STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to offer a choice in frequency of showers to 1 of 3 sampled residents who required assistance with showers (Resident #69). The findings included: Resident #69 was admitted to the facility on 08/23/17 with diagnoses which included diabetes mellitus, anxiety and depression. Review of Resident #69's admission Minimum Data Set (MDS) dated 08/30/17 revealed an assessment of intact cognition. The MDS indicated Resident #69 required the assistance of one person for total dependence in bathing. Review of Resident #69's care plan dated 08/31/17 revealed interventions included	F 242	F242 1)Resident #69 was interviewed by the social worker for shower preference and the resident's shower schedule was updated to reflect the resident's choice 2)All residents are at risk for being affected by this deficient practice 3) Upon admission all residents or resident families will be interviewed by the admission nurse to determine time and day preferred for shower. This will be added to the nursing admission checklist. In addition, residents and families will be asked at routine care plan meetings if their needs are being met regarding frequency, time of day, and bath type preferences 4) Social Worker to complete an initial audit of all current residents to update shower preference. The DON or designee will complete quality improvement audits of Resident Right to Make Choices. A random sample of 5 interviewable residents will be reviewed weekly times 4 weeks, then every other week times 4 weeks, then monthly for 6 months. Results of all audits will be discussed at the facility's QA Committee meeting monthly for additional recommendations if necessary.	10/30/17

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

Calvin Arrington Jr. | Administrator/ Executie Director | Oct. 30, 2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 242	Continued From page 1 provision of assistance with activities of daily living as needed. Review of the West nursing unit's shower schedule revealed Resident #69's bed number was scheduled to receive showers every Monday and Thursday on the day shift. Interview with Resident #69 on 10/03/17 at 9:27 AM revealed staff assisted with showers twice weekly. Resident #69 reported he did not receive a choice in shower frequency. Resident #69 explained he would prefer to receive assistance with showers everyday if possible. Interview with Nurse Aide (NA) #1 on 10/04/17 at 11:00 AM revealed Resident #69 required assistance with showers. NA #1 explained all residents received showers twice weekly in accordance with shower schedule. NA #1 residents could receive more frequent showers if requested and the shower schedule changed. Interview with the full-time day shift charge nurse, Nurse #1, on 10/04/17 at 11:54 AM revealed all residents receive showers twice weekly. Nurse #1 explained the unit manager set the shower schedule. Interview with the unit manager on 10/05/17 at 8:30 AM revealed the shower schedule gave all residents a shower twice weekly. The unit manager explained the schedule could be adjusted if a resident requested a change in time. The unit manager reported the admission director interviewed residents upon admission regarding choice in frequency and time of showers. Interview with the admissions director on	F 242		

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F 242	Continued From page 2 10/05/17 at 8:48 AM revealed she did not specifically ask new residents and family members about choices in shower frequency. The admissions director explained she would communicate to nursing staff if a family member initiated a request in regards to showers. The admission director reported nursing staff would be responsible to interview the resident and determine frequency, time of day and bath type preferences. Interview with the Director of Nursing on 10/05/17 at 11:12 AM revealed residents should receive a choice in time of day and frequency of showers.	F 242		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair broken and splintered laminate on resident room doors on 5 of 12 resident rooms (Rooms 118, 117, 113, 110 and 126). The Findings Included: 1. The following observations were conducted: a. Observation of room #117 on 10/02/17 at 12:46 AM revealed the door of the resident's room was splintered and chipped. Observation of room #117 on 10/05/17 at 10:21 AM revealed the door of the resident's room was	F 253	F 253 1. Rooms 118, 117, 113, 110, and 126 were repaired to no longer have broken or splintered laminate. 2. All resident room doors were inspected by the maintenance department and any repairs that were noted will be repaired as of 11/3/17 so that all resident doors 3. Maintenance staff provided in-service education to include providing preventive maintenance checks of the building including checking and maintaining condition of resident doors so that they are safe and without hazards. 4. Maintenance Director or designee will conduct initial audit of all resident room doors to ensure that all doors are without have broken or splintered laminate and are free from safety hazards. After which 100% of resident room doors are to be checked daily x5 days, weekly x4 weeks, and weekly thereafter. Results of all audits will be discussed at the facility's QA Committee meeting monthly for additional recommendations if necessary.	11/3/2017

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F 253	Continued From page 3 splintered and chipped. b. Observation of room #118 on 10/02/17 at 12:47 PM revealed the door of resident's room had broken and splintered laminate and wood on the edges. Observation of room #118 on 10/05/17 at 10:23 AM revealed the door of resident's room had broken and splintered laminate and wood on the edges. c. Observation of room #113 on 10/02/17 at 12:50 PM revealed broken and splintered laminate and wood on the door of the room. Observation of room #113 on 10/05/17 at 10:27 AM revealed broken and splintered laminate and wood on the door of the room. d. Observation of room #110 on 10/02/17 at 12:52 PM revealed broken and splintered laminate and wood on the door of the room with a white thread caught in the splintered edge. Observation of room #110 on 10/05/17 at 10:30 AM revealed broken and splintered laminate and wood on the door of the room with a white thread caught in the splintered edge. e. Observation of room #126 on 10/02/17 at 12:57 PM revealed broken and splintered laminate and wood on the door of the room. Observation of room #126 on 10/05/17 at 10:36 AM revealed broken and splintered laminate and wood on the door of the room. An interview was conducted with the Maintenance	F 253		

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F 253	Continued From page 4 Director on 10/05/17 at 10:44 AM. He stated that the facility utilized a report slip program to make maintenance aware of any issues that needed attention. The Maintenance Director explained if someone mentioned a problem to him while he is walking down the hall he tried to remember the concern but encouraged all staff to complete the maintenance request slip and turn in. He reported that all nurse's stations had boxes where staff were able to drop off the maintenance request forms. He continued, stating that he and his assistant also tried make weekly rounds throughout the building as well but the main source of maintenance requests came from the maintenance request logs provided by the staff. The Maintenance Director stated the only current, large repair projects occurring in the building was routine maintenance on the residents heating and air conditioning units. Observations were conducted with the Maintenance Director on 10/05/17 at 10:53 AM. The Maintenance Director stated he was unaware of the chipped and splintered doors at each of the resident's rooms. When asked if the splintered edges were sharp he felt them and replied "yes". He reported he would immediately get with his assistant and begin sanding, smoothing and repairing the damaged doors. Interview and facility walk through with the Administrator on 10/05/17 at 11:16 AM revealed she was unaware of the splintered edges on the resident doors. She reported she felt if the edges could catch clothing and pull thread it was possible for the splintered edges to cause skin tears. She stated she expected doors to be in good operating order.	F 253		

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F 278 SS=E	Continued From page 5 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 278	F278 1) Residnet #69, #26, #44, #58 MDS assessments were corrected by the MDS nurse on 10/5/17 to reflect active dianoses to include the progonosis of life expectency of less then six months for hospice residents and dental status. 2) All residents are at risk for being affected by this deficient practice. All current resident's assesments audited and corrected to ensure proper prognosis of life expectency, dental status, and active diagnosis was properly coded, and any necessary corrections were made at that time. 3) By 11/2/16, MDS nurse will recieve education from the Administrator on conducting and properly coding a complete MDS assessment to include all active dianoses, certification of the prognosis of life expectency for hospice appropriate residents, and dental status. 4) DON or designee will monitor random sections of the MDS assesments for coompletion and signiture of 3 assessments monthly times 3 months. Results of all audits will be discussed at the facility's QA Committee meeting monthly for 3 months for any necessary additional recomendations.	11/2/17

