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 11/29/2017

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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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide incontinence care (Resident # 18) when needed for 1 of 3 sampled residents. Findings included: Review of Resident #18's quarterly Minimum Data Set (MDS) dated 09/12/2017 assessed the resident as cognitively able to respond to have her care needs met and indicated the resident needed extensive assistance with toileting and was incontinent. Observation on 11/28/2017 at 6:15 AM revealed Resident #18 was awake in bed, with an odor of urine, with her head at the foot of the bed. Nurse Aide (NA) #1 with the assistance of NA #3 repositioned Resident #18 in bed. Interview on 11/28/2017 at 6:15 AM with NA #1 revealed she would change Resident #18 before she went home at the end of her shift. Interview with NA #1 at 7:00 AM revealed she had clocked out and was going home. She stated her shift was over. Observation on 11/28/2017 at 7:05 AM revealed Resident #18 in bed with an odor of urine. Observation on 11/28/2017 at 7:10 AM revealed NA #1 in Resident #18's room with her jacket on	F 677		12/22/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/21/2017

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F 677	Continued From page 1	F 677		

and purse on her shoulder with NA #3 and were standing at the resident's bedside. NA #1 stated "patient care" but no incontinence care was being provided.

Interview on 11/28/2017 at 7:10 AM revealed NA #1 had brought NA #3 to "witness" Resident #18's refusal of incontinence care.

Observation on 11/28/2017 at 7:15 AM revealed Nurse #6 speaking to Resident #18 and she stated to NA #1 that the resident was not refusing care and she needed care.

Interview on 11/28/2017 at 7:15 AM with Nurse #6 revealed she could smell urine on Resident #18 which indicated the resident had not been changed. She stated the nurse aides could ask for help with a resident who was refusing care so the resident could be re-approached. The NAs were to tell the nurse so the nurse could help them. She stated the resident had needed to be changed.

Observation on 11/28/2017 at 7:19 AM revealed NA #1 providing incontinence care to Resident #18 as Nurse #6 told her to do before she left the building. The incontinence brief removed from the resident was soaked with urine. The bed linens were wet.

Interview on 11/28/2017 at 10:08 AM with NA #3 revealed NA #1 had asked her to come and "witness" Resident #18's refusal of care. She stated NA #1 had her jacket on and purse over shoulder ready to leave the building. She stated NA #1 had not asked her to assist her with providing incontinence care to the Resident #18.

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F 677	Continued From page 2 Interview on 11/28/2017 at 10:50 AM with the Assistant Director of Nursing (ADON) revealed they educated NAs that if the resident is refusing care they are to report it to the nurse and then the nurse can help assess the resident and intervene as needed. Interview on 11/28/2017 at 1:11 PM with the Director of Nursing (DON) revealed her expectation was if a resident refused care the nurse aide would let the nurse know of the refusal so the nurse could approach the resident about receiving care they needed.	F 677		

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F 000	INITIAL COMMENTS On November 29, 2017, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted an on-site follow and complaint survey. The facility remains out of compliance.	F 000		
{F 253} SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (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 resident and staff interviews, the facility failed to repair a wall that had two holes and exposed telephone wires and failed to replace cracked floor tiles on a hall for 1 of 1 room (room 118) and 1 of 7 halls. The findings included: On 11/28/17 at 1:58 PM an observation of was made of room 118. One of the interior walls of the room was noted to have two 5 inch by 5 inch busted holes in the wall. The holes were large enough to expose the adjacent wall to another room. The sheet rock was also observed to be cracked and crumbling away from the wall. The telephone jack was hanging by wires from one of the holes in the wall. During the observation, the resident in the room stated that when his bed was being adjusted it caught the telephone jack ripping the jack away	{F 253}		

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{F 253}	Continued From page 1	{F 253}		

from the wall causing the holes. The resident stated the holes in the wall had been there for 3 to 4 months and that staff were aware of the holes in the wall.

On 11/28/17 at 2:09 PM the Maintenance Director was interviewed and stated that following the annual recertification survey he had made rounds to identify concerns with rooms and felt the facility was in compliance and had made all necessary repairs to rooms. He also described that rooms were checked routinely for potential hazards such as lighting and bed rails. The Maintenance Director observed the holes in the wall of room 118 and stated he was aware of the holes but not certain how they would be repaired or when. The Maintenance Director stated he became aware of the holes on Saturday (11/25/17) but had not had time to repair the wall.

During the same interview with the Maintenance Director the threshold to the hallway with room 118 was noted to have six 12 inch tiles cracked. The cracks were caved-in creating a dip in the threshold to the hallway. The caved-in tiles spanned the width of the hallway. The Maintenance Director stated that he hadn't really noticed them before but that the caved-in tiles could be a trip hazard.

On 11/28/17 at 2:16 PM the Administrator observed the holes in the wall of room 118 and stated, "Oh wow." The Administrator reported that he expected all repairs to be handled by Maintenance in a timely manner and brought to his attention. The Administrator stated he was

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{F 253}	Continued From page 2 not aware of the holes in the wall. The Administrator stated he had not noticed the cracked tiles on the hall to room 118. He added that the facility had hopes to remodel but currently there was no plan or date in place.	{F 253}		
{F 431} SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) 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	{F 431}		

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professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(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 1 of 4 medication carts and 1 of 2 medication storage rooms.

