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 03/12/2019

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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews, and record review, the facility failed to conduct a physical assessment after a fall for 1 of 4 sampled residents at risk for falls (Resident #3). The findings included: Resident #3 was admitted to the facility on 02/23/18 with diagnoses which included epilepsy and type 2 diabetes mellitus. Review of Resident #3's quarterly Minimum Data Set (MDS) dated 01/10/19 revealed an assessment of intact cognition. The MDS indicated Resident #3 required the supervision of one person with transfers. Review of Resident #3's care plan dated 12/28/18 revealed interventions to prevent falls included reminders to ask for assistance, proper footwear and call light within reach. Review of a nursing note dated 02/15/19 at 5:17 AM revealed Resident #3 requested pain medication. Nurse #1 documented Resident #3 complained of left leg pain with swelling and	F 684	1) It was identified that the facility failed to conduct a physical assessment after Resident #3 fell. Facility unable to assess the Resident #3 as Resident #3 is no longer a resident at the facility. 2) 100% of residents with falls within the past 30 days were reviewed to ensure resident assessments were complete. This audit was complete by the DON and recorded on the Falls QI tool and any missing assessments were immediately corrected. 3) 100% of nursing staff received education to ensure a nurse assessment is immediately complete upon a fall and that staff are not to move a resident without a nurse assessment. 4) Director of Nursing or designee will review all new falls daily for 6 weeks to ensure all residents with falls have nurse assessments. Results of these audits will be discussed at the facility QA committee meeting monthly for additional recommendations if necessary.	4/1/19

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

Electronically Signed | 04/01/2019

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F 684	Continued From page 1	F 684		

discoloration. Resident #3 informed the nurse a nurse aide assisted her after a fall in the bathroom. The physician received notification.

Review of a left leg x-ray report dated 02/15/19 revealed acute fractures of Resident #3's distal tibia and fibula. Resident #3 received an orthopedic referral on 02/15/19 with subsequent admission to the hospital for treatment.

Telephone interview with Nurse #1 on 03/11/19 at 11:45 AM revealed Nurse Aide (NA) #1, a temporary agency nurse aide, informed her Resident #3 requested pain medication. Nurse #1 stated Resident #3 was in bed and informed Nurse #1 she fell in the bathroom. Resident #3 explained NA #1 assisted her off the floor and back into bed. Nurse #1 explained Resident #3's leg was swollen and discolored so the physician received immediate notification. Nurse #1 estimated the time between the fall and an assessment of injury was approximately 45 minutes.

NA #1 was not available for interview.

Telephone interview with Resident #3's physician on 03/11/19 at 2:16 PM revealed Resident #3 should receive a physical assessment after a fall. The physician reported a delay in assessment did not affect the outcome or worsen the injury.

Interview with the Director of Nursing (DON) on 03/11/19 at 3:22 PM revealed he began employment at the facility on 03/4/19 and had no direct knowledge of Resident #3's fall. The DON reported he expected a complete physical assessment to be immediately conducted after a fall. The DON reported he expected staff to

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

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F 684	Continued From page 2 immediately notify a nurse when a resident fell.	F 684		