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F 278	Continued From page 6 record review, the facility failed to accurately code the Minimum Data Set related to prognosis of life for 2 of 2 sampled residents who receive hospice services (Residents #69 and #26), dental condition for 2 of 3 sampled residents who required dental services (Residents #44 and #58), and active diagnoses for 1 of 17 sampled residents reviewed for active diagnoses (Resident #58). The findings included: 1. Resident #69 was admitted to the facility on 08/23/17 on hospice care. Review of Resident #69's admission Minimum Data Set (MDS) dated 08/30/17 revealed Resident #69 received hospice care. The MDS indicated Resident #69 did not have a prognosis of life expectancy of less than 6 months. Interview with the MDS Coordinator on 10/05/17 at 9:55 AM revealed Resident #69's clinical record did not contain a physician certification of prognosis of life expectancy of less than 6 months. The MDS Coordinator explained Resident #69 received hospice care. The MDS Coordinator reported she did not realize the MDS was coded inaccurately. Interview with the Administrator on 10/05/17 at 11:16 AM revealed the MDS should be coded accurately. 2. Resident #26 was readmitted to the facility on 08/09/17 on hospice care. Review of Resident #26's admission Minimum Data Set (MDS) dated 08/16/17 revealed	F 278		

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F 278	Continued From page 7 Resident #6 received hospice care. The MDS indicated Resident #26 did not have a prognosis of life expectancy of less than 6 months. Interview with the MDS Coordinator on 10/05/17 at 2:55 PM revealed Resident #26's clinical record did not contain a physician certification of prognosis of life expectancy of less than 6 months. The MDS Coordinator explained Resident #26 received hospice care. The MDS Coordinator reported she did not realize the MDS was coded inaccurately. Interview with the Administrator on 10/05/17 at 3:01 PM revealed the MDS should be coded accurately. 3. Resident #44 was admitted to the facility on 01/30/15 with diagnoses which included diabetes mellitus, peripheral neuropathy, hypertension and depression. Review of a nurse practitioner's note dated 01/03/17 revealed Resident #44 required a dental referral for extraction. Review of Resident #44's annual Minimum Data Set (MDS) dated 01/09/17 revealed an assessment of intact cognition. The MDS indicated Resident #44 had no broken teeth or dental problems. Review of Resident #44's dental exam dated 02/16/17 revealed the dentist documented "extensive decay" with pain in two teeth. The dentist recommended a hospital based referral for a full mouth extraction. Review of Resident #44's quarterly MDS dated	F 278		

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F 278	Continued From page 8 07/10/17 revealed an assessment of intact cognition and no problems in oral and/or dental status. Observation on 10/02/17 at 3:25 PM revealed Resident #44's mouth contained blackened, broken and missing teeth on both the upper and lower jaws. During an interview on 10/02/17 at 3:26 PM, Resident #44 reported her teeth required extractions. Resident #44 explained her teeth had been in very poor condition for the past several years but now caused her pain. Interview with the MDS Coordinator on 10/05/17 at 10:07 AM revealed she began her position as MDS Coordinator in February 2017 after the completion of Resident #44's annual MDS. The MDS Coordinator reported Resident #44's MDS was not accurate regarding her dental status. Interview with the Administrator on 10/05/17 at 11:18 AM revealed the MDS should accurately reflect Resident #44's dental condition. 4 a. Resident #58 was admitted to the facility on 6/10/17. Review of an admission Clinical Health Status dated 6/10/17 revealed the Condition of Teeth/Oral Cavity section was blank. Section L 0200 Oral/Dental status of an admission minimum data set (MDS) assessment dated 6/21/17, did not assess Resident #58 as edentulous, but rather indicated "None of the above were present." Resident #58's cognition was assessed as intact.	F 278		

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F 278	Continued From page 9 Resident #58 was observed in her room on 10/3/17 at 11:15 AM without dentures/natural teeth (edentulous). Resident #58 stated she did not have dentures/natural teeth upon admission and could not get dentures because a dentist told her that she did not have the bone structure in her mouth to support dentures. During an interview on 10/05/17 at 12:40 PM, MDS Coordinator #1 stated she completed the dental section of the admission MDS dated 6/21/17 for Resident #58. MDS Coordinator #1 stated she referred to the admission Clinical Health Status assessment dated 6/10/17 when she completed the MDS, but the oral section on this assessment was blank. MDS Coordinator #1 further stated that "I usually look at the resident, I will have to go look at her because I don't remember." MDS Coordinator #1 returned and stated Resident #58 did not have natural teeth, did not wear dentures and stated she should have coded Resident #58 as edentulous on the admission MDS. An interview occurred on 10/5/17 at 1:07 PM with the Director of Nursing (DON). The DON stated that she expected the MDS nurses to complete a visual assessment of the resident when completing the MDS, compare the previous assessment to the current assessment; if discrepancies were identified, there should be follow-up. An interview occurred on 10/5/17 at 5:07 PM with the Administrator and revealed that she expected the MDS to be completed accurately, to reflect all active diagnoses and not to leave areas that were not assessed.	F 278		

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b. Resident #58 was admitted to the facility on 6/10/17. A hospital discharge summary dated 6/10/17 included the diagnoses of bipolar disorder.

A Physician's Admission Medical Care Plan, History and Physical (Physician's H & P) dated 6/14/17 included the diagnoses of dementia, bipolar disorder and cerebrovascular disease with a history of a cerebrovascular accident (CVA).

Sections I 4500, 4800 and 5900, Active Diagnoses of a quarterly MDS assessment dated 9/13/17, did not include the diagnoses of dementia, bipolar disorder or cerebrovascular disease/accident for Resident #58.

Review of the October 2017 medication administration record revealed Resident #58 had physician's orders for and received the following medications routinely:
·6/16/17, Buspirone HCL 10 milligrams (mg) twice daily for bipolar disorder
·6/11/17, Atrovastatin Calcium 20 mg at bedtime for high cholesterol (a medication to reduce the risk of a CVA)

A telephone interview was conducted on 10/5/17 at 3:03 PM with MDS Coordinator #2. During the interview, MDS Coordinator #2 stated she completed the quarterly MDS dated 9/13/17 for Resident #58 and referred to the medical record, cumulative diagnoses, face sheet, Physician's H & P and hospital discharge summary when completing the active diagnoses section of the MDS. MDS Coordinator #2 stated she should have coded all active diagnoses on the MDS and

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F 278	Continued From page 11 stated that she must have missed coding bipolar disorder, dementia and CVA as diagnoses for Resident #58. An interview occurred on 10/5/17 at 5:07 PM with the Administrator and revealed that she expected the MDS to be completed accurately, to reflect all active diagnoses and not to leave areas that were not assessed.	F 278		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 279	F279 1. Resident # 69 will receive care plan meeting to include hospice reprehensive to coordinate care between the facility and hospice on 10/24/17 and a care plan was developed to include hospice involvement on this date. Residents #55 and #23's care plans were updated to contain information r egarding the potential for drug related complications associated with the use of psychotropic medication related to antidepressant medication on 10/24/17. 2. All care plans of residents under hospice care were audited to determine if the plans of care for each resident had been coordinated with the hospice company. All care plans of residents noted to be actively t aking any psychotropic medication will be completed by 11/3/17 to ensure that all care plans appropriately addressed for potential compilations associated with the medication use. Any deficiencies with either audit is to be noted and addressed appropriately by 11/3/17. 3. Facility Social Worker and MDS Coordinator will be provided in-service education regarding the importance of developing accurate and resident specific care plans for all residents to ensure that all residents have resident specific and properly coordinated plans of	

