STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facility's desire to comply with the requirements and to continue to provide high quality care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elisa Matheny — TITLE: Administrator — (X6) DATE: 12/28/12

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.

DHSR Received DEC 31 2012 by: PAM WRO Blue Mountain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 156	F156 • The listing of State Agency telephone numbers were enlarged from an 8X10 size to a 24 x 36 and placed in the main hallway of the facility. • Resident # 209 and #6 viewed the new posting in the hallway and all verbalized that they could easily read the posting. • Administrator met with Resident Council and discussed the posting and its location. Residents were informed that they could also request from any administrative staff member their own copy of this listing. Four Residents did request a copy and were given a copy during the Resident council Meeting. • Activity Director will continue to remind Residents where the listing is posted and ask for any concerns with the posting at the monthly Resident Council Meeting. • Resident Council Minutes will be reviewed monthly times 3 months ongoing reviews will be based on the first three months data review.	12/6/12 12/12/12 12/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview the facility the facility failed to prominently post the state survey and certification agency's toll free complaint telephone number and failed to provide Medicare non-coverage notice to 2 of 4 sampled residents (Resident # 55 and #166). The findings include: 1. On 12/04/12 at 5:03 PM Resident # 209, the president of the Resident council, was interviewed and stated he was unaware of where the state survey and certification agency's toll free complaint telephone number was posted in the facility. On 12/04/12 at 5:17 PM it was observed that the state survey and certification agency's toll free	F 156	• The results of the resident council meetings will be discussed in the facility's Quality Assurance meetings monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 156	Continued From page 3	F 156		

complaint telephone number could not be located in any prominent location within the facility.

On 12/05/12 at 9:15 AM the Director of Nursing (DON) was interviewed and stated the state survey and certification agency's toll free complaint telephone number was posted in a frame on the wall of the administration hallway near the main dining area.

On 12/05/12 at 9:17 AM the DON pointed to an 8x11 frame approximately 6 feet from the ground, located on the wall in the administration hallway. The framed sheet listed the state agency and certification agency's toll free complaint number.

On 12/05/12 Resident #6 was observed wheeling by the framed sign and interviewed at 9:22 AM. Resident #6 stated he was not aware of the location of the state agency and certification agency's toll free complaint number and when showed the posting's location stated the sign was too high up and he was unable to see the names or numbers.

During an interview with the Administrator on 12/05/12 at 9:25 AM, the Administrator stated residents who have vision problems probably would not be able to read the posting due to the location on the wall and its size and she would immediately have it enlarged.

During a follow-up interview with Resident #206 on 12/05/12 at 9:45 AM, Resident # 206 stated he asked the DON and Administrator where the posting of the state agency and certification agency ' s toll free complaint number was and he was taken to the location of the posting near the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 156	Continued From page 4 front lobby and main dining room. Resident # 206 stated it was quite small and was about 5-6 feet up on the wall. " I was not even able to read it with my glasses on and I do not think residents in wheelchairs who cannot stand would be able to read the posting. " 2. A review of Resident #55's financial records revealed an intent to discharge from rehabilitation department form dated 10/26/12 which indicated Resident # 55's Medicare covered services would end on 11/01/12 and indicated " no cut letter to be given, going home " . A facility Notice of transfer/ discharge dated 11/02/12 indicated the Resident was being discharged due to no longer requiring services from the facility. Resident # 55 was discharged from the facility on 11/02/12 to home. There was no record of Resident # 55 being provided an approved Notice of Medicare non-coverage letter that notified her in advance of her Medicare services ending; what the estimated cost of services would be and her right to appeal. On 12/05/12 at 6:10 PM the business office manager reported it was not the practice of the facility to notify residents who were returning home with a Notice of Medicare non-coverage letter prior to their Medicare services ending. The business office manager further explained residents were notified of their right to appeal upon admission. The business office manager also stated the facility was under the impression when residents discharged home they did not have a right to appeal because they were choosing to go home. Therefore, the Notice of Medicare non-coverage letters were only given to residents who were remaining in the facility and	F 156	F156 • In-service training was conducted for Business Office Managers and Social Workers by the Administrator. • In-service/Education included that all residents discharged from a Medicare Part A benefit period regardless of reason must have a (cut letter) Approved Medicare non-coverage letter. Form must be complete 72 hrs before coverage expires when feasible and as soon as discharge is known in cases where resident decides to go home prior to their planned discharge.	12/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 156	Continued From page 5 had not exhausted their Medicare days. 3. A review of Resident #166's financial records revealed an intent to discharge from rehabilitation department form dated 11/05/12 which indicated Resident #166's Medicare covered services would end on 11/12/12 and the Resident would be discharged home. A facility notice of transfer/discharge dated 11/08/12 indicated the Resident was being discharged due to no longer requiring services from the facility. Resident # 166 was discharged 11/13/12 to home. There was no record of Resident #166 being provided an approved Notice of Medicare non-coverage letter that notified her of her Medicare services ending; what the estimated cost of services would be and her right to appeal. On 12/05/12 at 6:10 PM the business office manager reported it was not the practice of the facility to notify residents who were returning home with a Notice of Medicare non-coverage letter prior to their Medicare services ending. The business office manager further explained residents were notified of their right to appeal upon admission. The business office manager also stated the facility was under the impression when residents discharged home they did not have a right to appeal because they were choosing to go home. Therefore, the Notice of Medicare non-coverage letters were only given to residents who were remaining in the facility and had not exhausted their Medicare days.	