PRINTED: 04/26/2018 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(>	X3) DATE S COMPLI	
		345201	B. WING _			C 03/1	2/2018
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	E	(X5) COMPLETION DATE
F 000	Service Regulation, N Certification Section of complaint investigation information requested investigation, the exit March 12, 2018.  Immediate Jeopardy of CFR 483.10 at tag F5 of J CFR 483.25 at tag F6 of J Tag F689 constituted	3, The Division of Health Jursing Home, Licensure & conducted an onsite on. Due to additional date was extended to  was identified at: 880 at a scope and severity  substandard quality of care.  began on 2/20/18 and was	FO	00			
F 580 SS=J	completed. Notify of Changes (In CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the reside consistent with his or representative(s) where (A) An accident involvesults in injury and his physician intervention (B) A significant chan mental, or psychosocideterioration in health status in either life-threclinical complications	cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or n); eatment significantly (that is,	F 5	80		3	3/12/18
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		()	X6) DATE

Electronically Signed 03/29/2018

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.

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345201	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204	03/12/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 580	commence a new for (D) A decision to trar resident from the fact §483.15(c)(1)(ii).  (ii) When making not (14)(i) of this section all pertinent informat is available and proviphysician.  (iii) The facility must resident and the resimplement and the resimplement in room as specified in §483.  (B) A change in resident of the representative (e)(10) of this section (iv) The facility must update the address (phone number of the representative(s).  §483.10(g)(15)  Admission to a competitation of the representative (e)(15)  Admission to a competit	erse consequences, or to m of treatment); or isfer or discharge the dility as specified in diffication under paragraph (g), the facility must ensure that son specified in §483.15(c)(2) dided upon request to the disconsequence of the disconseq	F 58	1. The facility contacted resident #1' guardian on 2/21/18 and notified her o resident leaving the facility on 2/20/18	f
		d interviews with staff, the diately notify DSS when 1 of		failed to return. In addition to this, the facility continued to assist in filing a	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BOILDI	_		С	
		345201	B. WING				12/2018
NAME OF P	ROVIDER OR SUPPLIER	0.020.		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2010
TO UNE OF TH	NOVIDER OR GOLF EIER				616 EAST 5TH STREET		
COMPLET	E CARE AT CHARLOTT	E			CHARLOTTE, NC 28204		
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 2	F	580			
		Resident #1, reviewed for	•		missing person's report with the local la	aw.	
		uardianship, left the facility,			enforcement and cooperating with the	444	
	_	ave of absence (LOA). DSS			guardian to help locate and ensure		
		notified when Resident #1			resident is safe. Resident was located	in	
	,	the facility and left the			the emergency room of the hospital		
	•	5:15 PM. Resident #1			unharmed on 2/21/18.		
	_	acility for approximately 12			2. 100% audit conducted of all resident	ents	
	hours before DSS wa	s notified.			with documented DSS guardians		
					appointed to them to ensure that they a	are	
	Immediate jeopardy b	pegan on 2/20/18 at 5:15 PM			safe and remain in the facility and have	<u>ڊ</u>	
	when Resident #1 lef	t the facility, unauthorized,			not left the facility without the guardian	s	
	and the facility failed				permission on 3/7 by facility Social		
	_	ediately. Immediate jeopardy			Worker.		
		18 at 5:55 PM when the			3. 100% in-service education and		
		cceptable credible allegation			training provided to all licensed nurses	,	
	of compliance. The fa				nurse managers, and facility		
	· ·	r scope and severity of D			administrative staff stating that any		
		potential for more than			resident deemed incompetent with		
		not immediate jeopardy) to			guardianship paperwork must have		
	· ·	and ensure monitoring			approval from the guardian prior to	ilita	
	systems put into plac	e are effective.			facilitating any request to leave the facilitating and the facilitation and the facilitation and the facilitation and the fa	iity.	
	The findings included				notified of all emergent and non-emerg	ont	
	The findings included				transfers, requests for leave of absence		
	Resident #1 was adm	nitted to the facility on			or AMA (against Medical Advice).	-	
	l	skilled nursing facility, per			Resident guardian ship information car	າ be	
		t. Diagnoses included			located in the resident's clinical chart, a		
		nce, multiple sclerosis			that chart must be reviewed by the cha		
		ng type, major depressive			nurse, nurse supervisor, DON, or other	-	
		to thrive, tachycardia,			administrative staff, and guardian		
	chronic pain, general	muscle weakness,			contacted prior to resident leaving the		
		isease, hypersomnia (falls			facility. To ensure resident safety the D	oss	
	asleep easily) due to				or Legal Guardian is the only person	ſ	
	1	ght upper extremity and			authorized to permit resident to leave t	he	
	fingers of right hand,				facility. The Administrator and the	ſ	
		, chronic tobacco/marijuana			Director of Nursing must be immediate		
		vith cognitive deficits, and a			notified of any attempts of a resident to		
	history of falling.				leave the facility. The nurse responsib	le	
					for resident wishing to leave must		

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NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2010
					S16 EAST 5TH STREET		
COMPLET	E CARE AT CHARLOTT	E			HARLOTTE, NC 28204		
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F 580	Continued From page	e 3	F 5	580			
	Guardian (due to poo Guardian/Emergency				document in the resident's medical rec the name and contact number of perso notified and time of notification.  4. In order to ensure that the facility is	n s to	
	Memo of Understand	ty's Guardianship Policies ing, for Resident #1, signed the Administrator on 10/4/17,			remain in compliance for the above cite deficiency, the Director of Nursing or designee to review residents charts wit DSS appointed guardianship to ensure	h	
	Facility personnel und Court has given (nameresponsibilities. By land all decisions regarding of Resident #1 and all ward (Resident #1). It matters legally rests to permission for out-of- A quarterly Minimum 12/19/17, assessed Figure 12.	derstand that the Clerk of ned guardian) guardianship w, she is required to make g the care and maintenance ny changes that affect the The final decision for these with DSS. DSS must grant facility visitations.  Data Set (MDS) dated Resident #1 with intact ch/communication skills, and			resident with DSS guardianship has be allowed to leave the facility without the guardian's permission, that proper documentation is in the resident's med record upon times of approved leaves absence ensuring guardians are notific in the appropriate time frame. This rewill be reflected on the Resident Guard Approval and Notification monitoring to These reviews will be conducted daily days, weekly x4 weeks, and monthly x months. Upon these dates of review, if any inconsistency is noted it is to be addressed and corrected at that time. Results of these review will be present.	een ical of ed iew lian ol. x5 3 f	
	Nurse #1 (Unit Management on a LOA from to (5:00 PM)." Nurse #1 the facility alone due he stated he was "cate on the west side of C documented that Rest the facility. There was authorization/notificated A NN dated 2/20/18 and documented that Rest facility earlier that every series of the state of the st	sident #1 signed out and left some sident #1 signed out and left sides.			to the facility's monthly Quality Assurar Committee for review and any adjustments needed to this plan will be made at the time.		