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F 279	Continued From page 12 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff and hospice nurse interviews and record review, the facility failed to develop and coordinate care with a resident who required hospice services for 1 of 2 sampled residents who received hospice care (Resident #69) and failed to develop an individualized care plan for 2	F 279	care evidenced by the written care plan. 4. DON or designee will audit all care plans developed since the completion of the initial audit the ensure that they are properly coordinated and resident specific. These audits are to be conducted daily times 5days , weekly times 4 weeks, then monthly times 6 months. Results of all audits will be discussed at the facility's QA Committee meeting monthly for additional recommendations if necessary.	11/3/17

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F 279	Continued From page 13 of 5 sampled residents who received psychoactive medications (Residents #55 and #23). The findings included: 1. Resident #69 was admitted to the facility on 08/23/17 with diagnoses which included diabetes mellitus, anxiety and depression. Resident #69 was admitted on hospice care. Review of the facility's contract with Resident #69's hospice dated 08/23/17 revealed the hospice, physician, resident and primary caregiver would collaborate and establish a written, individualized plan of care. This plan of care would be revised in consultation with the nursing facility as frequently as required but no less frequently than every fifteen days. Review of Resident #69's admission Minimum Data Set (MDS) dated 08/30/17 revealed an assessment of intact cognition. The MDS indicated Resident #69 received hospice care. Review of Resident #69's care plan dated 08/31/17 revealed there was no documentation of the provision or coordination of hospice care. Telephone interview with the hospice nurse on 10/05/17 at 9:32 AM revealed the hospice nurse gave an oral report to Resident #69's charge nurse after each visit. The hospice nurse explained the facility received a written care plan from hospice. Interview with the charge nurse, Nurse #1, on 10/05/17 at 9:47 AM revealed the hospice nurse gave an oral report which included changes in	F 279		

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F 279	Continued From page 14 orders after Resident #69's hospice visit. Nurse #1 reported she did not receive a written care plan and the MDS coordinator collaborated with hospice. Interview with the MDS Coordinator on 10/05/17 at 9:55 AM revealed hospice and the facility had not coordinated Resident #69's care plan. The MDS Coordinator explained the facility's social worker coordinated hospice involvement in care plans. Interview with the facility's social worker on 10/05/17 at 10:55 AM revealed hospice did not coordinate with Resident #69's care plan. Interview with the Administrator on 10/05/17 at 11:16 AM revealed she expected Resident #69's care plan to contain coordination between hospice and the facility. 2. Resident #55 was admitted to the facility on 10/4/13 with diagnoses of mood disorder, anxiety disorder, unspecified psychosis, insomnia, cerebral infarction (stroke) and dementia with behavioral disturbance, among others. Further review of resident's electronic record revealed resident was prescribed and actively taking Seroquel 50 mg and Zoloft 50 mg. Review of resident's most recent comprehensive assessment dated 9/14/17 and coded as an annual assessment revealed resident to be mildly impaired cognitively. Resident was coded as having no current signs or symptoms of psychosis and having not had any documented behaviors during the look back period. Resident was coded as needing supervision with all activities of daily living except bathing in which	F 279		

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F 279	Continued From page 15 she needed limited assistance. Review of resident's care plan dated 10/2/17 revealed care plan area for "potential for drug related complications associated with use of psychotropic medications related to: antidepressant medications". Further review of resident's care plan revealed no care planned areas for use of anti-psychotic medications. An interview with the MDS nurse on 10/5/17 revealed she completed the MDS from information that was gathered from the resident's chart and interviews with staff and residents. She stated she always looked at the resident's physician orders to gather the types of medications that each resident was currently taking at the time of the MDS. She continued, reporting she always looked for anti-coagulants, anti-psychotics, anti-depressants, anti-anxiety medications among others. She reported once the medications were entered into the system it caused the medications to be "triggered" for care planning. She stated at that time, the resident would be care planned for whichever medication required care planning for. She informed it was her responsibility to ensure care plans were developed. When asked if Resident #55's anti-psychotic medication should be care planned, she reported "Yes, it should be". When asked to show where resident's care plan was for the anti-psychotic, the MDS nurse was unable to provide any care plan regarding the use of anti-psychotic medications. An interview with the Director of Nursing on 10/5/17 at 11:05 AM who reported she expected all medications that required a care plan to be care planned appropriately.	F 279		

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F 279	Continued From page 16 An interview with the Administrator on 10/5/17 at 10:55 AM revealed it was her expectation that all anti-psychotics were to be care planned. 3. Resident #23 was admitted to the facility on 8/1/17 with diagnoses which included dementia, epilepsy, Alzheimer's disease, unspecified psychosis and stroke. Review of resident's most recent comprehensive assessment dated 8/14/17 which was coded as a quarterly revealed resident to be cognitively impaired with no signs of psychosis or behaviors noted during the look back period. Resident needed extensive assistance with most activities of daily living and was totally dependent with bathing. Resident was coded as receiving an anti-psycholic medication 5 of 7 days and an anti-depressant 5 of 7 days during the look back period. Review of Resident #23's care plan dated 7/17/17 revealed a care plan area for potential for drug related complications associated with the use of psychotropic medications related to anti-depressants. Further review of resident's care plan revealed no care planned area for the use of anti-psychotics. An interview with the MDS nurse on 10/5/17 revealed she completed the MDS from information that was gathered from the resident's chart and interviews with staff and residents. She stated she always looked at the resident's physician orders to gather the types of medications that each resident was currently taking at the time of the MDS. She continued, reporting she always looked for anti-coagulants,	F 279		

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F 279	Continued From page 17 anti-psychotics, anti-depressants, anti-anxiety medications among others. She reported once the medications were entered into the system it caused the medications to be "triggered" for care planning. She stated at that time, the resident would be care planned for whichever medication required care planning for. She informed it was her responsibility to ensure care plans were developed. When asked if Resident #55's anti-psychotic medication should be care planned, she reported "Yes, it should be". When asked to show where resident's care plan was for the anti-psychotic, the MDS nurse was unable to provide any care plan regarding the use of anti-psychotic medications. An interview with the Director of Nursing on 10/5/17 at 11:05 AM who reported she expected all medications that required a care plan to be care planned appropriately. An interview with the Administrator on 10/5/17 at 10:55 AM revealed it was her expectation that all anti-psychotics were to be care planned.	F 279		
F 363 SS=E	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed;	F 363	F363 1. DS #1 was re-educated to prepare and provide residents with correct preparation of food and portion according the posted menu for each meal. 2. All residents are at risk for being affected by this deficient practice 3. All dietary staff educated on	

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F 363	Continued From page 18 (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility menus/production sheets, the facility failed to provide 1 slice garlic bread (1 ounce) and ½ cup (4 ounces) regular lemon pepper broccoli to 8 residents (Residents #24, #42, #54, #71, #79, #87, #89, and #95) and ½ cup (4 ounces) pureed lemon pepper broccoli to 7 residents (Residents #1, #10, #12, #28, #48, #59 and #104) for 1 of 2 meals observed. The findings included: Review of the 10/2/17 facility menu and production sheet for the lunch meal revealed the facility would provide 1 slice of garlic bread (1 ounce) and ½ cup (4 ounces) regular lemon pepper broccoli to 57 residents on a regular diet and ½ cup (4 ounces) pureed lemon pepper broccoli to 9 residents on a pureed diet. Review of a portion control chart posted on the wall next to the cook's prep area revealed the following guide:	F 363	preparing and providing residents meals that are appropriate in both the texture and portion as posted on menus and tray cards of each resident. This education is to be completed by 11/3/17. 4. Dietary manager or designee is to audit meal preparations to ensure that they are of the appropriate texture and proper portion as posted on the menus. Meal texture audits are to be conducted during meal preparation, and portion audits are to be conducted by taking a 5% sample of each meal prepared. Audits are to be conducted and turned into the Administrator for review daily x5days, weekly x4 weeks, and monthly x6 months. Results of all audits will be discussed at the facility's QA Committee meeting monthly for additional recommendations if necessary.	11/3/17