F 156	• Form will be explained to Resident/Responsible Party by Social Worker or Business Office manager with reasons for services ending and the estimated cost of services. Resident/Responsible Party will also be informed of their right to Appeal. • Financial files for all Residents Discharged from Medicare Part A Benefits will be audited by Administrator monthly to assure cut letters were completed appropriately and timely. • Audits will be conducted monthly times two months. Ongoing Audits will be based on the first two months audit results • The findings/Outcome will be addressed at the QA committee meeting monthly.	12/10/12 12/29/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 309	Continued From page 6 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and nurse practitioner interviews, and record review, the facility failed to schedule an orthopedic appointment to evaluate shoulder pain for 1 of 3 sampled residents (Resident #22) and failed to apply anti-embolism hose for 1 of 3 sampled residents (Resident #140). The findings are: 1. Resident #22 was admitted to the facility on 11/04/05 with diagnoses which included quadriplegia, degenerative joint disease and chronic pain. Review of Resident #22's annual Minimum Data Set (MDS) dated 8/24/12 revealed an assessment of Resident #22's cognition as intact. The MDS assessed Resident #22 required a pain management program for almost constant severe pain. Review of Resident #22's care plan dated 09/05/12 revealed interventions for maintenance of an acceptable pain level included medication administration, positioning and assessment of pain levels.	F 309	F309 Residents affected: Resident # 140 , clarification order written to Address TED hose application, resident has Bi-lateral TED hose applied in AM off in PM 12/6/12 Resident # 22 Was evaluated for pain – MD evaluated Pain regime and made changes in pain medication Orders. 12-14 12 Resident # 22 was seen by the orthopedist 12/12/12 OT services initiated per orthopedist 12/6/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 309	Continued From page 7 Review of physician's orders dated 8/3012 revealed Resident #22 required an orthopedic consultation due to shoulder pain. Review of Resident #22's September 2012 Medication Administration Record (MAR) revealed Resident #22 received a scheduled narcotic analgesic, Morphine Sulfate Extended Release (ER) 160 milligrams (mg.) twice daily at 9:00 AM and 8:00 PM. In addition, Resident #22 received two tablets of another narcotic analgesic medication, Lortab (Hydrocodone 7.5 mg/ Acetaminophen 500 mg) as needed (prn) for complaint of pain three times daily on 6 days (9/01/12, 9/15/12, 9/16/12, 9/21/12, 9/23/12 and on 9/30/12); twice daily on 8 days (9/02/12, 9/03/12, 9/09/12, 9/17/12, 9/18/12, 9/25/12, 9/26/12 and on 9/27/12); and once daily on 15 days(9/04/12, 9/0512, 9/06/12, 9/07/12, 9/08/12, 9/10/12, 9/11/12, 9/12/12, 9/13/12, 9/14/12, 9/19/12, 9/20/12, 9/21/12, 9/28/12 and 9/29/12). Review of Resident #22's October 2012 MAR revealed Resident #22 received Morphine Sulfate ER 160 mg. scheduled twice daily at 9:00 AM and 9:00 PM. In addition, Resident #22 received two tablets of Lortab 7.5 mg/500 mg. prn for complaint of pain four times daily on 12 days (10/02/12, 10/04/12, 10/05/12, 10/06/12, 10/07/12, 10/13/12, 10/14/12, 10/15/12, 10/20/12, 10/21/12, 10/22/12, and 10/28/12); three times daily on 8 days (10/03/12, 10/8/12, 10/10/12, 10/11/12, 10/18/12, 10/23/12, 10/25/12, and 10/26/12); and twice daily on 7 days (10/01/12, 10/09/12, 10/16/12, 10/17/12, 10/19/12, 10/24/12 and 10/27/12). Review of a physician's note dated 10/24/12	F 309	Residents with potential: All residents with orders for TED hose were reviewed By RN Supervisor for appropriate orders. 12/7/12 No other issues were identified With TED hose orders. All residents' medical records (100%) from October, November and December 2012 12/11/12 Were review related to physician orders for Appointments as well as the resident's attendance to that appointment. This was Completed by the Director of nurse's and the RN Supervisor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 309	Continued From page 8 revealed right shoulder and elbow pain continued and Resident #22 "needs ortho (orthopedic) appt. (appointment)." The physician's order dated 10/24/12 directed an orthopedic appointment for right elbow and right shoulder pain with a referral to occupational therapy for range of motion as tolerated. Review of Occupational Therapist referral/screen form dated 10/25/12 revealed Resident #22 could not receive treatment for severe pain of the left side of the neck and left shoulder until completion of an orthopedic consultation. Review of Resident #22's November 2012 MAR revealed Resident #22 received Morphine Sulfate ER 160 mg. administration scheduled twice daily at 9:00 AM and 8:00 PM. In addition, Resident #22 received two tablets of Lortab 7.5 mg/500 mg prn for complaint of pain 4 times on 11/11/12 and 3 times daily on 11/06/12 and 11/08/12. Resident #22 also received the prn Lortab twice daily on 6 days (11/04/12, 11/12/12, 11/13/12, 11/14/12, 11/15/12, and 11/16/12); and once daily on 9 days (11/01/12, 11/02/12, 11/05/12, 11/07/12, 11/09/12, 11/17/12, 11/18/12, 11/29/12 and 11/20/12. Review of a physician s note dated 11/20/12 revealed Resident #22 continued to complain of pain of the right upper extremity. Resident #22's Morphine Sulfate ER was increased to 200 mg. twice daily and 100 mg. at 2:00 PM. MS Immediate Release (IR) 30 mg every 6 hours was ordered for breakthrough pain and the Lortab discontinued. Review of Resident #22's November 21, 2012 to	F 309	Measures put in place/systemic changes: • In-service was done by the Staff Development Coordinator for licensed nurses in the building Regarding TED hose orders and appropriate Application • Appointments: in-service completed with licensed Nurses regarding resident appointments and Implementation of "appointment book" and Process of communication when a resident Appointment has been ordered. This was Done by the Staff Development Coordinator.	12/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 309	Continued From page 9 November 30 MAR revealed Resident #22 requested and received MSIR 30 mg for breakthrough twice on 11/25/12 and once on 11/29/12. Review of Resident #22's December 2012 MAR revealed administration of the MSIR 30 mg. for breakthrough pain once on 12/2/12. Review of the record revealed documentation of an orthopedic consult was not available. Interview with Resident #22 on 12/3/12 at 1:31 PM revealed pain medication did not completely ease the pain of the right shoulder and arm. Resident #22 explained the pain did not interfere with his usual activities. Interview with Nurse #4 on 12/06/12 at 2:03 PM revealed Resident #22 required administration of the prn pain medication on a daily basis to lower the pain level to 2 based on a scale of 1 to 10 with 10 described as unbearable. Nurse #4 was not aware of an orthopedic appointment. Interview with Nurse #2 on 12/06/12 at 2:10 PM revealed Resident #22 did not have an orthopedic consult. Nurse #2 could not provide a reason but thought one had been scheduled. Interview with the ward clerk on 12/06/12 at 2:20 PM revealed Resident #22's orthopedic consult had not been scheduled. The ward clerk explained she needed the primary physician's license information so did not schedule the appointment. The ward clerk reported she informed nursing staff of the requirement.	