STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345201

(X2) MULTIPLE CONSTRUCTION A. BUILDING ____________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
03/12/2019

A. BUILDING ____________________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345201

STREET ADDRESS, CITY, STATE, ZIP CODE
2616 EAST 5TH STREET CHARLOTTE, NC 28204

C. WING _____________________________

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

FORM APPROVED
OMB NO. 0938-0391

PRINTED: 04/02/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed
04/01/2019

04/02/2019

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: 2IK411
Facility ID: 952971
If continuation sheet Page 1 of 3
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 684</td>
<td>Continued From page 1 discoloration. Resident #3 informed the nurse a 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 revealed acute fractures of Resident #3’s distal tibia and fibula. Resident #3 received an orthopedic referral on 02/15/19 with subsequent admission to the hospital 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 Nurse #1 she fell in the bathroom. Resident #3 explained NA #1 assisted her off the floor and back into bed. Nurse #1 explained Resident #3’s leg was swollen and discolored so the physician received immediate notification. Nurse #1 estimated the time between the fall and an assessment of injury was approximately 45 minutes. NA #1 was not available for interview. Telephone interview with Resident #3’s physician on 03/11/19 at 2:16 PM revealed Resident #3 should receive a physical assessment after a fall. The physician reported a delay in assessment did not affect the outcome or worsen the injury. Interview with the Director of Nursing (DON) on 03/11/19 at 3:22 PM revealed he began employment at the facility on 03/4/19 and had no direct knowledge of Resident #3’s fall. The DON reported he expected a complete physical assessment to be immediately conducted after a fall. The DON reported he expected staff to</td>
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<td>684</td>
<td>Continued From page 2</td>
<td>F 684</td>
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immediately notify a nurse when a resident fell.