed to conduct a physical assessment after resident #3 as Resident #3 is no longer a resident at the facility. 1). It was identified that the facility failed to conduct a physical assessment after resident #3 as Resident #3 is no longer a resident #3 thin the past 30 days were reviewed to ensure resident #3 as Resident #3 is quarterly Minimum Data Set (MDS) dated 01/10/19 revealed an assessment of intext cognition. The MDS indicated Resident #3 required the supervision of one person with transfers. 3) 100% of fursing or designer will review of Resident #3 required the supervision of one person with transfers. 3) 100% of fursing or designer will review all new falls daily for 6 weeks to reminders to ask for assistance, proper footwear and call light within reach. 3) 100% of fursing or designer will review all residents with falla mare tha tat af are no to mowe a runse assessment is	COMPLET	E CARE AT CHARLOTTI	E				
SS=D CFR(\$): 483.25 \$ 483.25 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents: Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews, and record review, the facility failed to conduct a physical assessment after a fall for 1 of 4 sampled residents at risk for falls (Resident #3). The findings included: Resident #3 was admitted to the facility on 02/23/18 with diagnoses which included epilepsy and type 2 diabetes mellitus. Review of Resident #3's quarterly Minimum Data Set (MDS) dated 01/10/19 revealed an assessment of intact cognition. The MDS indicated Resident #3's care plan dated 12/28/18 revealed interventions to prevent falls included reminders to ask for assistance, proper foottwear and call light within reach. Review of Resident #3's care plan dated 12/28/18 revealed interventions to prevent falls included reminders to ask for assistance, proper foottwear and call light within reach. Review of a nursing note dated 02/15/19 at 5:17 AM revealed Resident #3' requested pain mediation. Nurse #1 documented Resident #3' complained of left leg pain with swelling and	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE		
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' fohices. This REQUIREMENT is not met as evidenced by:1) It was identified that the facility failed to conduct a physical assessment after Resident #3 trisk for falls (Resident #3).The findings included: 02/23/18 with diagnoses which included epilepsy and type 2 diabetes mellitus.1) It was identified that the facility failed to conduct a physical assessment after Resident #3 squarterly Minimum Data Set (MDS) dated 01/10/19 revealed an assessment falts required the supervision of on eperson with transfers.1) It was identified that the facility assessment simediately complete by the DON and recorded on threat cognition. The MDS indicated Resident #3 care plan dated 12/28/18 review of Austion to prevent falls included reminders to ask for assistance, proper footwear and call light within reach.1) Director of Nursing or designee will review all new falls daily for 6 weeks to ensure all resident #3 requised pain medication. Nurse #1 documented Resident #3 complained of left leg pain with swelling and1) Director Mursing or designee will recommendations if necessary.				F 684		4/1/19	
complained of left leg pain with swelling and		 S=D CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews, and record review, the facility failed to conduct a physical assessment after a fall for 1 of 4 sampled residents at risk for falls (Resident #3). The findings included: Resident #3 was admitted to the facility on 02/23/18 with diagnoses which included epilepsy and type 2 diabetes mellitus. Review of Resident #3's quarterly Minimum Data Set (MDS) dated 01/10/19 revealed an assessment of intact cognition. The MDS indicated Resident #3's care plan dated 12/28/18 revealed interventions to prevent falls included reminders to ask for assistance, proper footwear and call light within reach. 			 to conduct a physical assessment af Resident #3 fell. Facility unable to a the Resident #3 as Resident #3 is not longer a resident at the facility. 2) 100% of residents with falls with past 30 days were reviewed to ensur- resident assessments were complete This audit was complete by the DON recorded on the Falls QI tool and any missing assessments were immediat corrected. 3) 100% of nursing staff received education to ensure a nurse assessmi is immediately complete upon a fall a that staff are not to move a resident without a nurse assessment. 4) Director of Nursing or designee review all new falls daily for 6 weeks ensure all residents with falls have n assessments. Results of these audit be discussed at the facility QA comm meeting monthly for additional 	ter ssess 50 in the re 50 and 70 and	
				_		(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.

04/01/2019

PRINTED: 04/02/2019

		FORM APPROVED							
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING				PLETED		
		345201	B. WING			C 03/12/2019			
NAME OF PI	ROVIDER OR SUPPLIER	1			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.			
COMPLET	E CARE AT CHARLOTT	E			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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
F 684	Continued From page	2 1	F	684	4				
		ent #3 informed the nurse a		00					
	nurse aide assisted her after a fall in the bathroom. The physician received notification.								
	Review of a left leg x-	ray report dated 02/15/19							
		res of Resident #3's distal							
	tibia and fibula. Resid								
	admission to the hosp	02/15/19 with subsequent bital for treatment.							
	Telephone interview with Nurse #1 on 03/11/19 at								
	11:45 AM revealed Nurse Aide (NA) #1, a								
	temporary agency nurse aide, informed her Resident #3 requested pain medication. Nurse								
	#1 stated Resident #3 was in bed and informed								
		ne bathroom. Resident #3 sted her off the floor and							
	· ·	#1 explained Resident #3's							
	leg was swollen and o	discolored so the physician							
	received immediate notification. Nurse #1 estimated the time between the fall and an								
		was approximately 45							
	minutes.								
	NA #1 was not availa	ble for interview.							
	Telephone interview v	vith Resident #3's physician							
	on 03/11/19 at 2:16 P	M revealed Resident #3							
		sical assessment after a fall. ed a delay in assessment did							
		e or worsen the injury.							
		ector of Nursing (DON) on							
	03/11/19 at 3:22 PM r								
		cility on 03/4/19 and had no Resident #3's fall. The DON							
	reported he expected								
		nediately conducted after a ed he expected staff to							

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 04/02/2019

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345201	B. WING	3. WING		C 03/12/2019		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
COMPLET	E CARE AT CHARLOTTI	E		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)			PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE G CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 684	1.0	e 2 hurse when a resident fell.	F	584				

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Facility ID: 952971

If continuation sheet Page 3 of 3

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