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

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disposal procedures, and reordered from the pharmacy if a current order existed. Review of the medication appendix resources for medications with Special expiration date requirements for insulins stated Lantus vials and pens 28 days after opening.

Observation on 11/27/2017 at 11:22 AM with Nurse #3 of the West Wing medication cart #1 revealed:

Humulin RU-500 1000 Unit/220 milliliter (ml) was opened and not dated when it was opened.

Toujeo pen 300 units/ml was opened 10/07/2017 for Resident #130 to receive 30 Units subcutaneously daily. The manufacturer's information stated to discard 28 days after being opened.

Atropine 1% eye gtts 2 bottles opened, there was no date on it when it was opened.

Observation on 11/27/2017 at 12:02 PM with Nurse #5 of the East medication storage room refrigerator revealed:

1 vial of tuberculin Aplisol 5T unit/0.1 ml vial was opened, there was no date opened on the label or box.

3 vial of promethazine injectable 25milligram (mg)/ml with a pharmacy label to discard after 10/30/2017.

4 suppositories-promethazine HCL 12.5 mg had an expiration date of 4/2017 on each suppository.

Interview on 11/27/2017 at 6:35 AM with Nurse #4

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on the East Wing revealed it was everyone's responsibility to check medication carts for expired or discontinued medications.

Interview on 11/28/2017 at 8:00 AM with the Pharmacist stated he did spot checks and checked the medication refrigerators for expired medications. He stated their nurse consultants came periodically to audit the carts and medications refrigerators. They did a more thorough check. He stated the facility staff was responsible for regular checks of the medication carts and refrigerators. When the pharmacy did audits the report of findings were sent to the Director of Nursing (DON) and the Administrator.

Interview at 10:21 AM Nurse #3 stated all medications no longer being used or for discharged residents were pulled off the medication carts. Expired medications were pulled from the carts also. She stated it was everyone's responsibility and there was no particular system for doing this.

Interview on 11/28/2017 at 10:36 AM with Nurse #2 on the East Wing revealed it was everyone's responsibility to remove discontinued medication and medications of discharged residents. Those medications were sent back to pharmacy. All expired medications were removed from the carts.

Interview on 11/28/2017 11:00 AM with Assistant Director of Nursing (ADON) stated that if the resident had expired medications or if the resident had gone to the hospital, the medications were to be removed and place in a tote and returned to pharmacy. She stated expired medications were pulled off the carts and

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discarded. She stated the nurses were to put the date the medication was opened on the medication. She stated all nurses were responsible for making sure medications were in date and stored properly.

Interview on 11/28/2017 at 11:24 PM with Nurse #1 on the West Wing revealed every nurse was expected to remove expired medications or medication that were no longer being used. She stated she checked the medication carts every other day. She checked one cart each day. She stated she found medications the nurses missed removing.

Interview on 11/28/2017 at 12:30 PM with the Director of Nursing (DON) stated they were going to move to weekly medication cart check, but they found medications that should have been removed from the carts so they were continuing daily medication cart checks. She stated the pharmacy came in and found some medications and things with that audit.

Interview on 11/27/2017 at 1:04 PM with the DON revealed as they monitored medication storage they identified they were still having problems with expired medications and medications that were dated when they were opened to be used. She stated every nurse was expected to look at the medications before they use them. She stated she expected the medication carts and medications rooms to have all medications in date and stored properly. She stated medications for discharged residents and expired medications were to be removed from the carts.

Interview on 11/29/2017 at 3:50 PM with the Medical Director (MD) revealed he thought the

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{F 431}	Continued From page 7 medication storage issue was improving. He stated the pharmacy had come in and found some things, but it was better. He stated the medications should be stored correctly. He stated there would not be any harm if something was recently expired. He expected if the pharmacy label stated the medication needed to be refrigerated then the medication should be refrigerated. Interview on 11/29/2017 at 4:00 PM with the Administrator and DON revealed they expected 100% of medications to be stored correctly.	{F 431}		
{F 520} SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (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	{F 520}		

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{F 520}	Continued From page 8 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 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: The facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in October 2017. This was for 2 recited deficiencies originally cited in October 2017 on an annual recertification survey. The 2 deficiencies were recited on the current recertification survey. The deficiencies were in the areas of maintenance and housekeeping services and drug storage. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Committee. The findings included: This tag is cross referred to:	{F 520}		

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1. F 253 Based on observations resident and staff interviews, the facility failed to repair a wall that had two holes and exposed telephone wires and failed to replace cracked floor tiles on a hall for 1 of 1 room (room 118) and 1 of 7 halls.

The facility was cited for F 253 in October 2017 for splintered doors.

2. F 431 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 1 of 4 medication carts and 1 of 2 medication storage rooms. (Insulin, eye drops, tuberculin skin test, suppositories, anxiety, nausea and allergy injectable and suppositories).

The facility was cited for F 431 in October 2017 for expired medications.

On 11/29/17 at 3:51 PM the Administrator was interviewed and explained he was new in his role but had assisted in monitoring compliance from the annual recertification. He stated he felt the facility was incompliance with the areas cited including housekeeping and maintenance services.

During the same interview, the Director of Nursing (DON) reported that she had identified

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{F 520}	Continued From page 10 that the deficiency for drug storage had not been corrected because in auditing medication carts and medications rooms she was finding errors. She stated she was continuing to make changes and educate nursing staff.	{F 520}		