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	ROVIDER OR SUPPLIER	TE	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204	03/12/2010
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F 580	documented the fact (named contact) contified the Director did not document specified by the DSS/DON.  A progress note dat Social Worker (SW) #1 left the facility or returned. As a result contacted the police Persons Report.  Review of the Charl Department Incident 09:06 AM, revealed Persons report for Findicated Resident 5:15 PM. His incapation of the Department of the Department of the Department for Findicated Resident 5:15 PM. His incapation of the Department of the Depar	ge 4  at 6:52 AM by Nurse #3 cility spoke to DSS after hours incerning Resident #1 and of Nursing (DON). The NN oecifics of the conversations  and 2/21/18 at 2:41 PM by documented that Resident of 2/20/18 and had not at the SW documented she department to file a Missing ootte - Mecklenburg Police at Report, dated 2/21/18 at Nurse #1 filed a Missing Resident #1. The report #1 left the facility on 2/20/18 at acity types were listed as rysical disability and poor	F 580		
	transcript revealed ED 2/21/18 at 1:56 weakness/fatigue, r episodes and smelli Resident #1 reported Guardian in place wattempts to contact documented they whad been declared when he became agassessment, demark	gency Department (ED) Resident #1 presented to the PM with complaints of eported multiple incontinent ed of strong urine odor. ed to the ED he had DSS with multiple unsuccessful ED The ED transcript ere unaware if Resident #1 medically incompetent, and gitated with plans for further nded to be released, he e ED on 2/21/18 at 7:13 PM			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(>	(3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	'E	STREET ADDRESS, CITY, STATE, ZIP CODE  2616 EAST 5TH STREET  CHARLOTTE, NC 28204			03/12/2010
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F 580	against medical advi  A telephone interview DSS Guardian reveat DSS after hours around 5:00 PM and facility. The DSS Guardian reveat around 5:00 PM and facility. The DSS Guardian SW and advised her Missing Persons Restated DSS was legal #1 which required Disprior to any out of fact Guardian stated Resauthorization to leave notification due to his DSS should have be he left the facility on  An interview was conwith Nurse #1, (Unit she knew Resident # that she did not notification due to his DSS should have be he left the facility on  An interview was conwith Nurse #1, (Unit she knew Resident # that she did not notification due to his DSS should have notified signed himself out be required because I he before." Nurse #1 station on 2/2 to sign out, planned told him it was not sa Nurse #1 stated she #1 wanted to do and	v on 3/5/18 at 2:29 PM with alled the facility contacted and 6:00 AM on 2/21/18 to #1 left the facility on 2/20/18 had not returned to the facility on 0 - 9:00 AM, spoke to the to call the police to file a cort. The DSS Guardian ally responsible for Resident SS authorization/notification cility visitations. DSS ident #1 did not have the facility without DSS incompetent status and ten notified immediately when 2/20/18.  Inducted on 3/5/18 at 2:45 PM Manager). Nurse #1 stated #1 had a DSS Guardian, but by DSS. Nurse #1 stated #1 had a DSS Guardian, but by DSS. Nurse #1 stated #1 had a DSS Guardian, but by DSS. Nurse #1 stated #1 had a DSS Guardian, but by DSS. Nurse #1 stated #1 had a DSS Guardian, but by DSS because he never the fore, not sure if that's have never dealt with this tated Resident #1 came to the 20/18 and stated he wanted to return that night, and she afte to leave the facility alone. It told the DON what Resident the DON stated to make	F 5	80		
		Administrator on 3/5/18 at at on 2/20/18, he was made				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
			A. BOILD			С	
		345201	B. WING			03/	12/2018
	ROVIDER OR SUPPLIER TE CARE AT CHARLOTT	E		2	TREET ADDRESS, CITY, STATE, ZIP CODE 616 EAST 5TH STREET CHARLOTTE, NC 28204		
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F 580	Resident #1 signed hut was expected to stated Resident #1 hwhen he (the administivation notify the DS) instruct his staff to not considered Resident based on intact cognifurther stated that on AM, the SW advised return to the facility, notified and the policic Administrator stated was something wron Resident #1 left the finotified the DSS Guawas not the case.  An interview with the revealed she reporte PM to the DON, Administrator #4 and Nurse #5 that assisted up the hill. If and #5 both immediate the hill to find Reside unsuccessful. The State Resident #1 had a Dimmediately notify DS that administration/notify DS that administration that administr	either the SW or a nurse that himself out, left the facility, return. The Administrator ad already left the facility strator) became aware, he S Guardian, nor did he otify DSS because he #1 safe to leave the facility ition. The Administrator 2/21/18 around 9:00 - 9:30 him that Resident #1 did not DSS Guardian had been e had been called. The that if the facility felt there	F	580			
	revealed Nurse #1 to 5:00 PM that Reside to go visit friends. Th facility at the time, bu	8 at 3:55 PM with the DON old her on 2/20/18 around ont #1 wanted to leave facility e DON stated she was in the ut that she did not speak to ew his medical record, but					

STATEMENT OF DEFI AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345201	B. WING		C 03/12/2018
NAME OF PROVIDE	ER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE  2616 EAST 5TH STREET  CHARLOTTE, NC 28204	1 00/12/2010
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knew state Under the rauth facili SW Resi force want allow state Guaretur DSS that G	ed she did not reverstanding and the restanding and the need to immediate orization for Restanding the restanding and the pools and they both against the facility did red and until the near. The DON states of the facility should red and revealed the facility of the facility with Nurse was unable to care of the facility. Nurse #4 state ident #1 was with the facility and alerted the facility and	Guardian in place. The DON view the DSS Memo of herefore was not aware of tely notify DSS to obtain ident #1 to have an out of a stated she spoke to the hered that due to the nition, the facility could not stay in the facility if he she advised nursing staff to sign himself out. The DON I not contact the DSS axt day when he did not led that she just read the standing and realized now do have notified the DSS authorization at the time wanted to leave the facility.  8 at 4:39 PM with the NP led the staff to have contacted then Resident #1 left because	F 58		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204	1 00/12/2010
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F 580	she known she would because she knew the An interview on 3/5/1 revealed she was not Resident #1 was with hill with assistance. It worked with Resident him, but went outside Nurse #5 stated "whore turned to the facility DON/Administrator" Resident #1. Nurse #5 of the DSS Guardian known I would have called."  A telephone interview 3/6/18 at 9:34 AM ar worked on the 11 PM Resident #1. Nurse #5 work on 2/20/18, she that Resident #1 signand had not returned notified DSS and Nu stated "That was unumy shift." Nurse #3 signardian around 1:0 around 5:00 AM at worked DSS receptionist and was not in the facility 11:00 PM, that he lef shift around 5:00 PM	Nurse #4 further stated had d have notified the Guardian nat was required.  8 at 5:38 PM with Nurse #5 tified by the SW that nessed outside going up the Nurse #5 stated she had not t #1 before and did not know e with Nurse #4 to locate him. en we did not find him, we y and told the	F 58		
	Nurse #2 revealed sl Resident #1 a few tir	ne had only worked with nes before 2/20/18 and she e had a DSS Guardian.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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F 580	facility around 5:00 F the nurse's station dr requested to sign hin LOA to visit with som she contacted Nurse direction because Re facility on her shift be #1 spoke to the DON Resident #1 to sign h medical record and a the Release of Resp. Home Visits sheet to #2 stated he signed of she was not aware h Nurse #2 stated that 11:30 PM, he was not Nurse #3, but she did An interview with the PM revealed he expe. Guardian for Resider of their legal respons  The Administrator an notified of immediate PM. The facility proviallegation of complia  Credible Allegation of F580:  In order to correct the to providing the prop guardians upon resid facility that was cited	on 2/20/18 she arrived to the M and Resident #1 was at lessed, in his wheel chair and inself out of the facility for a le friends. Nurse #2 stated #1, the supervisor, to get esident #1 had never left the efore. Nurse #2 stated Nurse who advised to allow himself out, so she got his allowed Resident #1 to sign consibility for Therapeutic sign out of the facility. Nurse out and left the facility, but he was a ward of the state. When she left shift around with back, she passed report to do not notify anyone else.  In physician on 3/6/18 at 1:05 lected staff to notify the DSS and #1 as a courtesy because ibility for the Resident.  In d Director of Nursing were jeopardy on 3/6/18 at 3:55 lided an acceptable credible ince on 3/7/18 at 3:11 PM.  In Compliance:  In deficient practice pertaining the deficient practice pertaining the resident wishing to leave the as an Immediate Jeopardy 3:55pm, the facility has	F	580		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		TE SURVEY MPLETED