F 309	Monitoring: • TED Hose: an audit tool was developed to Assess that all TED hose orders are specific as well As on-site observation that TED hose have Been applied per MD order. This will continue 2 x weeks for 4 weeks, then weekly For 4 weeks. The ongoing need for audits Will be determined by the prior 2 months of audits. Audits will be completed by the Director of Nurses or other assigned licensed nurse.	12/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 309	Continued From page 10 Interview with Nurse #1, nursing supervisor, on 12/6/12 at 2:22 PM revealed she was not aware of the order for the orthopedic consultation. Interview with the occupational therapist (OT) on 12/6/12 at 2:28 PM revealed Resident #22 required an orthopedic consult prior to treatment. The OT explained range of motion could not begin until the orthopedist evaluated and approved Resident #22 for treatment. Interview with Resident #22 on 12/06/12 at 2:40 PM revealed his shoulder continued to hurt. Resident #22 reported he was to see an orthopedist but staff did not inform him of the date. Interview with the Director of Nursing (DON) on 12/06/12 at 4:00 PM revealed she expected staff to arrange residents' appointments upon receipt of the order. The DON reported Resident #22's orthopedic appointment should have been arranged. 2. Resident #140 was admitted to the facility on 04/09/12 with diagnoses which included right side hemiplegia due to cerebral vascular accident and gout. Review of Resident #140's quarterly Minimum Data Set (MDS) dated 10/12/12 revealed an assessment of severe impairment of cognition. Resident #140 required the extensive assistance of one person with dressing. Review of a nurse practitioner's order dated 9/25/12 revealed direction for anti-embolism hose application in the morning and removal in the	F 309	• Appointment: an audit tool was developed to See that appointments have been followed Up as per MD order. Appointment audits will continue on 20% Of residents weekly for 8 weeks, then 10% of Residents for 4 weeks. The need for ongoing Audits will be determined by the results of the Prior 12 weeks of auditing. Audits will be completed By Director of nurses or assigned licensed staff. QA: Results of the audits for both TED hose and resident Appointments will be discussed and reviewed at the QA committee meeting monthly.	12/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 309	Continued From page 11 evening. Review of Resident #140's Treatment Records for September 2012, October 2012, November 2012 and December 1 through 5, 2012 revealed documentation of daily application and removal of anti-embolism hose. Observation of Resident #140 on 12/3/12 at 10:10 AM revealed one anti-embolism hose on a slightly swollen right leg and a sock on a non-swollen left leg. Observation of Resident #140 on 12/4/12 at 10:50 AM, 11:40 AM, and 12:32 PM revealed one anti-embolism hose on the slightly swollen right leg and a sock on the non-swollen left leg. Observation of Resident #140 on 12/5/12 at 9:13 AM and 10:21 AM revealed one anti-embolism hose on the slightly swollen right leg and a sock on the non-swollen left leg. Interview with Nurse Aide (NA) #1, who regularly cared for Resident #140, on 12/5/12 at 11:00 AM revealed Resident #140 required an anti-embolism hose only on the right leg. NA #1 explained she applied the anti-embolism hose every morning. Interview with Nurse #4 on 12/5/12 at 12:08 PM revealed Resident #140 should wear anti-embolism hose on both legs. Nurse #4 reported she initialed the Treatment Record to verify the nurse aide applied the hose. Interview with Nurse #3, nursing supervisor, on 12/5/12 at 4:25 PM revealed she took off the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 309	Continued From page 12 nurse practitioner order on 9/25/12. Nurse #3 explained the order directed application of anti-embolism hose for both legs since both legs were affected with circulation problems. Interview with Nurse Aide #2 on 12/5/12 at 4:36 PM revealed she removed one anti-embolism stocking from Resident #140's right leg every evening. Interview with the nurse practitioner (NP) on 12/6/12: at 8:41 AM revealed Resident #140 should have anti-embolism hose on both legs. During this interview, the NP wrote an order dated 12/6/12 for application of the anti-embolism hose to both legs. Interview with the Director of Nursing (DON) on 12/6/12 at 9:05 AM revealed orders for anti-embolism hose would mean both legs unless otherwise specified.	F 309		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to ensure medication errors less than 5.00% as evidenced by 3 non-significant errors out of 51 opportunities, resulting in medication error rate of 5.76%. The accurate dose of Dilantin (for seizures) was not administered and Advair Diskus inhalers were not	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 332	Continued From page 13 administered appropriately. (Resident #51, #130 and #55) The findings are: 1. Resident #51 was admitted to the facility on 7/25/07 with diagnoses which included Dementia. Review of physician's orders dated 12/4/12 revealed direction to administer Dilantin suspension 125 milligrams (mg.)/5 milliliters (ml.) for a total dose of 250 mg. twice daily for a new onset of seizures. Review of Resident #51's December 2012 Medication Administration Record (MAR) revealed a handwritten transcription to administer 10 ml. of the Dilantin suspension for 250 mg. Observation on 12/5/12 at 7:49 AM revealed Medication Aide (MA) #1 removed an unopened bottle of Dilantin suspension from a zip lock plastic bag. The bag also contained a measuring syringe. MA #1 did not remove the syringe from the plastic bag. MA #1 shook and opened the bottle of Dilantin suspension. MA #1 poured the suspension into a plastic medicine cup. MA #1 placed the plastic medication cup on top of the medication, looked at the graduations at eye level and pronounced the dose was correct. MA #1 reported she intended to administer the dose to Resident #51. Observation on 12/5/12 at 7:51 AM revealed the Dilantin suspension was approximately 12.5 ml. Interview with MA #1 on 12/5/12 at 7:53 AM revealed she agreed the dose appeared to more	F 332	F 322 Resident #51 The resident had a Dilantin level done On 12/10/12, results were WNL Resident # 130 No adverse reaction R/T Administration of inhaler Medication was identified. Resident # 55 No adverse reaction R/T administration of inhaler Medication was identified. Resident has since gone home Independently. Resident with potential: The SDC initiated medication pass Observations with licensed nurse's On all shifts including weekend Staff.	