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F 363	Continued From page 19 ·Green handled scoop, 1/3 cup (2.66 ounces) ·Grey handled scoop, ½ cup (4 ounces) A continuous observation of the lunch meal tray line occurred on 10/2/17 from 11:53 AM - 11:58 AM and revealed garlic bread was available in ½ ounce portions (1/2 slice), lemon pepper broccoli (regular texture) was not available and a green handled, 1/3 cup scoop was available/used to serve pureed lemon pepper broccoli. During the continuous observation, Dietary staff #1 was observed to plate ½ slice (1/2 ounce) of garlic bread and ½ cup "soft cooked" lemon pepper broccoli to 8 residents (Residents #24, #42, #54, #71, #79, #87, #89, and #95) and 1/3 cup (2.66 ounces) pureed lemon pepper broccoli to 7 residents (Residents #1, #10, #12, #28, #48, #59, and #104). An interview on 10/2/17 at 2:10 PM with Dietary staff (DS) #1 revealed she did not prepare regular lemon pepper broccoli per the menu, but rather prepared "soft cooked" lemon pepper broccoli for all residents who received a regular or mechanical soft diet. DS #1 stated she did so because residents who received a mechanical soft diet could not chew regular textured lemon pepper broccoli. DS #1 also stated that she served 1/2 slice of garlic bread instead of 1 whole slice, but she was not sure why. DS #1 further stated that the garlic rolls she was accustomed to serving was not available and stated "So I made my own, I thought that was the correct portion, but I see now on the production sheet, I should have served 1 slice instead of half slice." DS #1 stated that she used the green handled scoop (1/3 cup) to serve pureed lemon pepper broccoli because it was the size scoop she was trained to use.	F 363		

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F 363	Continued From page 20 During an interview on 10/04/17 at 12:51 PM, the Certified Dietary Manager (CDM) #2 stated that she was not in the facility during the preparation of the lunch meal on 10/2/17 and in her absence, the cook was in charge. CDM #2 stated that she expected the cook to prepare all items on the menu and that the regular lemon pepper broccoli should have been available for the lunch meal on 10/2/17. CDM #2 also stated that she had trained staff to serve ½ cup of vegetables to residents who received a pureed diet and thought that was the green handled scoop, but that the cooks should look at the color and size of the utensil and serve portions according to the portion control guide posted on the wall. During an interview on 10/5/17 at 2:58 PM, the Consultant Registered Dietitian stated that dietary staff should provide residents with portions of food according to the menu. During an interview on 10/5/17 at 5:07 PM, the Administrator stated that she expected the staff in the dietary department to follow menus and provide foods in the correct portions.	F 363		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 371	F371 1. All identified food items that were improperly stored or labeled were disposed of to include the improperly labeled leftovers, the uncooked brussels sprouts, bread crumbs, improperly stored potatoes, and bad containing spoiled onions. Potatoes and onions were moved to cooler for storage in clear bins with lids to prevent spoilage. Gnat activity decreased due to disposing of soiled onions and cleaning of entrance area. 2. 100% audit of dietary dry and cold storage to be conducted by the Dietary Manager to ensure that all food items are being stored properly per manufactures recommendations and all items are labeled and dated appropriately. Any discrepancies are to be noted and corrected at this	

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F 371	Continued From page 21 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, USDA and manufacturer recommendations and review of facility records, the facility failed to label/date leftovers (tomato soup, boiled eggs and pork chops) and uncooked Brussels sprouts stored in refrigeration, store bread crumbs and food thickener in closed/sealed containers and store onions and potatoes at 45 to 55 degrees Fahrenheit per USDA/manufacturer recommendations, to prevent spoilage and gnat activity in dry storage for 2 of 3 food storage areas observed. The findings included 1. An observation of the walk-in refrigerator occurred on 10/2/17 from 12:24 PM to 12:29 PM and revealed the following: 1a. One unopened bag of Brussels sprouts with manufacturer instructions to "keep frozen"; there was no thaw date or date of storage on the bag.	F 371	time. Audit to be completed by 11/3/17. 3. 100% of dietary staff to be in-serviced regarding the requirements for proper storage of food items and utilizing appropriate label and dating procedures. Education also provided to report increased gnat activity to the Maintenance Department or Administrator for addressing. 4. Dietary manager or designee is to audit food storage areas to ensure that all food items are being stored appropriately and labeled appropriately. Audits are to be conducted and turned into the Administrator for review daily x5days, weekly x4 weeks, and monthly x6 months. Results of all audits will be discussed at the facility's QA Committee meeting monthly for additional recommendations if necessary.	11/3/17.

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F 371	Continued From page 22 1b. A plastic container of a red liquid, identified by Dietary Manager (DM) #1 as "tomato soup" was stored with no label and no date of storage. 1c. A plastic container of cooked meat, identified by DM #1 as "pork chops" was stored with no label and no date of storage. 1d. A plastic container of shelled eggs, identified by DM #1 as "12 - 15 Pasteurized boiled eggs" was stored with no label or date of storage. During the observation on 10/2/17 from 12:24 PM to 12:29 PM, DM #1 stated that all leftover foods should have a label to include the name of the food item stored, the date of storage and expiration date. 2. Review of USDA recommendations for storage of onions (https://www.onions-usa.org/retail/onions-fresh-market-retail-processing) revealed a recommendation to store onions at 45 to 55 degrees Fahrenheit. A thermometer located on the wall next to the door of the dry storage room registered a temperature of 78 degrees Fahrenheit. An observation of the dry storage room occurred on 10/2/17 from 12:30 PM to 12:48 PM and revealed the following: 2a. One 25 pound box, of white potatoes was stored with minimal gnat activity observed. Manufacturer instructions, recorded on the box, revealed to "Store 45 - 50 degrees Fahrenheit." 2b. One 25 pound box of sweet potatoes was	F 371		

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F 371	Continued From page 23 stored with minimal gnat activity observed. Manufacturer instructions, recorded on the box, revealed to "Store below 55 degrees Fahrenheit." 2c. Two, fifty pound bags of onions was stored with excessive gnat activity. One onion was odorous, soft to touch and showed signs of spoilage with black and green spots. There was no manufacturer instructions for storage on the bag of onions. 2d. One half full plastic bag of egg noodles was stored with the top of the bag rolled down, covered with plastic wrap and no date of storage. 2e. One 25 pound bag of bread crumbs was stored open to air with minimal gnat activity and no date of storage. 2f. One 25 pound bag of instant food thickener, stored open to air with minimal gnat activity and no date of storage. During the observation on 10/2/17 from 12:30 PM to 12:48 PM of the dry storage room, DM #1 stated there was no manufacturer guidance for storing onions and therefore it was up to the DM as to how to best store them. DM #1 also stated that due to the size of the walk-in refrigerator, DM #2 chose to store the potatoes and onions in dry storage. DM #1 stated he was not aware of a current system for monitoring the temperature of the dry storage room, but that he would place a thermometer inside the room for follow up. DM #1 stated that due to the gnat activity, the items stored open to air (bread crumbs and instant food thickener) and the potatoes and onions would have to be discarded.	F 371		