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F 580	resident at Comple been appointed a g Social Services (Di the interest to leave would return later to leave the facility facility. The reside prior to his departu against the guardiathis action, the faci guardian on 2/21/1 situation and continmissing person's reenforcement and chelp locate and enswas located in the hospital unharmed.  2. The facility has illed to this deficient understanding of the resident wishing to treated as an incordecision to leave the authorized by the repartment of Social residents with diappointed to them and remain in the facility without the grand facility administresident deemed in resident deemed in res	intified as resident #1 was a set to the Care at Charlotte and has guardian by the Department of SS). On 2/20/18 he expressed to the facility stating that he hat evening and was allowed but choose not to return to the int's guardian was not notified are to the facility, which acted in's wishes. In order to correct lity contacted resident #1's 8 and notified her of the nued to assist in filing a eport with the local law cooperating with the guardian to sure resident is safe. Resident emergency room of the on 2/21/18.  Identified the processes that by was the lack of the nursing staff that the leave the facility was to be in petent individual and the facility could only be esident's appointed ital Services (DSS) guardian. The sess the facility initially checked focumented DSS guardians to ensure that they are safe acility and have not left the guardian's permission on	F	580		

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		345201	B. WING			1	12/2018
NAME OF PI	ROVIDER OR SUPPLIER	1	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
001101 57				20	616 EAST 5TH STREET		
COMPLET	E CARE AT CHARLOT	TE		С	HARLOTTE, NC 28204		
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F 580	The guardian must I emergent and non-efor leave of absence Advice). Resident go be located in the reschart must be review nurse supervisor, Dostaff, and guardian cleaving the facility. DSS or Legal Guardianthorized to permit The Administrator almust be immediately resident to leave the responsible for residence in the resident in the resident in the resident and non-efficient solutions.	ny request to leave the facility. De immediately notified of all emergent transfers, requests a or AMA (against Medical guardianship information can sident's clinical chart, and that wed by the charge nurse, ON, or other administrative contacted prior to resident To ensure resident safety the dian is the only person a resident to leave the facility. In the Director of Nursing y notified of any attempts of a	F	580			
	in compliance for the Director of Nursing of residents' charts wit guardianship to ensiguardianship has be facility without the giproper documentation record upon times of ensuring guardians time frame. This revident Guardian amonitoring tool. The daily x5 days, week months. Upon these inconsistency is not corrected at that time will be presented to	e that the facility is to remain to above cited deficiency, the for designee to review th DSS appointed the ure no resident with DSS appointed to leave the ure no resident's medical of approved leaves of absence are notified in the appropriate approval and Notification approved the second the experience of the second the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPR  DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641 SS=D	the time.  The facility has taken and initiated this plan met the requirements Immediate Jeopardy notification effective Madministrator is to be implementing this Alle Immediate jeopardy with 5:55 PM when interviting administrative staffing on the facility's revise notifying the DSS Guan appointed DSS Guan appointed DSS Guan appointed DSS Guanuthorized.  Accuracy of Assessm CFR(s): 483.20(g)  §483.20(g) Accuracy The assessment must resident's status.  This REQUIREMENT by:  Based on medical resinterviews, the facility Section 0800, Behavit the Minimum Data Section 11 MDS assessment The admission MDS and a quarterly MDS	the before mentioned steps in order to attest that it has to alleviate the status if for providing proper March 7, 2018. The facility responsible for egation of Compliance.  Was removed on 3/7/18 at ews with nursing staff and evealed staff were educated d procedures regarding ardian when a resident with transitional leaves the facility, sents  of Assessments. It accurately reflect the responsible to accurately code ors, Rejection of Care, on the total condition of Care, on the total condition of Care, on the total condition of Care, assessment dated 9/29/17 assessment dated 12/19/17 ident #1 rejected medication		1. Resident #1's MDS assessment be amended to accurately reflect the resident's condition at the time of the assessment. 2. 100% of all resident's most curre MDS assessment will be audited by the Administrator or designee to ensure the assessment accurately matches the nurse's notes documented in the resident's chart at during the time fram of the assessment. Any inconsistence	s to  nt ne nat ne	3/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER:  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345201	B. WING _				C <b>12/2018</b>
	ROVIDER OR SUPPLIER	TE	,	STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204			
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F 641	9/22/17 from another the Resident's requestive leads on the Resident's requestive leads on the Resident's requestive leads on the Review of nursing procession of the Resident #1 refused 9/24/17 and 9/26/17 (multiple attempts).  Review of a social standard of the Resident with Resident rursing reports of result of bed, attend and progress note docured to refuse conversation with the Review of the admistance of the Resident from the Resident from the Resident from the Review of the September of t	mitted to the facility on er skilled nursing facility, per est, and discharged on a history of medical competent with cognitive depressive disorder, among rogress notes revealed a medications on 9/23/17, and showers on 12/18/17 revices progress note, dated ed that the social worker (SW) that that day regarding epeated recent refusals to get citivities or take showers. The mented that Resident #1 these services during the e SW.  Sision MDS assessment dated arterly MDS dated 12/19/17, that was assessed with intact of reject care according to viors, Rejection of Care, uency.  Sember 2017 Care Plan aviors (refusing 1) were not documented. The revised on 1/2/18, but did not	F6	will be noted on the MDS At tool and the assessment wi at that time. Audit to be cor 3/30/18.  3. 100% education to be presented to be provided to the MDS regard depicting resident behaviors documented in the resident on the MDS assessments in depict a complete picture of This is to include but not liming refusals and aggressive belied education will be given by the Administrator by 3/30/18.  4. Proportions of all assess conducted in the months for conclusion of the initial audit selected at random by the adesignee to be reviewed for according to the clinical characteristic assessments completed will monthly x1, 25% of assessing completed in the following reviewed monthly x1, and 1 assessments completed in subsequent month will be remonthly x1. Result from the be brought to the facility's in Assurance Committee for rechanges recognized will be time.	ill be amended impleted by a provided to a per completing ding accurate as that are it's clinical channer of the resident inted to thavior. This intel the administrator of accuracy art. 50% of all be reviewed ments amonth will be allow of the eviewed ese audits we monthly Qual eview and ar	ed all dely art art it.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		345201	B. WING_			C <b>03/12/2018</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2616 EAST 5TH STREET  CHARLOTTE, NC 28204			
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F 641	A telephone interview 3/8/18 at 3:10 PM. The both the MDS assess and 12/19/17 (quarter Behaviors, Rejection The SW stated she remedical record and spresident regarding his attend activities or take continued to refuse the conversation. The SW reason or express a poshe did not code the lithese refusals because was updated on his codiscussed during depoint and the second of the second of the lithese refusals because was updated on his codiscussed during depoint and resources when staff assessment and had that the admission MI 9/29/17 for Resident and behavior related to redocumented in his metupdated on his care properties.	with the SW occurred on the SW stated she completed ment dated 9/29/17 (annual) of the SW stated she completed ment dated 9/29/17 (annual) of Care for Resident #1. Eviewed the Resident's tooke to the nurses and so refusals to get out of bed, are showers and that he these services during her was stated he did not give a the stated he did not give a the stated he was assessment regarding to see she thought this behavior are plan and it was artment meetings.  I occurred on 3/8/18 at 3:40 of nursing (DON). The DON staff to utilize the MDS dor come to her as completed the MDS questions. The DON stated DS assessment dated #1 should have coded the fusing medications as edical record and been to the stated of the s	F	541			
F 689 SS=J	assessment dated 12 code the MDS for rejerefusing showers.		F 6	689		3/12/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345201	B. WING		C 03/12/2018		
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204	1 00/12/2010			