12/10/12,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 332	Continued From page 14 than 10 ml. MA #1 explained she did not use the syringe to measure the dose since the plastic medicine cups also has milliliter graduations. Interview with the Director of Nursing (DON) on 12/5/12 at 1:40 PM and she expected staff to use the syringe for Dilantin measurement. 2. Review of the facility's revised September 2003 procedure for administration of inhaled medications revealed direction to ask the resident to inhale and exhale deeply for a few breath cycles prior to administration. On the last breath cycle, staff were to instruct the resident to exhale deeply. Resident #130 was admitted to the facility on 02/06/12 with diagnoses which included Chronic Obstructive Pulmonary Disease. Monthly medication orders dated 11/06/12 included Advair 250/50 Diskus, inhale one puff by mouth twice daily- rinse and spit after each use. Review of Resident #130's December 2012 Medication Administration Record (MAR) revealed transcription of the Advair Diskus 250/50 one puff twice daily without direction to rinse and spit after each use. Review of the pharmacy label of the Advair Diskus 250/50 revealed a dispense date of 11/23/12 with direction to rinse and spit after each use. Observation on 12/4/12 at 4:55 PM revealed Nurse #5 directed Resident #130 to suck the Advair Diskus "like a straw." Nurse # 5 did not ask Resident #130 to exhale deeply prior to the	F 332	In-service education was completed With nursing staff regarding medication Administration with emphasis on measuring Liquids properly and use of inhalers. 12/5/12 Measures put in place: An audit tool was developed To address specific issues i.e.: inhaler Administration and liquid medication Dispensing. During medication administration Return demonstrations were a Accomplished. Monitoring: Medication administration observation Will be done with a random sample of Licensed nurses/medication aides by the SDC and/or pharmacist i.e.: 10% of nurses 2x a month for the next 3 months, then monthly for the next 2 months Ongoing observations will be determined by the Results of the prior months audits.	12/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 332	Continued From page 15 one puff. Nurse #5 did not ask Resident #130 to rinse and spit after the one puff. Interview on 12/4/12 at 5:00 PM with Nurse #5 revealed she forgot to ask Resident #130 to exhale deeply prior to the inhaler administration. Nurse #5 reported she used the MAR as a guide for direction and did not ask the Resident to rinse and spit after the puff. Interview with the Director of Nursing (DON) on 12/5/12 at 1:35 PM revealed Resident #130 should have been directed to exhale deeply prior to administration of the inhaler and asked to rinse and spit after the puff. 3. Review of the facility's revised September 2003 policy and procedure for administration of medications through metered dose inhalers revealed direction to ask the resident to inhale and exhale deeply for a few breath cycles prior to administration. On the last breath cycle, staff were to instruct the resident to inhale deeply when the mouthpiece of the inhaler was in place. Resident #55 was admitted to the facility on 11/27/12. The Residents diagnoses included asthma, chronic airway obstruction, chronic bronchitis and sinusitis, obstructive sleep apnea and shortness of breath among several other conditions. Monthly physician medication orders renewed for the month of November 2012 included Advair Diskus 250-50 mcg/dose (microgram per dose) administered as: one inhalation two times daily at 9:00 AM and 9:00 PM. Resident #55 was observed during medication	F 332	QA: Results of the audits will be Presented at the QA committee meeting monthly.	12/6/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 332	Continued From page 16 administration and Medication Aide (MA) #2 was seen administering medications to Resident #55 on 12/05/12 at 8:29 AM. MA #2 prepared all oral medications and got the Advair 250-50 Diskus ready. MA #2 administered all oral medications with the aid of water and handed the Advair Diskus to Resident #55 and instructed her to inhale. The observation revealed MA #2 did not follow the protocol to instruct the Resident to inhale/exhale few breath cycles before the inhaler administration. MA #2 appropriately rinsed the mouth of Resident #55. Interview with MA #2 on 12/05/12 at 8:35 AM revealed that she forgot to instruct Resident #55 to complete the inhale/exhale cycles before administering the inhaler for complete absorption. Interview with the Director of Nursing (DON) on 12/5/12 at 1:35 PM revealed Resident #55 should have been directed to follow the breathing cycle protocol and exhale deeply prior to the administration of Advair inhaler and that was what was expected from all the nursing staff..	F 332		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 363	Continued From page 17 of facility menus, the facility failed to serve a portion of vegetables according to the menu. An observation of the dinner meal tray line occurred on 12/4/12. The posted menu included green beans. Mashed potatoes were also available on the tray line. Review of the menu revealed residents were to receive a four ounce portion of green beans and a four ounce portion of mashed potatoes. Dietary staff #2 was observed on 12/4/12 at 5:31 PM, 5:37 PM and 5:38 PM to plate four dinner meals of green beans and mashed potatoes using a four ounce serving utensil without measuring a full four ounce portion. The serving utensil was not filled, but rather approximately 3/4 full of green beans and mashed potatoes. Dietary staff #2 stated on 12/4/12 at 5:43 PM that he did not realize he was not serving a full portion of mashed potatoes or green beans. He stated "I just scoop the food and sometimes I may not get the serving utensil full, I'm sorry about that." The certified dietary manager (CDM) was observed on 12/412 at 5:44 PM to instruct dietary staff #2 to serve residents a full portion of food. The CDM confirmed that residents should have received a four ounce portion size of green beans and mashed potatoes according to the menu.	F 363	F363 • The Current Dietary Manager was replaced. A new Dietary Manager who is also a Registered Dietician was hired and will officially start 1-14-2013. The interim dietary manger will be Ron Dewy HCSG District manager until the new manager begins. The district Manager will assure that the new manager is well trained and complies with the plan of correction in place.	12/28/12
			• In-service training was conducted by Health Care Services Group District Manager for all dietary staff on proper serving utensils, portion sizes, diet extensions, consistencies and food temperatures.	12/10/12