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F 371	Continued From page 24 During an interview on 10/2/17 at 2:10 PM, Dietary Staff (DS) #1 stated that she saw gnats in the dietary department and reported the activity to DM #1 last week. DS #1 also stated that she opened the bag of instant food thickener and bread crumbs on 10/2/17 to prepare the lunch meal and did not close/seal the bags at the time because she was planning to go back and close/seal them. A follow up observation of the dry storage room occurred on 10/2/17 at 2:30 PM. The thermometer inside the dry storage room registered a temperature of 68 degrees with the door to dry storage room closed. An interview on 10/2/17 at 3:15 PM with the Administrator revealed she was aware of gnat activity in facility, but not in the dry storage room of the dietary department. The Administrator stated that pest control services came and treated the facility and so she did not know why gnat activity was still being seen. The Administrator stated that since pest services came to treat the facility, the gnat activity had improved. An observation of the service hall occurred on 10/2/17 at 5:00 PM and revealed 2 food carts were stored on the service hall with dirty food trays and gnat activity. A telephone interview on 10/04/17 at 11:54 AM with the pest control specialist (PCS) revealed she treated the facility (plumbing/electrical voids and sinks) in July 2017 twice due to reports of gnat activity and left monitoring devices to track/verify the activity. The PCS stated that she observed food carts on the facility's service hall	F 371		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 25 with dirty meal trays and gnat activity and advised the facility to remove the food trays immediately and to clean the service hall in order to get rid of the gnat activity. The PCS further stated that on her return visit in July 2017, she made the same recommendation and advised the facility that the gnat activity was due to sanitation that needed to be addressed. An interview on 10/04/17 at 12:51 PM with DM #2 revealed that she had been in her role at the facility since July 2017. DM #2 stated dietary staff were trained to store the potatoes in the cooler, but the potatoes were being stored temporarily in dry storage while the facility waited for the repairs to be completed on the milk cooler. DM #2 further stated that it was a routine practice to store onions in the dry storage room because onions were not typically refrigerated and without manufacturer instructions, she thought it was okay to store onions in dry storage. DM #2 also stated that the gnat activity was bad a few months ago, resolved and re-started recently. DM #2 stated the PCS treated the facility in July 2017 and the dietary department was encouraged to keep food out of the garbage disposal, and to keep pooled water to a minimum. DM #2 stated that she did not recall being told that the food carts on the service hall should be removed in order to resolve the gnat activity. DM #2 further stated that food carts with dirty food trays were placed on the service hall by nursing staff after each meal and remained there for about 30 minutes until dietary staff began washing dishes. DM #2 also stated that it was possible that some dirty food trays could be left overnight after the supper meal and washed the next morning. A follow up observation of the dry storage room	F 371		

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F 371	Continued From page 26 occurred on 10/4/17 at 1:00 PM. The thermometer inside the dry storage room registered a temperature of 60 degrees with the door to dry storage room closed. An interview occurred on 10/05/2017 at 8:41 AM with the Maintenance Director and the Maintenance Assistant. During the interview, the Maintenance Director stated he had been in his role for about 1 ½ months and the Maintenance Assistant in his role for about 4 months. The Maintenance Assistant stated he was in the facility in July 2017 when the PCS came and treated for gnats, ants and water bugs. The Maintenance Assistant stated that the PCS informed him during the July 2017 visit that the gnat activity was a sanitation issue that would be resolved by removing food carts with dirty meal trays off the service hall, housekeeping would need to keep all the trash cans/facility clean and no food should be left in resident rooms. The Maintenance Assistant stated that he shared these recommendations with the dietary and housekeeping departments.	F 371		
F 411 SS=D	483.55(a)(1)(2)(4) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS (a) Skilled Nursing Facilities A facility- (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; (a)(2) May charge a Medicare resident an additional amount for routine and emergency	F 411	F411 1) The social worker has contacted the outpatient dental clinic to schedule resident #44 dental appointment. Resident #44 has been notified the dental office schedules their own appointments and are waiting for the next available surgical date to schedule the appointment. 2) All residents' dental records were reviewed for timely dental visits. Social Worker has been instructed to document reasons for failure to see dentist as scheduled. 3) The Social Worker or designee will audit the past 6 months of dental visits for all residents. Any identified missed appointments will be scheduled, and resident and family notified.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

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F 411	Continued From page 27 dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff and nurse practitioner interviews, and record review, the facility failed to obtain a referral for teeth extraction for 1 of 3 sampled residents who required dental services (Resident #44). The findings included: Resident #44 was admitted to the facility on 01/30/15 with diagnoses which included diabetes mellitus, peripheral neuropathy, hypertension and depression. Review of a nurse practitioner's note dated 01/03/17 revealed Resident #44 required a dental referral for extraction. Review of Resident #44's annual Minimum Data Set (MDS) dated 01/09/17 revealed an assessment of intact cognition. The MDS indicated Resident #44 had no broken teeth or dental problems. Review of Resident #44's dental exam dated 02/16/17 revealed the dentist documented "extensive decay" with pain in two teeth. The dentist recommended a hospital based referral for a full mouth extraction.	F 411	4) DON or designee will monitor section J-Prognosis and section L-Dental for completion on the frequency of three random assesments monthly times three months. All results of audits will be discussed at the facility's QA Committee meeting monthly for three months for any necessary additional recommendations.	11/2/17

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F 411	Continued From page 28 Review of Resident #44's quarterly MDS dated 07/10/17 revealed an assessment of intact cognition no problems in oral and/or dental status. Observation on 10/02/17 at 3:25 PM revealed Resident #44's mouth contained blackened, broken and missing teeth on both the upper and lower jaws. During an interview on 10/02/17 at 3:26 PM, Resident #44 reported her broken teeth required extractions. Resident #44 explained her teeth had been in very poor condition for the past several years but now caused her pain. Resident #44 reported the facility had not arranged the oral surgeon appointment and did not know the reason for the delay. Interview with the facility's social worker on 10/04/17 at 11:31 AM revealed Resident #44 inquired about the appointment "several weeks ago." The social worker explained she began her position several months and ago and was not aware of the referral until Resident #44's question. The social worker reported the referral had not been scheduled. Interview with the Director of Nursing on 10/04/17 at 3:15 PM revealed she expected staff to arrange for Resident #44's teeth extraction when ordered. Interview with the Nurse Practitioner on 10/05/17 at 12:47 PM revealed she expected Resident #44's dental referrals to be implemented when ordered.	F 411		

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COMPLETE CARE AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

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F 425 F 425 SS=D	Continued From page 29 483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, staff and nurse practitioner interviews, and record review, the facility failed to obtain an ophthalmologic medication for 1 of 7 residents observed during the medication pass (Resident #90). The findings included: Review of a nurse practitioner's order dated 10/02/17 revealed direction to administer tobrex 0.3% eye ointment to Resident #90's left eye twice daily for conjunctivitis (eye infection). Observation on 10/04/17 at 8:24 AM revealed Nurse #2 looked in all the drawers of the medication cart for Resident #90's tobrex 0.3% eye ointment medication. Nurse #2 announced the medication was not available for administration for the second day. Interview with Nurse #2 on 10/04/17 at 8:25 AM revealed Resident #90's tobrex eye ointment was	F 425 F 425	F425 1) Resident #90 eye drops were received from the pharmacy and order was clarified for eye drop administration. 2) Pharmacy process for facility notification of unavailable medications was updated. Pharmacy to call facility and send notification in the medication delivery tote of any unavailable medications 3) All Licensed Staff Nurses educated on the updated pharmacy process. All Licensed Staff Nurses educated to call pharmacy for any missing medications and notify the MD/NP if medication is unavailable and obtain new orders 4) DON or designee will complete quality improvement audits of Pharmaceutical Services. Medication orders will be reviewed in clinical meeting to ensure transcribed to administration record. Pharmacy receipt of delivery will be compared to medication orders daily times 4 weeks, then weekly times 4 weeks, then monthly times 6 months to ensure all medications ordered are available. Pharmacy Director will be notified of any concerns with unavailable medications. Results of all audits will be discussed at the facility's QA Committee meeting monthly for additional recommendations if necessary	11/3/17

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F 425	Continued From page 30	F 425		

ordered on 10/02/17 but had yet to be delivered. Nurse #2 explained she notified the pharmacy yesterday (10/03/17) when it was not available. Nurse #2 reported she would notify the pharmacy again to ensure delivery of the medication by 2:00 PM.