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 689	Continued From page The facility must ensign §483.25(d)(1) The reas free of accident has §483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by:  Based on medical rewith the legal guardia Services (DSS)), the practitioner (NP), a reinterviews with staff, and obtain authorizat (LOA) for a ward of Nassessed with mental prevent an unauthori. The facility failed to authorization for Resigned himself out of permission of facility public transportation, unauthorized. Reside facility for approximal presented to the Eme 2/21/18 at 1:56 PM for	e 15  ure that - sident environment remains azards as is possible; and esident receives adequate stance devices to prevent  is not met as evidenced ecord review, an interview an (Department of Social physician, the nurse esident (Resident #6) and the facility failed to supervise tion for a leave of absence lorth Carolina (Resident #1) al/physical disabilities to zed LOA from the facility. Sobtain DSS Guardian ident #1 on 2/20/18 when he the facility at 5:15 PM with staff, left the facility and took	F 689	DEFICIENCY)	s lity st the nt of		
	with an appointed DS  Immediate jeopardy I when the facility faile DSS Guardian prior t sign out of the facility unsupervised/unauth jeopardy was remove when the facility prov allegation of complian	oss Guardian of the person.  oss Guardian of		safety of all other residents with exit seeking ideations or behaviors the fact has checked all residents with documented wandering and exit seeking behaviors and ensured that they are so and remain in the facility. The facility elopement prevention system was also tested to ensure it was functional and place on 3/5 by the Administrator.  3. 100% in-service and training proversity of the safety of the saf	ility ng afe □s o in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	5/12/2010	
				2616 EAST 5TH STREET			
COMPLET	E CARE AT CHARLOTT	E		CHARLOTTE, NC 28204			
				CHARLOTTE, NC 20204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 16	F 68	39			
F 689	Severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective.  The findings included:  Resident #1 was admitted to the facility on 9/22/17 from another skilled nursing facility, per the resident's request. Diagnoses included medical non-compliance, multiple sclerosis (MS) relapsing and remitting type, major depressive disorder, adult failure to thrive, tachycardia, chronic pain, general muscle weakness, peripheral vascular disease (PVD), hypersomnia (falls asleep easily) due to medical condition, contractures of the right upper extremity and fingers of right hand, bladder spasms/incontinence, chronic tobacco/marijuana usage, incompetent with cognitive deficits, and a history of falling.		F 68	to all certified nurse sassistants, licensed nurses, and facility administrative staff stating that the facility has the responsibility to ensure the safety and supervision of residents of the facility in order to prevent accidents. To maintain this supervision, if a resident expresses the intent to leave the facility to a CNA, that aide must immediately notify the charge nurse, nursing supervisor, Director of Nursing, and or Administrator. This is to ensure the resident safety and the DSS or Legal Guardian is the only person authorized to permit resident to leave the facility. The guardian must be immediately notified of all emergent and non-emergent transfers, requests for leave of absence or AMA (Against Medical Advice) by the change nurse, nursing supervisor, DON, Administrator, or any member of administrative staff. Resident guardianship information can be located in a resident clinical chart, and that			
	Memo of Understand	ty's Guardianship Policies ing, for Resident #1, signed the Administrator on 10/4/17,		contacted prior to resident lear facility. To ensure resident satisfies or Legal Guardian is the only pauthorized to permit resident the facility.	fety the DSS person		
	Court has given (nam responsibilities. By la all decisions regardin of Resident #1 and an ward (Resident #1). T	derstand that the Clerk of ned guardian) guardianship w, she is required to make g the care and maintenance ny changes that affect the The final decision for these with DSS. DSS must grant facility visitations.		4. In order to ensure that the remain in compliance with safe supervision of residents deem incompetent with DSS guardia Director of Nursing or designe residents charts with DSS app guardianship to ensure no res DSS guardianship has been a	e ed anship, the e to review pointed ident with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
COMPLETE CARE AT CHARLOTT	F		26	16 EAST 5TH STREET			
COMPLETE CARE AT CHARLOTT	<b>=</b>		CI	HARLOTTE, NC 28204			
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Resident #1 had functional diagnoses of MS, PV weakness and major required maximum - to most of his functional mechanical lift for transfunctional decline and antidepressant which adverse side effects.  A quarterly Minimum 12/19/17, assessed Foognition, clear speed adequate vision/heari extensive/total staff a hygiene, and bathing feeding abilities and bowel, impaired upper (ROM) on right side, in ROM on both sides, is surface transfers and During the assessmenot transfer, move from position, walk, or turn antidepressant 7 of the Review of the medical notes (NN), occupation physician's orders and revised 1/2/18, reveal transfers with a mechanical ideations with (1/24/18) and violation policy (12/18/17, 1/2/17) resulted in a facility is	nent dated 9/29/17 identified tional deficits related to his D, general muscle depressive disorder. He total staff assistance with needs, required a nsfers, was at risk for direceived routine placed him at risk for Data Set (MDS) dated Resident #1 with intact ch/communication skills, ing, no behaviors, required ssistance with toileting, he was independent with ped mobility, incontinent of the extremity range of motion impaired lower extremity unsteady with surface to moving on/off the toilet. In the review, Resident #1 did on seated to standing around and he received and the 7 days reviewed.	F	689	leave the facility without the guardian permission, that proper documentation in the resident smedical record upon times of approved leaves of absence ensuring guardians are notified in the appropriate time frame. The resident sign out sheets will be reviewed, which located in the resident smedical recording the review will be reflected on the Resident Guardian Approval and Notification monitoring tool. These reviews will be initiated 3/8/18 and be conducted daily x5 days, weekly x4 weeks, and monthly x3 months by the Director of Nursing or Designee. Upon these dates of review, if any inconsiste is noted it is to be addressed and corrected at that time. Results of these review will be presented to the facility monthly Quality Assurance Committee review and any adjustments needed to this plan will be made at the time.	s is rd.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345201 B. WING			C 03/12/2018		
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CO 2616 EAST 5TH STREET CHARLOTTE, NC 28204		3/12/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	in the medical record signed himself out of 5:10 PM. According the date recorded as should have been 2/2 A NN dated 2/20/18 a Manager) recorded From the facility "at al #1 educated him on to the need for assist ambulation, but he st bus to visit friends or The NN documented and left the facility. To f supervision or DS A NN dated 2/20/18 a documented that Resfacility earlier that evifacility and a report with a number of the process of the Director of did not document spewith DSS/DON.  A progress note date Social Worker (SW) #1 left the facility or returned. As a result	ending placement).  The Release of Brapeutic Home Visits, kept Increased Resident #1  The facility on 2/21/18 at the facility on 2/21/18 at the multiple staff interviews, 2/21/18 was an error and 20/18.  The facility on 2/21/18 at the multiple staff interviews, 2/21/18 was an error and 20/18.  The facility alone #1 (Unit Resident #1 went on a LOA cout 1700 (5:00 PM)", Nurse eaving the facility alone due ance with wheel chair ated he was "catching the inthe west side of Charlotte." That Resident #1 signed out there was no documentation in authorization for this LOA.  The facility alone due ance with wheel chair ated he was "catching the inthe west side of Charlotte." That Resident #1 signed out there was no documentation in authorization for this LOA.  The facility on 2/21/18 by Nurse #2, sident #1 signed out of the ening, had not returned to was passed to the oncoming at 6:52 AM by Nurse #3 ity spoke to DSS after hours cerning Resident #1 and off Nursing (DON). The NN exifics of the conversations	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345201	B. WING _			C <b>03/12/2018</b>	
	NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204		03/12/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Persons Report.  Review of the Charlo Department Incident 09:06 AM, revealed Nersons Report for Rindicated Resident #75:15 PM. His incapace mental handicap, phy health/illness.  Review of an Emerge transcript revealed ReED 2/21/18 at 1:56 Pweakness/fatigue, repeisodes and smelled Resident #1 reported Guardian in place with attempts to contact. In documented they we had been declared mwhen he became agit assessment, demand	tte - Mecklenburg Police Report, dated 2/21/18 at Jurse #1 filed a Missing esident #1. The report left the facility on 2/20/18 at ity types were listed as sical disability and poor  ency Department (ED) esident #1 presented to the M with complaints of ported multiple incontinent d of strong urine odor. to the ED he had DSS h multiple unsuccessful ED the ED transcript re unaware if Resident #1 edically incompetent, and tated with plans for further ed to be released. He ED on 2/21/18 at 7:13 PM	F 6	89			