			• All Cooks will utilize a tray line check list • Checklist will be completed prior to each meal service and will focus on proper serving utensils, portion sizes, diet extensions, consistencies and food temperatures. • Dietary Manager/Supervisor at the time of meal service will observe the tray line for proper portion sizes before each meal. • Dietary Manager/Supervisor will utilize the Diet Extension	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 364	Continued From page 18 temperature. This REQUIREMENT is not met as evidenced by: Based on a sample test tray, observations of meal preparation, interviews with residents and staff, and review of food committee minutes and recipes, the facility failed to provide palatable foods that were seasoned according to the recipe and served at temperatures per resident preference for 11 of 11 residents, (Resident #22, 135, 57, 39, 152, 45, 253, 61, 119, 163, and 2). 1a. Review of Resident #22's annual minimum data set (MDS) dated 8/24/12 revealed the Resident had the ability to understand others, was able to make self understood and had no problems with cognition. Interview on 12/3/12 at 1:32 PM with Resident #22 revealed the food had no taste and no seasoning; sometimes the toast, bacon and sausage was burned really bad for breakfast. b. Review of Resident #135's quarterly MDS dated 8/30/12 revealed the Resident had the ability to understand others, was able to make self understood and had no problems with cognition. Interview on 12/3/12 at 1:03 PM with Resident #135 revealed that eggs were served cold about five days per week and the food tastes terrible. Resident #135 further stated that the resident group asked administration to have input in the menus because the food tastes as if most of it was canned.	F 364	checklist and will sign off on before each meal daily. • Checklist will be reviewed weekly by District Manager times three months. Ongoing reviews will be based on the first three months audit results. • The results from audits will be reviewed at the Quality Assurance meetings monthly. F364 • Dietary Manager and or RD met with Residents # 22, 135, 57, 39, 152, 45, 253, 119, 61, 163 and #2 on food concerns and preferences. • All cooks and dietary aids were in serviced by the District Manager on correctly following recipes for all diets and maintaining food temperatures. • Dietary Manager/Supervisor will taste test all foods on steam table prior to meal service. • Cooks will initial off on their daily logs that they have followed the recipes for items prepared. Supervisor will also check temps of food leaving tray line.	12/10/12 12/29/12 12/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 364	Continued From page 19 c. Review of Resident #57's quarterly MDS dated 9/7/12 revealed the Resident had the ability to understand others, was able to make self understood and had no problems with cognition. Interview on 12/4/12 at 10:17 AM with Resident #57 revealed the meals served did not taste good; tasted as if it came out of a can. Resident #57 explained the potatoes were particularly "awful" and she refused to eat them. d. Review of Resident #39's quarterly MDS dated 10/5/12 revealed the Resident had the ability to understand others, was able to make self understood and had no problems with cognition. Interview on 12/4/12 at 11:46 AM with Resident #39 revealed the meals served "had no flavor." Resident #39 reported the addition of salt and pepper did not seem to help the food's flavor. e. Review of Resident 152's quarterly MDS dated 10/10/12 revealed the Resident had the ability to understand others, was able to make self understood and had no problems with cognition. Interview on 12/4/12 at 10:35AM revealed the food looks good, but had no taste. Resident #152 explained that the food tastes like it was cooked in water; it looks good, but tastes like nothing. f. Review of Resident #45's quarterly MDS dated 10/12/12 revealed the Resident had the ability to understand others, was able to make self understood and had impaired cognition. Interview on 12/4/12 at 1:22 PM with Resident	F 364	• Dietary Manager will complete a weekly unit inspection which will include observing preparation, cooking methods along with recipes being followed by cooks. System of maintaining food temps throughout food delivery process will also be observed and food temperatures logged. • Resident Satisfaction Surveys will be conducted on 10% of Resident census on weekly bases and reviewed by District Manager. All concerns from audits will be placed on a facility concern and grievance form and addressed timely as per policy by Dietary manger/Supervisor. • All audit tools and Surveys will be reviewed and analyzed weekly by District Manager and Dietary Manager X3 months. Ongoing reviews will be based on outcome of the first 3 months audits and surveys • The findings/Outcome will be addressed at the QA committee meeting monthly.	12/10/12 12/29/12 12/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 364	Continued From page 20 #45 revealed that she did not like the food and did not always get the food she asked for. An interview with Resident #45 on 12/5/12 at 1:30 PM revealed she did not eat the green beans or mashed potatoes for lunch because she did not like the taste. g. Review of Resident #253's admission MDS dated 11/2/12 revealed that the Resident had the ability to understand others, was able to make self understood and had no problems with cognition. Interview on 12/4/12 at 11:37 AM with Resident #253 revealed the food was often bland, was not necessarily hot, the vegetables were not cooked well and he wanted a salt substitute to season his foods, but the kitchen didn't provide it. h. Review of Resident #61's admission MDS dated 11/15/12 revealed the Resident had the ability to understand others, was able to make self understood and had no problems with cognition. Interview on 12/4/12 at 12:17 PM with Resident #61 revealed that the food had no taste and was bland. i. Review of Resident #119's quarterly MDS dated 11/16/12 revealed the Resident had the ability to understand others, was able to make self understood and had no problems with cognition. Interview on 12/4/12 at 5:21 PM with Resident #119 revealed the food had no seasoning and tasted as if the only seasonings used were salt and pepper. Resident #119 stated that salt and	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 364	Continued From page 21 pepper was also provided on the meal tray, but did not help. Resident #119 also stated "I have told the nurse aides and they just laugh; half of the time I order out." The Resident further stated that the potato soup was watery and all meals needed seasoning. A follow-up interview with Resident #119 on 12/5/12 at 4:19 PM revealed that the lunch meal was warm, not hot and the "turkey was awful, the food had no seasoning to it". j. Review of Resident #163's admission nursing assessment dated 11/27/12 revealed the Resident had the ability to understand others, was able to make self understood and had no problems with cognition. Interview on 12/4/12 at 12:51 PM with Resident #163 revealed that the food had no taste, the broccoli was too hard and the grits taste like instant grits. 