Interview with Nurse #2 on 10/04/17 at 2:55 PM revealed Resident #90 received the medication. Observation revealed the tobrex eye ointment in the medication cart. Review of the pharmacy label revealed a fill date of 10/03/17.

Interview with the unit manager on 10/05/17 at 10:19 AM revealed medication orders were filled the same day as written and delivered by the pharmacy. The unit manager reported she did not know the reason for the delivery delay of Resident #90's eye medication.

Telephone interview with the facility's pharmacy representation on 10/05/17 at 10:28 AM revealed the pharmacy received the order on 10/02/17. The pharmacy representative explained the tobrex was out of stock so could not be filled. The pharmacy representative reported the facility received written notification in the 10/02/17 delivery.

Interview with the Director of Nursing (DON) on 10/05/17 at 11:03 AM revealed she expected Resident #90 to receive the medication when ordered. The DON reported if the medication was out of stock, then the NP could either order a hold or another medication.

Interview with the NP on 10/05/17 at 1:06 PM revealed she expected Resident #90 to receive the medication timely. The NP explained the

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F 425	Continued From page 31 tobrex could be ordered to be held since it was not significant.	F 425		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F431 1) All expired, discontinued, and undated medication was removed from all medication carts 2) Pharmacy List of Medication Expiration Dates was placed in front of each medication cart Narcotic book for a reference 3) All Licensed Staff Nurses were educated on the pharmacy list of medication expiration dates, pharmacy policy for medication storage, discharge medications, discontinued medications, and returning medications to the pharmacy 4) DON or designee will audit Medication Carts to ensure proper labeling, dating, expiration dates, discharged and discontinued medication removal. Medication carts will be audited daily times 4 weeks, then weekly times 4 weeks, then monthly times 6 months. Results of all audits will be discussed at the facility's QA Committee meeting monthly for any necessary additional recommendations	11/3/17

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F 431	Continued From page 32 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to remove expired medications, medications no longer ordered for residents, or medications of residents no longer present in the facility from 3 of 4 medication carts and 1 of 2 medication storage rooms. (Insulin, eye drops, nasal spray, antibiotics, liquid stool softener, antidyskinetic medication) Finding include: Review of the facility's Nursing Center Care Policies and Procedures manual 2007 revealed insulin vials were good to use for 28 after being opened or after they were removed from the refrigerator. Medications that are outdated or discontinued were to be removed immediately and disposed of according to the medication disposal procedures, and reordered from the pharmacy if a current order existed. Review of	F 431		

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the medication appendix resources for medications with Special expiration date requirements stated Novalog vials and Novalog pens 28 days after opening, and Lantus vials and pens 28 days after opening.

Observation on 10/04/2017 at 5:12 PM revealed East medication cart #2 had 2 insulin vials opened and not labeled.

Interview on 10/04/2017 at 5:12 PM with Nurse #3 revealed she was did not know the policy or procedure about opened medication or labeling including insulin. She stated she could find out. She asked Nurse #8 who stated insulin was good to use for 28 days after being opened.

Interview on 10/05/2017 at 6:45 AM with Nurse #5 stated all medications that were discontinued or the medication was changed were to be removed from the medication cart and returned to the pharmacy. She stated she went through the carts on the night shift if she had time.

Observation on 10/05/2017 at 6:50 AM of West medication cart # 1 revealed:

Lantus insulin opened 09/5/2017 labeled for Resident #90.
Lumigan eye drops on the cart with a manufacturer's expiration date of 9/17. It had no facility label.
Lantanoprost 0.005% eye drops for Resident #18 labeled instill 1 drop each eye at bedtime for glaucoma. There was no facility label for when the eyes drops were opened.
Neomycin-Palyn-Dexamet apply 1.4 inch strip at bedtime for one week for Resident # 37. The order was discontinued. Medication was still on

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F 431	Continued From page 34 the cart. Novalog insulin 100 units/ml (milliliter) opened 06/08/2017. Facility label on it stated discontinue use 28 days after opening. New order was written on 08/10/2017. This insulin was still on the cart. Lantus insulin 100 units/ml was ordered for Resident #35. The insulin was opened 08/13/2017 and discard after 28 days was written on the label. On the insulin hand written was 08/14/17 to 09/12/2017 for dates to be used. Observation on 10/05/2017 at 7:15 AM of East medication cart #1 revealed: Atropine sulfate solution 1% instill 1 drop left eye at bedtime for Resident #67. There was no facility labeled when the eye drops were opened. Flonase nasal spray opened 11/01/2016. There was no facility label. Lantus insulin 100 units/ml inject twice a day for Resident #109 was opened with no labeled on it. Interview on 10/05/2017 at 7:17 AM with Nurse #5 revealed that eye drops were used for 30 days after being opened then they were discarded. Insulin was kept and used for 28 days after opening, then it should be discarded. Resident #109 just got here but still there was no label on his insulin when it was opened and there should have been a facility label on it so we would know when to discard it. Interview 10/05/2017 at 11:29 AM with Nurse #1 revealed insulin was good to use 28 days after opening the vial. She stated the nurses checked for expiration dates on the medications. Observation on 10/05/2017 at 11:58 AM of the East medication storage room revealed:	F 431		

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F 431	Continued From page 35 Amantadine 50 mg (milligrams)/ml with no date when the bottle was opened for Resident # 98. Diocto 50 mg/5 ml, two bottles with an expiration of 8/17. There was no other expiration date on them. Vancomycin 175 mg in 500 ml give 250 ml every 12 hours IV for Resident # 88 was in the medication refrigerator. This resident had been discharged. There were three doses in the medication refrigerator. Cefedine Hcl 1 gram for Resident # 67. This order had been discontinued. There were three doses in the medication refrigerator. Ampicillin 3000 mg in 100 ml of normal saline to be given over 30 minutes every 24 hours for Resident #102. It had been discontinued. Observation on 10/05/2017 at 12:08 PM East medication cart #2 had a bottle of cod liver oil on it dated 06/17 and the manufacturer expiration date was 09/2016. An interview on 10/5/2017 at 12:10 PM with Nurse #7 She stated the unit manager removes expired medications from the carts and medication storage room including the refrigerator and those not used in the Pyxis anymore. She stated medications not used anymore or expired went back to the pharmacy. Interview on 10/05/2017 at 0:07 PM with the Administrator revealed her expectation was for nurses to go through their medication carts when they report on duty. She stated she expected when a resident was discharged the medication were removed from the medication cart and returned to the pharmacy or discarded. The Administrator further stated she expected the	F 431		

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F 431	Continued From page 36 staff to follow the facility's policies and procedures for dating medications and removal of expired medications. The interview further revealed the Administrator also expected when medications were opened they were labeled and stored properly. Interview on 10/05/2017 at 3:27 PM with the Nurse Practitioner (NP) revealed the pharmacy recommendations and protocols should be followed. With any antibiotics she expected the nursing staff would administer the medications per pharmacy label on the bottles and follow the facility policies regarding use of medications and when medications were discontinued or expired. All medications should be in date when administered. Interview on 10/05/2017 at 4:32 PM with the Medical Director revealed medications have expiration dates but most medications including insulin would have the efficacy up to about 6 months after their expiration date. The only issue would be if a medication was to be refrigerated and it had not been refrigerated.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 441	F441 1) NA #2 was re-educated on the facility policy for hand hygiene and proper storage and handling of linen by the DON 2) All residents are at risk for being affected by this deficient practice 3) All staff educated on the facility hand hygiene policy and proper storage and handling of linen 4) DON or designee will audit proper storage and handling of linen and completing hand hygiene by random observation of 5 staff members daily times	