	DSS Guardian reveal DSS after hours arou notify that Resident # around 5:00 PM and facility. The DSS Gureceived the message 2/21/18 between 8:30 SW and advised her Missing Persons Rep	on 3/5/18 at 2:29 PM with ed the facility contacted and 6:00 AM on 2/21/18 to 1 left the facility on 2/20/18 had not returned to the ardian stated when she es, she called the facility on 0 - 9:00 AM, spoke to the to call the police to file a ort. The DSS Guardian ly responsible for Resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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00MBI ET	'E OADE AT OUADI OTT	_		2616	EAST 5TH STREET			
COMPLET	E CARE AT CHARLOTT	E		CHA	RLOTTE, NC 28204			
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F 689	Continued From page	e 20	F 6	889				
F 689	#1 which required DS out of facility visitation Resident #1 did not he the facility unsupervision status, poor decision-capacity and physical DSS Guardian stated have been allowed to unsupervised, she she for authorization regainmediately if he left.  An interview on 3/5/1 (Unit Manager) revea SW on 2/20/18 aroun had left the facility. Not Resident #1 had a DS authorization had not Resident leaving the should have notified I signed himself out be required because I have before." Nurse #1 stated stated in the safe to leave the facil limitations with wheel #1 responded that his Nurse #1 stated she aleave the facility alone decision-making as it	as authorization prior to any as. DSS Guardian stated ave authorization to leave sed due to his incompetent making ability, mental limitations/poor health. The Resident #1 should not leave the facility ould have been contacted rding a LOA and notified the facility unauthorized.  8 at 2:45 PM with Nurse #1, led she was advised by the d 5:00 PM that Resident #1 urse #1 stated she knew SS Guardian, and that DSS been obtained prior to the facility. Nurse #1 stated "I DSS because he never fore, not sure if that's ave never dealt with this ted Resident #1 came to the 0/18 dressed and stated he ut planned to return that d she told him it was not ity alone due to his physical chair ambulation. Resident sfriends would help him. also felt he was unsafe to be because of his poor related to a 30 Day	F	589				
	Discharge Notice that violated the facility's s stated she told the Do wanted to do and the Resident #1 signed h	t was issued because he smoking policy. Nurse #1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER:  A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE  2616 EAST 5TH STREET  CHARLOTTE, NC 28204	1 00/12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 689	called his case worker had not returned, and his case worker to cat Persons Report, which An interview with the 3:10 PM revealed the aware in passing by Resident #1 signed halone, but was expect Administrator stated the facility when he (faware. The Administrator stated the facility when he (faware that supervision required. The Administrator also stated "I did not alware decision-making, for and violated the smood Administrator stated issued a 30 Day Discontended and the DSS Guardian was Administrator stated been discharged due The Administrator fur around 9:00 - 9:30 Al Resident #1 did not reguardian had been in been called. The Administrator was abnormal when Resident would have notified the time that was resident was a stated they would have notified the series of the state of the series of the seri	In had not returned, she er, advised that he left and direceived instruction from all the police to file a Missing ch she did.  Administrator on 3/5/18 at at on 2/20/18, he was made either the SW or a nurse that aimself out, left the facility eted to return. The Resident #1 had already left the administrator) became rator stated that he was not on or DSS authorization was strator stated he considered eave the facility on intact cognition. The ated that "He was on-making was intact, but yes agree with all of his example he liked to smoke king policy." The as a result Resident #1 was charge Notice on 1/2/18 and as made aware. The Resident #1 had not yet to location of placement. The stated that on 2/21/18 M, the SW advised him that eturn to the facility, DSS notified and the police had ninistrator stated that if the something wrong or dent #1 left the facility alone, fied the DSS Guardian, but	F 68		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) ML IDENTIFICATION NUMBER: A. BUIL		TIPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		345201	B. WING _			C 03/12/2018	
	NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODI 2616 EAST 5TH STREET CHARLOTTE, NC 28204	E	03/12/2010	
(X4) ID PREFIX TAG			ID PREFII TAG	PROVIDER'S PLAN OF COI  X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 689	PM to the DON, Adm #4 and Nurse #5 that pushed up the hill. Th #5 both immediately hill to find Resident # unsuccessful. The SN Resident #1 had a Di immediately contact that administration/nu Guardian. The SW st The SW stated Resid the facility alone beca assistance with his n propelling in his whee had poor decision-ma irrational decisions at smoking policy. The arrived to work the ne the DSS Guardian, re police and file a Miss she did.	d on 2/20/18 around 4:45 hinistrator, Nurse #1, Nurse a she saw Resident #1 being he SW stated Nurses #4 and left the facility going up the hin, but their efforts were W stated she was aware that SS Guardian, but did not DSS because she expected hurses would contact the DSS hated "I guess I should have." Hent #1 was not safe to leave he required total staff hursing care, had difficulty hel chair independently, and haking skills based on hind violating the facility's hind system of the same had haking skills based on hind violating the facility's hind system of the same had have been deceived instruction to call the hing Person Report, which	F	589			
	revealed Nurse #1 to 5:00 PM that Resider to go visit friends. The facility at the time, but the Resident, or review he had a DSS stated she did not revenue to have an out of facility at the Resident's could not keep Resident's could not keep Resident's	8 at 3:55 PM with the DON Id her on 2/20/18 around Int #1 wanted to leave facility In DON stated she was in the Int that she did not speak to It was his medical record, but Guardian in place. The DON Inview the DSS Memo of Interefore was not aware that It is required for Resident #1 It is visit. The DON stated It is and they both agreed that It is intact cognition, the facility It is in the facility if he Is the advised nursing staff to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345201			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345201	B. WING _		0,	C <b>03/12/2018</b>	
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP C 2616 EAST 5TH STREET CHARLOTTE, NC 28204	•	0/12/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	independently. The D not supervise him wh contact the DSS Gua he did not return. The read the DSS Memo realized now that the the DSS Guardian to time Resident #1 said facility.  An interview on 3/5/1 revealed she was aw be transferring to and Guardian was aware, should have contacte he left because he wa and had a history of of  An interview with Nur 5:23 PM and revealed supervisor for both un Resident #1 signed h alone. Nurse #4 state Resident #1 was with hill, she and Nurse #8 stated that when they was after 5:00 PM an heavy", Resident #1 to the facility and aler who said that Reside there was nothing the Nurse #4 stated she Guardian because sh #1 had a Guardian. S	sign himself out and leave PON stated, the facility did en he left and did not rdian until the next day when a DON stated that she just of Understanding and facility should have notified obtain authorization at the did he wanted to leave the did he wanted to leave the did the facility and that the but stated that the staff did the DSS Guardian when as unable to care for himself drug abuse.  See #4 occurred on 3/5/18 at did she was the nurse hits on 2/20/18 the day imself out and left the facility and the SW advised her that lessed being assisted up the forward was gone, so they returned the ted the DON/Administrator and the staff could do at that point and estaff could do at that point of the further stated had she we notified the Guardian	F6	589			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
		345201	B. WING _			C 3/12/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2616 EAST 5TH STREET CHARLOTTE, NC 28204		3/12/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	revealed she was no Resident #1 was with hill with assistance. Now worked with Residen him, but went outside Nurse #5 stated whe returned to the facility DON/Administrator the #1. Nurse #5 stated so DSS Guardianship, would have inquired.  A telephone interview 3/6/18 at 9:34 AM and worked on the 11 PM Resident #1. Nurse #5 work on 2/20/18, she that Resident #1 signand had not returned notified DSS and Nurstated "That was unumy shift." Nurse #3 so Guardian around 1:0 around 5:00 AM at worked DSS receptionist and was not in the facility 11:00 PM, that he left shift around 5:00 PM.  A telephone interview Nurse #2 revealed st Resident #1 a few times worked with the second strength of the shift around 5:00 PM.	8 at 5:38 PM with Nurse #5 tified by the SW that nessed outside going up the Nurse #5 stated she had not t #1 before and did not know with Nurse #4 to locate him. n we did not find him, we	F6	89		