2a. On 12/4/12 the dinner meal tray line was observed at 5:05 PM. Dietary staff #2 was observed plating the meal. The menu included barbecue riblette, green beans, macaroni and cheese, roll and chocolate brownie. At 5:25 PM dietary staff #2 plated two servings of barbecue riblettes, green beans and macaroni and cheese and put the plate uncovered, on the shelf of the steam table. The plate remained uncovered until 5:35 PM when dietary staff #6 removed the plate, covered it with an insulated dome lid and stored it on the cart for delivery to a resident. Temperature monitoring was requested and completed at 5:36 PM by the certified dietary manager (CDM) with the following temperatures: • Barbecue riblette, 115.7 degrees Fahrenheit	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 364	Continued From page 22 (F) · Green beans, 122.3 degrees F · Macaroni and cheese, 110 degrees F After temperature monitoring, the CDM covered the meal and placed it on the cart for service. At 5:45 PM, staff returned the dinner meal for Resident #2, who ate in the main dining room, to the kitchen and stated the Resident complained that her food was cold. b. On 12/4/12 the dinner meal tray line was observed at 5:05 PM. Dietary staff #2 was observed plating the meal. At 5:46 PM dietary staff #2 plated barbecue riblette, green beans and macaroni and cheese and placed the plate uncovered, on the shelf of the steam table. The plate remained uncovered on the steam table until 6:02 PM when dietary staff #6 removed the plate, covered it with an insulated dome lid and stored it on the cart for delivery. Temperature monitoring was requested and completed at 6:04 PM by the consultant registered dietitian (RD) with the following temperatures: · Barbecue riblette, 88 degrees F · Macaroni and cheese, 94 degrees F · Green beans, 95 degrees F Interview on 12/4/12 at 6:05 PM with the RD revealed that when food was plated, it should be covered and placed on the cart for meal service. She confirmed that hot foods should leave the steam table at least 135 degrees F so that the food would still be hot when it reached the resident. The RD was observed to instruct the tray line staff that this plate could not be served. Interview on 12/4/12 at 6:06 PM with dietary staff	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 364	Continued From page 23 #6 revealed she did not realize the plates of barbecue riblette, macaroni and cheese and green beans sat on the steam table uncovered so long before being covered for service. 3. The lunch meal tray line was observed on 12/5/12. The menu included roast turkey with poultry gravy and cranberry sauce, zucchini with stewed tomatoes, mashed potatoes, roll and ice cream. At 11:05 AM, temperature monitoring revealed the turkey had varying temperatures of 102 degrees F, 156 degrees F and 165 degrees F. Dietary staff #3 was observed to put portions of the turkey back in the steamer to reheat. At 12:07 PM, dietary staff #2 was observed to prepare additional mashed potatoes for the lunch meal using hot water to which he added instant potato flakes until the mashed potatoes were a thick consistency with form. No seasonings were added. A sample test tray was requested on 12/5/12 at 12:20 PM for the lunch meal. The sample test tray was plated at 12:23 PM, placed on the cart with residents meal trays for service and arrived on the 400 hall at 12:25 PM. All residents were served their lunch meal by 12:45 PM and the test tray was set-up and sampled by the certified dietary manager (CDM) and surveyor using all of the condiments including cranberry sauce, salt, pepper and butter. The CDM stated during the observation that the mashed potatoes could use more seasoning and that the turkey was lukewarm. The turkey was noted to be cool to taste with the poultry gravy congealed, the mashed potatoes and the zucchini and stewed tomatoes were bland and the mashed potatoes	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 364	Continued From page 24 were thick, not creamy. The CDM further stated that more mashed potatoes were made towards the end of the tray line and she was not sure how the potatoes were seasoned. When she cooked she stated that she used seasonings like garlic salt, salt, or onion powder to season mashed potatoes. The CDM stated she did not notice what seasonings were used to prepare the vegetables and potatoes because sometimes staff used different seasonings. The CDM also revealed that some residents had requested, but were not provided a salt free herb seasoning to add to their foods, just salt, pepper and butter. Review of recipes revealed the following instructions: · Turkey, roast - rub turkey with softened margarine, season with salt and pepper. · Zucchini and tomatoes - recommended seasonings include chives, coriander, dill, garlic powder, ginger, marjoram, oregano, rosemary, tarragon, herb de provence, salt free herb seasonings. Add 2 ½ tablespoons seasoning of choice per 10 pounds. · Potatoes, mashed (flakes) - mix potato flakes and water together, add margarine and mix thoroughly. An interview on 12/5/12 at 1:00 PM with dietary staff #3 revealed that she cooked the turkey roast on 12/4/12, seasoned it with salt and pepper and the second shift staff placed the turkey in the walk-in to cool after it was cooked. Dietary staff #3 stated that when she came to work on 12/5/12, she sliced the turkey and placed it in a long deep pan and put it in the warmer to get hot. Before the tray line started she checked the temperature and all of the turkey was not hot	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 364	Continued From page 25 enough so some of it was placed back in the warmer. Dietary staff #3 stated she poured the zucchini and stewed tomatoes from a can, added a little salt, garlic powder, onion powder, and butter. She stated that when she prepares food for residents on a mechanical soft diet, she did not add salt. An interview on 12/5/12 at 1:04 PM with dietary staff #2 revealed he prepared more mashed potatoes towards the end of the lunch meal tray line by adding instant potato flakes to hot water. He confirmed that he did not follow a recipe when he cooked the mashed potatoes, nor did not use a recipe each time he cooked. A follow up interview with the CDM occurred on 12/5/12 at 1:15 PM. The CDM stated that some of her cooks prepared foods from memory and not from a recipe book. She stated that she did observe meal preparation at times, but that she was not able to see all foods prepared. The CDM also stated that the facility had a food committee comprised of about twenty residents. Review of the minutes revealed there were resident comments regarding cold foods. The CDM stated that whenever she received a complaint about cold foods, she encouraged residents to eat in the main dining room, checked the water on the steam table to ensure that it made contact with the bottom of the pans, and checked holding temperatures and the timeliness of the meals. She also explained to residents that the dietary staff took food temperatures before the food was served. The CDM stated she was not aware that mechanical soft foods were not being seasoned the same as other foods and stated that it should be seasoned the same.	