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COMPLETE CARE AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 37 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 441	4 weeks, then 5 staff members weekly times 4 weeks, then 5 staff members monthly times 6 months. On the spot re-education will be provided for any staff member found not properly storing or handling linen or completing hand hygiene. Results of all audits will be discussed at the facility's QA Committee meeting monthly for any necessary additional recommendations	11/3/17

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	345201	A. BUILDING _____ B. WING _____	C 10/05/2017

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F 441	Continued From page 38 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, review of the medical record and facility policy, the facility failed to transport soiled linen to prevent cross contamination of microorganisms. Nurse Aide #2 transported visibly soiled linen with bare hands and did not complete hand hygiene before handling clean linen and the clean linen cart, for 1 of 3 observations of staff handling soiled items (Resident #112). The findings included: Review of the facility policy, Proper Storage and Handling of Linen, undated, revealed, the purpose was to ensure that linen was properly handled to prevent cross contamination of microorganisms. The transporting process described that soiled linen (whether visibly soiled or not) should be handled with gloves, placed into plastic bags and carried away from the body to the dirty linen carts. Additional instruction included that after removal of gloves, staff should perform hand hygiene using an alcohol based	F 441		

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F 441	Continued From page 39	F 441		

hand rub or soap and water for visibly soiled hands after handling contaminated or soiled linen.

On 10/3/17 at 3:42 PM, Nurse Aide (NA) #2 walked out of Resident #112's room holding gloves in her right hand that were wrapped around the exterior of a plastic bag that was tied in a knot. NA #2 was not wearing gloves and the bag contained soiled incontinence products. NA #2 opened the lid to one of the bins of the soiled utility cart (positioned along the wall to the left of the Resident's door), placed the plastic bag and gloves inside the bin and closed the lid. A continuous observation occurred on 10/3/17 from 3:42 to 3:48 PM when NA #2 removed the top and bottom sheets, from Resident #112's bed, with bare hands. The sheets were visibly soiled with yellow and brown stains. NA #2 gathered the soiled sheets into a bundle and made contact with the soiled areas of the sheets with her bare hands. NA #2 walked out of the room, holding the soiled sheets with bare hands, opened the lid to the same soiled utility cart, placed the soiled sheets inside the bin and closed the lid. NA #2 then walked to the clean linen cart (positioned across the hall), and with bare hands and without performing hand hygiene, pulled back the cart cover, removed clean linen from the cart, walked back to Resident's #112's room, placed the clean linen on Resident #112's mattress and then washed her hands with soap and water.

NA #2 was interviewed on 10/03/17 at 3:49 PM. During the interview, NA #2 stated she had just completed incontinence care (bowel/bladder) for Resident #112, a newly admitted resident to whom she was not familiar. NA #2 stated she wore gloves during incontinence care, removed her gloves and held the soiled gloves in her bare

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F 441	Continued From page 40 hands to discard the plastic bag of soiled incontinence products in the soiled utility bin. NA #2 also stated that when she removed the visibly soiled linen from the bed of Resident #112, she was not wearing gloves and confirmed that her bare hands made contact with the soiled areas of the bed sheets. NA #2 stated she had been trained to wear gloves when handling soiled linen and to wash hands after providing incontinence care or handling soiled items. NA #2 further stated that she did not follow her training because she stated "I was in a hurry." An interview occurred on 10/05/17 at 1:11 PM with the Director of Nursing (DON). The DON stated the facility did not currently have a staff member in the role of staff development coordinator. The DON stated NA #2 was trained per the facility's policy to wear gloves to handle soiled linen and to wash hands after providing care or after handling soiled items. The DON stated she expected all staff to follow the facility's policy on handling soiled linen and performing hand hygiene. An interview occurred on 10/05/17 at 3:20 PM with Nurse #3 who stated NA #2 should not have handled soiled linens with bare hands, but rather that gloves should be worn when handling soiled linen and to wash hands with soap/water after incontinence care and before handling clean linen or the clean linen cart.	F 441		
F 469 SS=E	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced	F 469	F469 1. Improperly stored food items were relocated to proper storage areas and treatments were provided to decrease and eliminate Gnat activity in dry storage and service hall. 2. Now contract obtained for new pest control contractor to service the facility 2x monthly to ensure facility is free of pests and rodents. Entire facility to be treated on 10/4/17. 3. Education provided to facility staff regarding proper	

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F 469	Continued From page 41 by: Based on 2 observations, staff interviews and review of facility records, the facility failed to maintain an effective pest control program as evidenced by excessive gnat activity in the dry storage room of the dietary department and gnat activity in the facility's service hall. The findings included: Review of USDA recommendations for storage of onions (https://www.onions-usa.org/retail/onions-fresh-market-retail-processing) revealed a recommendation to store onions 45 to 55 degrees Fahrenheit. Review of the facility's Pest Sighting sheet revealed the following: ·4/4/17, "Gnats" in the kitchen; treated by pest control services on 4/5/17 with baits/traps ·7/7/17, Facility obtained a new pest control contractor; kitchen was treated On 10/2/17 at 12:29 PM a thermometer located on the wall next to the door of the dry storage room registered a temperature of 78 degrees Fahrenheit. An observation of the dry storage room of the dietary department occurred on 10/2/17 from 12:30 PM to 12:48 PM and revealed excessive gnat activity on two, fifty pound bags of onions. One onion was odorous, soft to touch and showed signs of spoilage with black and green spots. Minimal gnat activity was also observed on one 25 pound box, of white potatoes and one 25 pound box of sweet potatoes. Manufacturer instruction recorded on the box of potatoes to	F 469	disposal procedures for trash, and storage of late evenings meal trays to prevent to reoccurrence of pests in the facility. Staff also provided education on reporting sighting of pests in the facility by utilizing pest sighting tools for the areas to be initially treated by the maintenance department or the pest control contractors. 4. Maintenance Director or designee will conduct audits of facility grounds to ensure that facility is free of pest and rodents, and if any are noted they are to be recorded and addressed appropriately and all reasonable recommendations from pest control contractors are adhered to. Audits are to be conducted and turned into the Administrator for review daily x5days, weekly x4 weeks, and monthly x6 months. Results of all audits will be discussed at the facility's QA Committee meeting monthly for additional recommendations if necessary.	10/4/17.

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COMPLETE CARE AT CHARLOTTE	2615 EAST 5TH STREET CHARLOTTE, NC 28204

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F 469	Continued From page 42 store under 55 degrees Fahrenheit. During the observation on 10/2/17 from 12:30 PM to 12:48 PM of the dry storage room, DM #1 stated there was no manufacturer guidance for storing onions and therefore it was up to the DM as to how to best store them. DM #1 also stated that due to the size of the walk-in refrigerator, DM #2 chose to store the potatoes and onions in dry storage. DM #1 stated he was not aware of a current system for monitoring the temperature of the dry storage room, but that he would place a thermometer inside the room for follow up. During an interview on 10/2/17 at 2:10 PM, Dietary Staff (DS) #1 stated that she saw gnats in the dietary department and reported the activity to DM #1 last week. A follow up observation of the dry storage room occurred on 10/2/17 at 2:30 PM. The thermometer placed inside the dry storage room by DM #1 registered a temperature of 68 degrees with the door to dry storage room closed. An interview on 10/2/17 at 3:15 PM with the Administrator revealed she was aware of gnat activity in facility, but not in the dry storage room of the dietary department. The Administrator stated that pest control services came and treated the facility and so she did not know why gnat activity was still being seen. The Administrator stated that since pest services came to treat the facility, the gnat activity had improved. An observation of the service hall occurred on 10/2/17 at 5:00 PM and revealed 2 food carts were stored on the service hall with dirty food	F 469		