	facility around 5:00 P the nurse's station dr had a bag packed an	on 2/20/18 she arrived to the M and Resident #1 was at ressed, in his wheel chair, and requested to sign himself a LOA to visit with some				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		OATE SURVEY OMPLETED
		345201	B. WING _			C 03/12/2018
	ROVIDER OR SUPPLIER	'E		STREET ADDRESS, CITY, STATE, ZIP COL 2616 EAST 5TH STREET CHARLOTTE, NC 28204		03/12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	the supervisor, to ge #1 had never left the Nurse #2 stated Nurse advised to allow Resso she got his medic Resident #1 to sign the facility. Nurse #2 the facility alone, but ward of the state. Nurse defined the facility alone, but ward of the state. Nurse facility alone, but ward of the state. Nurse defined to Nurse Aide (NA) #2 tworked with Residen NA #2 stated Reside assistance with show chair occasionally, had used a mechanic he could not bear we NA #2 stated that on requested assistance into his wheel chair the bus, by himself, the bus, by himself, the would need to talk to to leave the facility a	ted she contacted Nurse #1, t direction because Resident facility on her shift before. See #1 spoke to the DON who ident #1 to sign himself out, al record and allowed he Release of Responsibility e Visits sheet to sign out of stated he signed out and left she was not aware he was a rse #2 stated that when she DPM, he was not back, she see #3, but she did not notify won 3/6/18 at 11:00 AM with revealed she routinely truly and the signed out and left she was not back, she see #3, but she did not notify won 3/6/18 at 11:00 AM with revealed she routinely truly and the signed difficulty self-propelling, cal lift for transfers, because sight on his lower extremities. 2/20/18, Resident #1 to get dressed and to get because he wanted to take to Wilmore Avenue off of vest Charlotte to visit some I she advised him that he his nurse first if he wanted lone and he requested to NA #2 stated she got him	F	689		
	shirt and a hooded s bag which contained wallet and once he g to the nurse's station #2. Nurse #2 spoke f	erence in a pair of shorts, a weatshirt. He packed a small clothing, toiletries and his ot dressed she propelled him where he spoke to Nurse to Nurse #1 regarding his facility, he was told he could				

C 03/12/2018
03/12/2010
DN (X5) D BE COMPLETION PRIATE DATE
D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345201	B. WING		C 03/12/2018	
	ROVIDER OR SUPPLIER	E	STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 689	resident at Complete been appointed a gu Social Services (DSS the interest to leave would return later the allowed to sign hims and resident did not Resident's guardian of incident but was nowhen he did not retu contacting the resided 2/21/18 and assisting her in order to help and safe. This included request to file a miss attempt to locate resin the Emergency Roon 2/21/18.  2. The facility has idea to this deficiency by	ified as resident #1 was a care at Charlotte and has ardian by the Department of S). On 2/20/18 he expressed the facility stating that he at evening and resident was self out and leave the facility to return to the facility. was not notified at the time otified the following day rn. This was corrected by ent's DSS guardian on gher and cooperating with ensure resident was located ded following the guardian's ing person's report and help ident. Resident was located from of the hospital unharmed entified the process that led allowing resident to sign as the facility. The nurse	F 689	,		
	appointed a DSS Gu facility premises with consent of that resid proper supervision is residents with exit se the facility has also of documented wander behaviors and ensur remain in the facility. prevention system w	dian and lacked the resident that has been ardian cannot leave the out the notification and ent's guardian. To ensure sprovided to all other seking ideations or behaviors, shecked all residents with				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345201	B. WING			C 03/12/2018
	ROVIDER OR SUPPLIER	ITE		STREET ADDRESS, 2616 EAST 5TH ST CHARLOTTE, NO		1 00/12/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 689	allowing a resident has been deemed i immediately educat time of incident and provided to all certificensed nurses, an stating that the facility in order to maintain this sup expresses the intenthat aide must immurse, nursing superand or Administrator resident's safety and is the only person a leave the facility. Timmediately notified non-emergent transabsence or AMA (A change nurse, nursident, or an staff. Resident gual located in a resident must be reviewed, a to resident leaving that safety the DSS or Leavent and provided to the safety the DSS or Leavent and provided to the safety the DSS or Leavent and provided to the safety the DSS or Leavent and provided to the safety the DSS or Leavent and provided to the safety the provided to the safety that the safety the safety the safety the provided to the safety that the safety the safety the safety the safety that the safety th	ecting the deficient practice of with DSS guardianship who incompetent will consist of ting the charge nurse at the dinamentary assistants, and facility administrative staff lity has the responsibility to ind supervision of residents of to prevent accidents. In order derivision, if a resident in to leave the facility to a CNA, dediately notify the charge derivisor, Director of Nursing, for. This is to ensure the did the DSS or Legal Guardian authorized to permit resident to the guardian must be do of all emergent and defers, requests for leave of the did the DSS of Legal Advice) by the ding supervisor, DON, my member of administrative and guardian contacted prior the facility. To ensure resident to each guardian is the only to permit resident to leave the	F	689		
	in compliance with a deemed incompete Director of Nursing residents charts with	e that the facility is to remain safe supervision of residents nt with DSS guardianship, the or designee to review th DSS appointed				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		PLETED
		345201	B. WING			C / <b>12/2018</b>
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204	1 03	12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	facility without the guproper documentation record upon times of ensuring guardians a time frame. This review Resident Guardian Amonitoring tool. Thes 3/8/18 and be conducted weeks, and monthly Nursing or Designee review, if any inconsicular addressed and corrected these review will be promothly Quality Assurand any adjustments made at the time.  The facility has taken and initiated this plant met the requirements Immediate Jeopardy supervision effective	en allowed to leave the ardian's permission, that in is in the resident's medical approved leaves of absence re notified in the appropriate ew will be reflected on the pproval and Notification se reviews will be initiated cited daily x5 days, weekly x4 x3 months by the Director of a Upon these dates of stency is noted it is to be cited at that time. Results of presented to the facility's rance Committee for review needed to this plan will be at the before mentioned steps in order to attest that it has is to alleviate the status if	F 68	39		
F 755 SS=E	5:55 PM when intervial administrative staff reconstruction the facility's revise obtaining DSS Guard allowing a resident with Guardian to leave the Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b) §483.45 Pharmacy S		F 75	55		3/30/18

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345201	B. WING		C 02/42/2048
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204	03/12/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 755	them under an agree §483.70(g). The fac personnel to administ permits, but only und a licensed nurse.  §483.45(a) Procedur pharmaceutical servit that assure the accurdispensing, and administry biologicals to meet the service of the provision of	sto its residents, or obtain ement described in a controlled direct drugs if State law der the general supervision of the ses. A facility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and the needs of each resident.  Consultation. The facility in the services of a licensed des consultation on all ion of pharmacy services in sishes a system of records of on of all controlled drugs in able an accurate descended.  The inner that drug records are in count of all controlled drugs riodically reconciled.  This not met as evidenced descended de	F 75	1. All admission medication orders he been reviewed for resident #10. Glatiramer Acetate 40 mg Injections w noted on resident #10 pharmacy admission orders profile. All prior authorization forms from January to March have been reviewed. No prior authorization was identified for resider	ere

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVE	Y
		345201	B. WING		03/12/201	18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/12/20	
				2616 EAST 5TH STREET		
COMPLET	E CARE AT CHARLOTT	E		CHARLOTTE, NC 28204		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		PLETION ATE
F 755	Continued From page	e 31	F 75	5		
				#10. Resident #10 had no negative	e effect	
	Resident #10 was ad	mitted to the facility on		as a result of the alleged deficient	7 5.1.551	
		osis of multiple sclerosis.		practice. Resident #10 was in the	hospital	
	_	s orders included direction to		for unrelated occurrence during on	site	
	administer Glatirame	r Acetate Solution 40		complaint investigation from March	1 5-7,	
	milligrams (mg.) subo	cutaneously three times		2018.		