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility records, the facility failed to 1) wear beard restraints during meal preparation and meal service for 2 of 2 staff with facial hair, 2) store clean dishes to air dry prior to use, 3) serve food under sanitary conditions, and 4) monitor the wash/rinse cycle temperatures for the dish machine prior to use. 1. a. On 12/3/12, dietary staff #1 was observed at 7:01 AM to set up the breakfast meal tray line and at 7:04 AM he began to serve breakfast from the tray line. During this observation dietary staff #1 was observed with a mustache, a goatee and sideburns. Dietary staff #1 did not wear a restraint for his facial hair. A second observation of the same occurred on 12/5/12 at 11:25 AM. During this observation dietary staff #1 cooked and plated French fries, plated cheese burgers and conducted temperature monitoring for three soups which were stored on the stove without a restraint for his facial hair. He stated he was not aware that he should wear a restraint for his facial	F 371	F371 • In-service training was conducted by Health Care Services Group District Manager for all dietary staff facial hair regulations, company policy and beard guards • Appropriate beard guards were ordered and all staff with facial hair will be required to wear guards at all times while in the kitchen. • Dietary Manager/Shift Supervisor will inspect every meal for the use of beard guards. • Dietary Manager will include observing beard guards in her weekly unit inspection checklist • Checklist will be completed weekly times three months. Ongoing reviews will be based on the first three months audit results. • The results from audits will be reviewed at the Quality Assurance meetings monthly.	12/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 27 hair. b. On 12/4/12, dietary staff #2 was observed at 4:50 PM to set up the dinner meal tray line and at 4:55 PM he began to serve dinner from the tray line. During this observation dietary staff #2 was observed with a mustache, a goatee and sideburns. Dietary staff #2 did not wear a restraint for his facial hair. A second observation of the same occurred on 12/5/12. During this observation, dietary staff #2 was observed at 12:07 PM to cook mixed vegetables and at 12:15 PM to cook mashed potatoes for the dinner meal tray line without a restraint for his facial hair. He stated in an interview on 12/5/12 at 1:04 PM that he realized that his facial hair needed to be trimmed and that he tried to keep his facial hair low. An interview with the certified dietary manager (CDM) on 12/5/12 at 2:10 PM revealed she did not instruct staff to wear a restraint for facial hair, but rather just to keep their facial hair trimmed short. 2. The facility policy "Sanitation & Infection Control, Storage of Pots, Dishes, Flatware, Utensils", undated, recorded in part, "Dish handlers, tray line area employees - air dry pots, dishes, flatware and utensils before storage, or store in a self draining position." On 12/4/12 at 4:45 PM the dinner meal tray line was observed. Plates were observed stacked in the lowerator (a heated cylinder storage unit). The lowerator was turned off. Bowls were observed stacked on the steam table. From 5:08 - 5:15 PM, Dietary staff #2 was observed to plate 10 dinner	F 371	F371 • All dietary staff was in serviced on the prevention of wet nesting and the proper drying and storing of pots, dishes, flatware and utensils. New drying and storage racks were also purchased. • Dietary Staff were also in-serviced on how to check the Dish Machine Temps and mandatory Dish machine temperature logs • Facilities contracted plumber was called out and dish washer temperature adjusted accordingly • Dietary Manager/Supervisor will utilize dining services daily opening checklist and dining services closing checklist to monitor daily for wet nesting. The checklist will include proper drying and storing of pots, dishes, flatware and utensils as well as dish washer temperatures. • Staff instructed that if any wet nesting is noted the dishware must be rewashed and dried properly. • Staff also instructed/educated that if dish machine is not working properly they are to immediately notify dietary manager/Supervisor. Dietary	12/10/12 12/22/12 12/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 28 meals using plates and bowls that were observed wet on the surface. An interview with the certified dietary manager (CDM) on 12/4/12 at 5:18 PM revealed staff were trained to remove plates from the dish machine, store them stacked in a heated lowerator, uncovered, so that the heat from the lowerator would dry the plates. The interview further revealed that after the lunch dishes were washed, plates were typically stored in the lowerator from 2:30 PM until the dinner tray line began at 5:00 PM. The CDM observed the lowerator turned off and was uncertain as to why it was not heated while wet plates were stored. On 12/5/12 at 11:48 AM, the lunch meal tray line was observed. Plates were observed wet and stored in the lowerator. Dietary staff #3 was observed at 11:53 AM to remove 3 wet plates from the lowerator which were used to plate lunch. The lowerator was turned on and heated. On 12/5/12 at 1:45 PM, the dish machine was observed in use. Dietary staff #4 was observed to remove clean bowls and plates from the dish machine, stacked them and stored them on a cart. The bowls and plates were not air dried and observed still wet when stacked and stored for use. On 12/5/12 at 2:05 PM an interview with dietary staff #4 revealed he was trained to remove bowls and plates from the dish machine, stack the bowls and plates and after a few minutes store the bowls on the steam table and the plates in a heated lowerator.	F 371	Manager will then notify Maintenance Director and Ecolab for immediate response. • Dietary Manager/Supervisor will then instruct all dietary staff to utilize disposables until dish machine is working correctly. • A log will be completed and sent to district manager any time dish machine is not at correct temperature and working properly • Dietary Manager will complete a weekly unit inspection which will include wet nesting and dish washer temps on weekly bases x 3 months. • All audit tools and Surveys will be reviewed and analyzed weekly by District Manager and Dietary Manager X3 months. Ongoing reviews will be based on outcome of the first 3 months audits and surveys • The findings/Outcome will be addressed at the QA committee meeting monthly.	