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F 469	Continued From page 43 trays and gnat activity. A telephone interview on 10/04/17 at 11:54 AM with the pest control specialist (PCS) revealed she treated the facility (plumbing/electrical voids and sinks) in July 2017 twice due to reports of gnat activity and left monitoring devices to track/verify the activity. The PCS stated that she observed food carts on the facility's service hall with dirty meal trays and gnat activity and advised the facility to remove the food trays immediately and to clean the service hall in order to get rid of the gnat activity. The PCS further stated that on her return visit in July 2017, she made the same recommendation and advised the facility that the gnat activity was due to sanitation that needed to be addressed. An interview on 10/04/17 at 12:51 PM with DM #2 revealed that she had been in her role at the facility since July 2017. DM #2 stated dietary staff were trained to store the potatoes in the cooler, but the potatoes were being stored temporarily in dry storage while the facility waited for the repairs to be completed on the milk cooler. DM #2 further stated that it was a routine practice to store onions in the dry storage room because onions were not typically refrigerated and without manufacturer instructions, she thought it was okay to store onions in dry storage. DM #2 also stated that the gnat activity was bad a few months ago, resolved and re-started recently. DM #2 stated the PCS treated the facility in July 2017 and the dietary department was encouraged to keep food out of the garbage disposal, and to keep pooled water to a minimum. DM #2 stated that she did not recall being told that the food carts on the service hall should be removed in order to resolve the gnat activity. DM #2 further	F 469		

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F 469	Continued From page 44 stated that food carts with dirty food trays were placed on the service hall by nursing staff after each meal and remained there for about 30 minutes until dietary staff began washing dishes. DM #2 also stated that it was possible that some dirty food trays could be left overnight after the supper meal and washed the next morning. An interview occurred on 10/05/2017 at 8:41 AM with the Maintenance Director and the Maintenance Assistant. During the interview, the Maintenance Director stated he had been in his role for about 1 ½ months and the Maintenance Assistant in his role for about 4 months. The Maintenance Assistant stated he was in the facility in July 2017 when the PCS came and treated for gnats, ants and water bugs. The Maintenance Assistant stated that the PCS informed him during the July 2017 visit that the gnat activity was a sanitation issue that would be resolved by removing food carts with dirty meal trays off the service hall, housekeeping would need to keep all the trash cans/facility clean and no food should be left in resident rooms. The Maintenance Assistant stated that he shared these recommendations with the dietary and housekeeping departments.	F 469		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514	F514 1) Resident # 58 MDS was corrected by the MDS nurse on 10/5/17 to reflect resident's current dental assessment. 2) All residents are at risk for being affected by this deficient practice	

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F 514	Continued From page 45 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review, the facility failed to document the medical record to reflect the oral status for 1 of 17 residents reviewed for accuracy of the medical record (Resident #58). The findings included: Resident #58 was admitted to the facility on 6/10/17. Review of an admission Clinical Health Status	F 514	3) By 10/30/17, MDS nurse will receive education by the Administrator to perform visual assessments of residents and complete each section of the MDS accurately to reflect head to toe assessment. 4) DON or designee will review all residents admitted Monday through Thursday admission assessments for completeness within 24 hours of admission. Residents admitted Friday through Sunday admission assessments will be reviewed on Monday. MDS will audit recent admissions within the last 3 months for completeness of admission assessments. Results of all audits will be discussed at the facility's QA Committee meeting monthly for 3 months for any necessary additional recommendations	11/3/17

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F 514	Continued From page 46 dated 6/10/17 revealed the Condition of Teeth/Oral Cavity section was blank. Review of the Quarterly Interdisciplinary Resident Review, dated 9/13/17 revealed the Condition of Teeth/Oral Cavity section was blank. The quarterly MDS assessment dated 9/13/17, assessed Resident #58 with intact cognition. Resident #58 was observed in her room on 10/3/17 at 11:15 AM without dentures/natural teeth (edentulous). Resident #58 stated she did not have dentures/natural teeth upon admission and could not get dentures because a dentist told her that she did not have the bone structure in her mouth to support dentures. An interview with the director of nursing (DON) occurred on 10/05/17 at 1:07 PM. The DON stated that she expected nurses to complete a head to toe assessment for new admissions to include an assessment of oral status. During an interview on 10/05/17 at 3:15 PM, Nurse #4 stated that she started the admission assessment dated 6/21/17 for Resident #58, but did not complete it because she worked a split shift that day until 7 PM. Nurse #4 stated that she did recall Resident #58 did not have any natural teeth or dentures on admission or since admission. Nurse #4 stated that Resident #58 reported on admission that she had dentures at home and would bring them, but the Resident's family said Resident #58 refused to wear the dentures and so the dentures were never brought to the facility. Nurse #4 stated that the assessments should have documented the Resident's oral status.	F 514		

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F 514	Continued From page 47 The nurse who completed the Quarterly Interdisciplinary Resident Review, dated 9/13/17, was unavailable for interview.	F 514		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as	F 520	F520 1. Facility is to implement and follow procedures for monthly Quality Assessment and Assurance, QAA, program which involve the establishment of a QAA committee to evaluate results of corrective plans in place t o remedy defective practices and make necessary changes accordingly. 2. All residents are at risk for being affected by this deficient practice 3. All department head staff provided in- service education regards the requirements for a QAA committee and the purpose and impact of an effective QAA program. This education will also include each departments responsibility as it pertains to the committee. The education is to be completed by 11/3/17. 4. The Administrator will develop meeting forms and retain record of items discussed and record of addressing all current and past issues to make sure the facility remains in compliance. Records will be audited at each meeting to ensure all plans are followed as written and any corrections will be made at that time.	11/3/17.

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F 520	Continued From page 48 such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of medical records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in February 2017 and July 2017. This was for two recited deficiencies that were originally cited in January 2017 and June 2017 on Complaint Surveys and subsequently recited on the facility's current Recertification/Complaint survey. The recited deficiencies were in the areas of housekeeping and maintenance services and assessment accuracy. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. F 253 Housekeeping and Maintenance Services: Based on observations and staff interviews the facility failed to repair broken and splintered laminate on resident room doors on 5 of 12 resident rooms (Rooms 118, 117, 113, 110 and 126). During a Complaint survey of January 2017 the	F 520		

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F 520	Continued From page 49 facility was cited for failure to maintain a shared commode clean and operable. On the current Recertification/Complaint survey the facility failed to maintain room doors in good repair without splinters and chips. 1b. F 278 Assessment Accuracy: Based on observations, staff interviews and record review, the facility failed to accurately code the Minimum Data Set related to prognosis of life for 2 of 2 sampled residents who receive hospice services (Residents #69 and #26), dental condition for 2 of 3 sampled residents who required dental services (Residents #44 and #58), and active diagnoses for 1 of 17 sampled residents reviewed for active diagnoses (Resident #58). During a Complaint survey of June 2017 the facility was cited for failure to complete section G, Functional Status on the minimum data set (MDS). On the current Recertification/Complaint survey the facility failed to accurately assess sections I, J, and L for active diagnoses, prognosis of life, and dental status on the MDS. The Administrator was interviewed on 10/5/17 at 5:07 PM. The Administrator stated that the facility used monitoring tools to ensure that facility concerns identified on prior federal surveys remain resolved. The Administrator stated that she attributed a repeat deficiency related to MDS accuracy to the facility's focus for monitoring section G related to functional status and the new deficiency was in sections I, J and L related to prognosis of life, oral status and active diagnoses. The Administrator stated that she was not with the facility at the time of the June 2017 survey, but that although she was responsible to update the facility's survey book, she was not	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 50 aware of the housekeeping concerns from the June 2017 survey and these concerns had not been discussed during the QA meetings since she came on board.	F 520		