		Vednesday and Friday		All residents needing Prior Ap		
	evenings. (Glatiramer Acetate is a medication			for high cost meds are at risk to be		
		weakness related to multiple		affected by the alleged deficient pr		
	sclerosis.)			3. Effective March 26, 2018, Edu		
	Davious of the admiss	sion Minimum Data Set		has been provided to all Licensed	•	
		aled there were no injections		staff on the policy and protocols fo medication unavailability, obtaining		
		ered since admission on		medications from pharmacy, notific		
	01/11/18.	area office darringsfort off		of MD/NP and Director of Nursing		
				designee of unavailable medication		
	Review of Resident #	10's electronic Medication		medication reordering. Education		
	Administration Recor	d (eMAR) revealed no		provided to all Licensed Nurses for	· all	
	documentation of Gla	atiramer Acetate		orders faxed to the pharmacy to file	e the	
	administration. The	omitted doses occurred from		faxed confirmations. The faxed		
		02/18, a total of 22 doses.		confirmations will be kept in a note	book	
		ion listed the subcutaneous		by date at each nursing station.		
	injection to be admini	•		4. Director of Nursing or designe		
	Wednesday, and Frid	ау ат 9:00 Рм.		review all new admission and curre		
	Dovious of a pureing r	note dated 03/04/18 revealed		resident's orders 5 days per week ensure all medications have been	ıo	
		scharged to the hospital for		delivered to the facility and/ or una	vailable	
	evaluation of altered	- · · · · · · · · · · · · · · · · · · ·		medications protocol has been followed		
	evaluation of altered	mental datas.		include prior authorization when	wed to	
	Interview with Nurse	#6, unit manager, on		necessary. Prior Authorizations are	e also	
		revealed she was not aware		emailed to the Administrator, Direct		
	Resident #10 did not	receive the Glatiramer		Nursing, and Assistant Director of	Nursing	
		uring the interview, Nurse		weekly by the pharmacy. The		
		e facility's pharmacy. After		Administrator, Director of Nursing,	and/or	
		plained the facility did not		designee will review all prior		
		Slatiramer Acetate due to a		authorizations for high cost medica		
	prior authorization red	· ·		notify the MD/NP of drug availability	y, and	
		6 reported the Director of		seek alternative recommended		
	Nursing (DON) receiv	ed prior authorization		medication and/or order to hold		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345201	B. WING			l	C / <b>12/2018</b>
	ROVIDER OR SUPPLIER			26	TREET ADDRESS, CITY, STATE, ZIP CODE  516 EAST 5TH STREET  HARLOTTE, NC 28204	1 03/	12/2016
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	requests.  Interview with the DO revealed she did not in notice from the pharm Acetate injections. The not aware until today doses of Glatiramer Athe full-time evening anotify the physician of the medication's unawashe relied on the pharmability to dispense in The DON stated she authorization forms to Interview with Nurse revealed she contacted several times regarding Glatiramer Acetate. In not document the atternanager, DON or the doses due to unavailability of the unavailabilit	N on 03/07/18 at 2:51 PM receive a prior authorization macy for the Glatiramer he DON reported she was (03/07/18) of the omitted Acetate. The DON reported shift nurse, Nurse #5, did not r nursing management of vailability. The DON stated rmacy's notification of medications due to high cost. forwarded prior of the physician.  #5 on 03/07/18 at 3:35 PM red the facility's pharmacy ing the unavailability of the Nurse #5 reported she did rempts or notify the unit rephysician of the omitted ability.  with the physician on revealed he was not aware of the medication. The ompleted prior authorization receipt of high cost	F	755	medication if able without negatively affecting resident until medication is approved by insurance and/or available the facility. Findings will be reported monthly for 3 months to the Quality Assurance Committee for further review and recommendations.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION		E SURVEY IPLETED
			7 55.25			С
		345201	B. WING _		o:	3/12/2018
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	any doses of the Glat reported she expecte available for administ	pharmacy did not dispense iramer Acetate . The DON d medications to be	F 7	755		
F 756 SS=D	pharmacy sent notific needs to the DON. T to provide documenta pharmacist reported l unavailability of Glatin	ration of prior authorization The pharmacist was not able ation of the notification. The The was not aware of the Tramer Acetate. W, Report Irregular, Act On (2)(4)(5)	F7	756		3/30/18
	§483.45(c)(1) The drawst be reviewed at licensed pharmacist.	ug regimen of each resident east once a month by a view must include a review				
	irregularities to the at facility's medical direct and these reports mu (i) Irregularities inclu drug that meets the c (d) of this section for (ii) Any irregularities of during this review mu separate, written report attending physician a director and director cominimum, the resider and the irregularity the	de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		) DATE SURVEY COMPLETED
		345201	B. WING _			C 03/12/2018
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204		00/12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 756	irregularity has been action has been take be no change in the in physician should door the resident's medical §483.45(c)(5) The farmaintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action. This REQUIREMENT by:  Based on staff, pharmand record review, the Resident #10 did not multiple sclerosis (GI sampled residents where the process and step when he or she ident requires urgent action. This REQUIREMENT by:  Based on staff, pharmand record review, the Resident #10 did not multiple sclerosis (GI sampled residents where the sampled residents where the sampled resident #10 was ad 01/11/18 with a diaground threatment of the sampled resident #10 was ad 01/11/18 with a diaground threatment weekly of Friday evenings. (GI medication used to the related to multiple screen Review of the admission physical process.)	cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in all record.  cility must develop and procedures for the monthly that include, but are not is for the different steps in its the pharmacist must take iffes an irregularity that in to protect the resident. It is not met as evidenced macist, physician interviews in the facility failed to identify that include the receive medication to treat attramer Acetate) for 1 of 5 into received drug regimen on the receive medication to treat attramer Acetate is of multiple sclerosis. Calcian's orders included for Glatiramer Acetate is a leat muscle weakness	F 7	1. All medication orders have reviewed for resident #10. Due hospitalization resident #10 me were removed from the medica per facility protocol. Resident #10 the deficient practice. Resident #10 the hospital for unrelated occur during onsite complaint investig March 5-7, 2018.  2. Pharmacy Director notified of Nursing the oversight of omit medication by Pharmacy Const drug regimen review and pharm recommendations. Contacted Supervisor to perform education pharmacists to ensure subsequing regimen reviews are conducted to comply with state and federal regulations.  3. Facility obtained a differential of the state of the state and federal regulations.	to edications ation cart 10 had no e alleged 0 was in rence gation from I by Director tted ultants' nacy Pharmacy n with uent drug d fully and	
		ered since admission on		Facility obtained a different consultant with expectations of drug regimen will be completed.	f pharmacy	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  3	` '	TE SURVEY MPLETED
		345201	B. WING			C <b>3/12/2018</b>
	PROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CO 2616 EAST 5TH STREET CHARLOTTE, NC 28204		0/12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 756	Review of the electron Administration Recommendation of Gla administration. The control of the c	onic Medication and (eMAR) revealed no attramer Acetate comitted doses occurred from 02/18, a total of 22 doses.  Imen review dated 01/25/18 cist documented there were a for Resident #10's carmacist documented decent laboratory results and defor changes and dumentation.  Imen review dated 02/26/18 cist documented there were a for Resident #10's carmacist documented there were a for Resident #10's carmacist documented decent laboratory results and defor changes and defor chang	F 75	and immediate notification of MD/NP and Director of Nursing designee of any omitted mediate documented on the eMAR.  4. Director of Nursing and/will review randomly review of residents with a monthly of review of no recommendation pharmacy for completeness. Any deficiencies will be immediated and Quality Assurance Completeness and Quality Assurance Completeness.	ing and/or dications  for designee all the eMAR's drug regimen ons from for 3 months. ediately rted monthly by Director mittee for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345201	B. WING			C 03/12/2018
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE  2616 EAST 5TH STREET  CHARLOTTE, NC 28204		1 03/12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 756	Continued From pag	e 36	F 7	56		
	the evening shift did nursing managemen unavailability	not notify the physician nor t of the medication's				
	revealed she contact several times regard Glatiramer Acetate.	#5 on 03/07/18 at 3:35 PM ed the facility's pharmacy ing the unavailability of the Nurse #5 reported she did fy the unit manager, DON or omitted doses due to				
	was not aware of the medication. The phy	8 at 3:40 PM revealed he unavailability of the sician reported he relied on acility's pharmacy for				
F 760	on 03/08/18 at 10:40 January 2018 eMAR when he conducted t review. The pharma eMAR during the 02/ omitted doses. The The pharmacist repo administration docum notified the DON and pharmacist reported Resident #10's omitte Acetate.	with the facility's pharmacist AM revealed Resident #10's was not available for review he 01/25/18 drug regimen cist reported he reviewed the 26/18 review but missed the pharmacist stated he erred. rted if he identified lack of mentation, he would have I medical director. The notification did not occur with ed doses of Glatiramer	F 7	50		3/30/18