12/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 29 During a follow-up interview on 12/5/12 at 2:10 PM with the CDM she stated that staff was trained to store plates/bowls stacked because of the limited space and lack of equipment to store them individually to air dry. On 12/5/12 at 3:15 PM, the consultant registered dietitian confirmed that dishes should air dry before use. She stated that the facility would need to order storage units in order to store dishes to allow them to air dry. 3) On 12/4/12 the dinner meal tray line was observed. Dietary staff #2 was observed at 5:21 PM to remove a wet plate from the lowerator and used it to plate a dinner meal which included barbecue. Dietary staff #2 was then observed to scrape the barbecue meat back into a pan on the steam table that contained more of the same meat. Dietary staff #2 confirmed that there were still other residents to serve. On 12/4/12 at 5:22 PM dietary staff #2 stated that he did not realize the plate was wet. He also stated that he returned the barbecue back to the pan on the tray line because he needed to plate chopped barbecue without barbecue sauce and because the meat had not been served. The CDM was observed to instruct dietary staff #2 that the meat should not be put back on the dinner line to serve since he put the meat on a plate that was not allowed to air dry. 4. Review of manufacturer recommendations recorded on the panel of the facility ' s dish machine recorded in part that the minimum wash/rinse cycle temperature for a low temperature machine should be 120 degrees	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 30 Fahrenheit. On 12/5/12 at 1:45 PM dietary staff #5 was observed using the low temperature dish machine to wash insulated dome lids. Insulated dome lids, glasses, plates and bowls were also observed stacked. Dietary staff #5 confirmed that these dishes had just been washed. Review of the temperature log on the wall revealed that the dish machine wash/rinse cycle temperatures had not yet been recorded. Dietary staff #5 stated that the wash/rinse cycle temperature should be 120 degrees Fahrenheit, but that she had not monitored the dish machine temperatures yet for the lunch dishes. Further observation revealed the temperature gauge on the dish machine read 100 degrees Fahrenheit (F) for both the wash/rinse cycle temperatures. The CDM was interviewed during the observation and stated that the last health inspection occurred on 10/10/12 with a recommendation from the sanitarian that the water in the dish machine be hotter. The CDM stated she thought this had been corrected. On 12/5/12 at 1:50 PM the maintenance director was observed to use an infrared thermometer and obtained the following dish machine water temperatures: 107.5 degrees F, 114.5 degrees F, and 118.5 degrees F. He stated that he was not aware of the sanitarian's recommendation with the last health inspection that the water for the dish machine be hotter. The maintenance director stated he should have been informed of that. An interview with the facility's dish machine technician on 12/5/12 at 3:10 PM revealed that he serviced the dish machine monthly and as needed. He was observed to identify a water	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 31 temperature of 114 degrees F and a final temperature of 120 degrees F after continued use. The technician stated that the water temperature for a low temperature dish machine was controlled by the facility because the unit did not contain a heating element. He further reviewed the manufacturer recommendations on the panel of the dish machine and confirmed that the manufacturer instructions recorded a minimum wash/rinse temp of 120 degrees and stated this recommendation should be followed.	F 371		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to provide a functioning call bell system for 2 of 2 public bathrooms available for resident use. The findings include: Resident #187 was admitted on 08/10/12 with diagnoses of diabetes and hypertension. An admission Minimum Data Set (MDS) dated 08/17/12 indicated Resident #187's cognition was intact. Review of a nurse's note dated 11/19/12 indicated the nurse was notified by the supervisor that Resident #187 was observed in the visitor's	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 463	Continued From page 32 bathroom on the floor yelling for help. The note further indicated Resident #187 was trying to get back into his wheelchair and his chair moved and he lost his balance. Resident #187 denied pain and refused x-ray. Review of a facility incident/ accident report dated 11/19/12 indicated Resident #187 was heard calling out from the visitor's restroom for help. Resident # 187 was observed on the floor; the Resident stated he fell trying to transfer back to the wheelchair and had not locked his wheels. Interventions included educating the resident to lock his wheelchair before attempting to get out of the wheelchair; encourage Resident to call for assistance for transfers; keep call bell within reach and the Resident was told not to use, if possible, the guest/visitors bathroom to ensure assistance and monitoring would be provided with toileting. On 12/04/12 at 1:00PM an observation was made of two unlocked bathrooms available for public use, both located across from the main dining room. Neither bathroom had a call bell system or an emergency alarm system available. An interview with the Director of Nursing (DON) on 12/05/12 at 2:58PM revealed she was aware residents used the visitor's bathroom and confirmed these bathrooms were left unlocked and did not have a call bell system. The DON added the bathrooms were not safe for resident use because they lacked a call bell system and were left unlocked. An interview was conducted with Nurse #3, who functioned in a supervisory role, on 12/05/12 at	F 463	F463 • The locks were changed on the Public Restrooms so that the doors would automatically lock when shut and that a key would be required for access to Public bathrooms. • Sign was placed on Public bathrooms to alert visitors that key would be available at reception desk. Residents no longer have access to these restrooms. • Facility is in the process of getting quotes for the installation of a new Emergency Call station with addressable dome lights for Public restrooms. • Until Installation doors will remain locked at all times and inaccessible to residents. • Maintenance Director will check doors to public restrooms to assure they are shutting and locking properly on Routine monthly Safety rounds x 3 months with ongoing audits based on first three months results. • Audits will be reviewed at the Quality Assurance meetings monthly.	12/6/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 463	Continued From page 33 4:30PM. Nurse #3 revealed on 11/19/12 Resident #187 was heard calling for help by residents from the visitor's bathroom. Nurse #3 added she had observed alert residents using the visitor ' s bathroom and felt it should be equipped with a call bell system to notify staff if residents, staff or guest had fallen or had any incident. Interview with the Administrator on 12/05/12 at 5:11PM revealed she was aware residents utilized the visitors' bathroom and confirmed the bathrooms were left unlocked and did not have a call bell system because they were bathrooms intended for visitor and staff use. An interview was conducted with Resident # 187 on 12/06/12 at 9:47 AM. Resident # 187 explained that he frequently used the bathroom across from the dining room (visitor's bathroom). He explained that one day he had used the bathroom and forgotten to lock his wheelchair and fell to the floor, he stated he was yelling for help until a resident recognized his voice and called a nurse to assist him. Resident #187 added he was not hurt and has continued since then to use the visitor's bathroom especially at lunch and dinner times.	F 463		