SS=E	CFR(s): 483.45(f)(2) The facility must ens			טט		13/30/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:		MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345201	B. WING _			C <b>03/12/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O	CODE		
001101 55		_		2616 EAST 5TH STREET			
COMPLET	E CARE AT CHARLOTT	E		CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	by: Based on staff, phar and record review, the physician orders by record to treat multiple sclered of 5 sampled residemedications (Residemedications (Residemedications (Residemedications (Residemedications (Residemedications (Residemedications (Residemedications (Residemedications) included Resident #10 was accomply the sclerosian administer Glatirame milligrams (mg.) subweekly on Monday, vevenings. (Glatirame used to treat muscle sclerosis.)  Review of the admission dated 01/18/18 reveated of any type administer of any type administer of any type administer of Gladministration Record documentation of Gladministration. The 01/12/18 through 03/The eMAR transcripting injection to be administration to be administration to administration of a nursing the Review of t	macist, physician interviews are facility failed to follow not administering medication rosis (Glatiramer Acetate) for ents who received nt #10).  d:  Imitted to the facility on nosis of multiple sclerosis. Is orders included direction to ar Acetate Solution 40 cutaneously three times Wednesday and Friday ar Acetate is a medication weakness related to multiple sion Minimum Data Set aled there were no injections ered since admission on admiramer Acetate comitted doses occurred from 102/18, a total of 22 doses. ion listed the subcutaneous istered on Monday, day at 9:00 PM.	F7	1. All medication orders reviewed for resident #10. had no negative effect as a alleged deficient practice. I error report was completed was in the hospital for unreoccurrence during onsite of investigation from March 52. Since all residents redirected by the alleged define an ongoing audit was impleant orders are available. Defici immediately corrected by modifications reordered pharmacy. No significant in errors were identified.  3. Effective March 26, 20 has been provided to all Listaff on the policy and protimedication unavailable medication from pharmacof MD/NP and Director of Mesignee of unavailable medication reordering.  4. Director of Nursing an will randomly audit 10 eMadocumentation 3 days per months to ensure medicati available and Licensed Nufollowing the policy and promedication unavailability. An edication unavailability.	Resident #10 a result of the Medication d. Resident #10 elated complaint 6-7, 2018. ceiving ential to be ficient practice emented to s' medication iencies notifying the medications d from nedication densed Nursin cocols for obtaining cy, notification Nursing or edications, and ad/or designee AR's for week for 3 ions are irses are otocols for Any deficiencie	g	
	Resident #10 was dis	scharged to the hospital for mental status.		will be immediately correct of the quality assurance au	udits reported	js 	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
		345201	B. WING _			C 03/12/2018	
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP 2616 EAST 5TH STREET CHARLOTTE, NC 28204	•	00/12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Resident #10 did not Acetate injections. D #6 placed a call to the the call, Nurse #6 stareceive the ordered of prior authorization remedication. Nurse #6 Nursing (DON) received requests.  Interview with the DO revealed she was not of the omitted doses DON reported Nurse the evening shift did nursing management unavailability. The D staff to notify the physicand considered the of Glatiramer Acetate a reported she expected medications as order of medication.  Interview with Nurse revealed she contacts several times regarding Glatiramer Acetate. In not document or notif the physician of the immedication to Reside  Telephone interview of Glatiramer Acetate #10 but was a signification.	#6, unit manager, on revealed she was not aware receive the Glatiramer uring the interview, Nurse e facility's pharmacy. After ted the facility did not Glatiramer Acetate due to a quired for high cost 6 reported the Director of yed prior authorization  ON on 03/07/18 at 2:51 PM at aware until today (03/07/18) of Glatiramer Acetate. The #5 who worked full time on not notify the physician nor a of the medication's ON reported she expected sician of missed medications mission of Resident #10's medication error. The DON ad staff to administer ed and report unavailability  #5 on 03/07/18 at 3:35 PM and the facility's pharmacy ng the unavailability of the Nurse #5 reported she did by the unit manager, DON or nability to administer the nt #10.	F7	Assurance Committee for and recommendations.	further review		

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			C 03/12/2018			
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2616 EAST 5TH STREET CHARLOTTE, NC 28204				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 760 F 865 SS=E	reported he expected medications as ordered medications as ordered medications as ordered medications as ordered on 03/08/18 revealed omitted doses of Resulted Acetate, due to unavate the drug regimen revious 2/26/18. The pharm notice the medication Resident #10's medic QAPI Prgm/Plan, Dis CFR(s): 483.75(a)(2)	with the facility's pharmacist he was not aware of the ident #10's Glatiramer ailability when he conducted ew on 01/25/18 and facist explained he did not error when he reviewed eations.  closure/Good Faith Attmpt (h)(i)	F 760			3/30/18	
	Survey Agency no lat promulgation of this results of the Secretary of the	e of information.  ary may not require  rds of such committee  ch disclosure is related to  ch committee with the section.  by the committee to identify  ficiencies will not be used as  is not met as evidenced  iews, and record review, the ssment and Assurance		Quality Assurance meeting held or 3/21/18 and all cited deficient areas we reviewed and discussed at that time.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING		C 03/12/2018			
		345201						
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,		
				26	616 EAST 5TH STREET			
COMPLET	E CARE AT CHARLOT	ΓE		С	HARLOTTE, NC 28204			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 865	Continued From pag	ue 40	F	365				
	procedures and mor	nitor interventions that the			Facility is to implement and follow			
		lace in November, 2017.			procedures for monthly Quality			
		ency cited during the facility's			Assessment and Assurance, QAA,			
		omplaint investigation survey			program which involve the added focus	sed		
		17, F 425. The deficiency			review of areas identified to be have			
		narmacy services. The			repeated deficient practiced noted. Th	is		
	continued failure of t				new review system will be implanted by			
		wo federal surveys of record			the Administrator and will entail a throu			
		ne facility's inability to sustain			process evaluation of identified areas t	0		
	an effective Quality A	Assurance Program.			ensure processes are achieving desire	d		
					goals and identify areas that require			
	The findings include	d:			modifications to ensure continued			
					compliance.			
	This tag is cross refe	erred to:			2. All residents are at risk for being			
					affected by this alleged deficient praction	ce.		
		rvices and procedures to			Any area identified to have repeated			
		ased on staff, pharmacy			deficient practices will be subject to the			
	-	ve, pharmacist, physician			process evaluation program to resolve	the		
		d review, the facility failed to			issues and monitor the solution.			
		o treat multiple sclerosis			All department head staff provided			
	,	for 1 of 5 sampled residents			re-education regards the requirements			
	who received medica	ations (Resident #10).			a QAA committee and the purpose and			
	<b>-</b> ,				impact of an effective QAA program in			
	_	ed for F 755 for failure to			addition to new process evaluation por			
	<del>.</del>	nedication used to treat			added to the program. This education	WIII		
	•	ailable for administration.			also include each departments			
	The F 755 was origin	-			responsibility as it pertains to the committee. The education is to be			
		omplaint investigation survey re to have an ophthalmologic			completed by 3/30/18.			
		· · · · · · · · · · · · · · · · · · ·			4. The Administrator will develop			
	medication available for administration.				process evaluation forms and utilize the	em.		
	Interview with the Administrator on 03/07/18 at				to conduct and record evaluations and	<b>U</b> 111		
		e Director of Nursing (DON)			discuss finding during monthly Quality			
		n availability after the			Assurance Committee meeting in addit	ion		
	10/05/17 recertificati	-			to all current plans to correct any defici			
	investigation survey.				practices will also be reviewed by the			
	conganon canvoy.				facility administrator to ensure complet	ion.		
	Interview with the DO	ON on 03/07/18 at 5:35 PM			Records will be audited at each meeting			
	revealed each medic			to ensure all plans are followed as writi				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	345201	B. WING			C 03/12/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<b>I</b>	03/12/2010	
COMPLETE CARE AT CHARLOT	re		2616 EAST 5TH STREET			
COMPLETE CARE AT CHARLOT	<b>'</b> E		CHARLOTTE, NC 28204			
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
5, 2017 survey, until 11/29/17 when the fa medication availabili audited medication of progressed to a mor	availability after the October the revisit survey on acility achieved compliance in ty. The DON explained she carts on a weekly rotation and on the DON reported the audits	F 80	and any corrections will be made time.	de at that		