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 12/09/2021

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 000	INITIAL COMMENTS A complaint survey was conducted from 12/07/21 through 12/09/21. Event ID# S15W11. 3 of the 13 complaint allegations were substantiated resulting in deficiencies. Past-noncompliance was identified at: CFR 483.25 at tag F 689 at a scope and severity G.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Consultant Pharmacist interview the facility failed to prevent misappropriation of a resident's narcotic medication for 1 of 1 resident reviewed for misappropriation of resident property (Resident #3). The findings included: Resident #3 was admitted to the facility on 05/07/20 and most recently readmitted to the facility on 06/28/21. His diagnoses included: acute pain due to trauma, pain in left foot, chronic pain syndrome and others.	F 602	The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 discharged from the facility on 7/12/2021 and has not returned to the	1/12/22

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

Electronically Signed | 01/07/2022

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 12/09/2021

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 602	Continued From page 1 Review of a physician order dated 06/24/21 read, hydrocodone (narcotic pain medication) 5/325 milligrams (mg) by mouth every 6 hours as needed for pain. The order was discontinued on 07/08/21. Review of a physician order dated 6/28/21 read, Tylenol #3 (narcotic pain medication) 300/30 mg by mouth 4 times a day as needed for pain. Review of the Medication Administration Record (MAR) dated 07/01/21 through 07/31/21 revealed that Resident #3 had received the hydrocodone on 07/01/21, 07/05/21, and 07/07/21 and then the medication had been discontinued. Review of the MAR dated 07/01/21 through 07/31/21 revealed that Resident #3 had received the Tylenol #3 on 07/01/21 and 07/11/21. Resident #3 was discharged from the facility on 07/12/21. Review of a Controlled Substance Tracking log dated 07/20/21 and provided by the facility indicated that Resident #3 was supposed to have 12 hydrocodone 5/325 mg and 20 Tylenol #3 on the 700-hall medication cart. Review of an Initial Allegation Report dated 07/21/21 read in part that there had been a suspected controlled narcotic diversion of Resident #3's narcotic pain medication. No accused individuals were noted on the form. Local law enforcement had been notified and the form was signed by the Director of Nursing. Review of handwritten statement from Nurse #1 dated 07/21/21 read in part, on 07/20/21 at	F 602	facility. Resident #3 did not suffer any adverse effects from the alleged deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 1/6/2022, the Administrative Nurse, Staff Development Coordinator (SDC); Assistant Director of Nursing (ADON) and Director of Nursing (DON), reviewed each medication cart to ensure that change of shift controlled substance counts were completed and there were no additional identified narcotic diversions. All medication carts were reviewed with no additional issues identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 1/6/2022, the SDC began educating all licensed nurses and medication aides on the responsibility to count and accept responsibility for all narcotic medications on the medication cart during and between shifts. Any licensed nurse or medication aide that was not educated on 1/6/2022 will be educated prior to their next scheduled shift. The SDC is responsible for tracking completion of the education. The Administrator informed the SDC of this responsibility on 1/6/2022. All licensed nurses and medication aides newly hired are instructed on this process during their orientation.	

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 12/09/2021

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 602	Continued From page 2 approximately 8:30 PM I received a call from the Director of Nursing (DON) and asked if I had any of Resident #3's narcotics and stated that they could not be found on the medication cart. The DON asked me if the narcotic count was correct on 07/19/21 when I reported for duty at 3:00 PM and I told the DON that I was late coming to work that day and when I arrived at work was told that the medication cart had been counted by 2 nurses, so I took the keys and went down the hall to start my shift. "I said to myself let me write down the narcotics that are on this cart since I did not count with anyone" and I wrote them down along with amount of each medication. I worked from 3:00 PM on 07/19/21 to 7:00 AM on 07/20/21. At the 7:00 AM change of shift on 07/20/21 myself and Nurse #2 counted the narcotics, and everything was correct at that time. Attached is the narcotics that was on the medication cart on 07/19/21 3:00 PM to 11:00 PM shift. The handwritten statement was signed by Nurse #1. Review of another handwritten document provide by Nurse #1 read in part, on 07/19/21 I was handed the keys to the medication cart. No one counted the narcotics with me. I was late coming in around 4:00 PM. The list contained residents located on the 700 hall with a number next to each name. No medication name was included on the list and Resident #3's name did not appear on this list. An interview was conducted with Nurse #2 on 12/07/21 at 1:57 PM. Nurse #2 confirmed that she was working on 07/19/21 from 7:00 Am to 3:00 PM on the 700 hall and at 3:00 PM Nurse #1 was scheduled to be at work but had called and stated she would be late. Nurse #2 stated that	F 602	To ensure that this alleged noncompliance will not recur, each business day, the ADON or designee will review controlled substance tracking in the electronic medical record to ensure that change of shift procedures was completed and there is no evidence of narcotic diversion based on the narcotic count. The Administrator notified the ADON of this responsibility on 1/6/2022. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 1/6/2022 an audit tool was developed by the Quality Assurance and Performance Improvement Committee consisting of the Administrator, DON, ADON, SDC and Regional Nurse. The DON will use the audit tool to monitor whether change of shift controlled substance counts were completed and if there were any discrepancies and/or narcotic diversions identified. Monitoring will occur two times a week for 4 weeks; then one weekly for 4 weeks; then one time monthly x 1 month. The DON will report the results of the audit to the Quality Assurance and Performance Committee for tracking and trending monthly x 3 months. Include dates when corrective action will be completed. The date when the corrective action will be completed is, January 12, 2022.	

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 12/09/2021

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 602	Continued From page 3	F 602		

Nurse #3 counted the 700-hall medication cart with her. Nurse #2 confirmed that on 07/19/21 at 3:00 PM Resident #3's narcotic pain medication was in the narcotic drawer and the medication count was correct between herself and Nurse #3. Nurse #2 stated after she counted and reported off, she left the facility and retuned on 07/20/21 at 7:00 AM for her shift. She stated Nurse #1 had worked third shift and they began to count the 700-hall medication cart. Nurse #2 explained that the narcotic count was conducted by using the computer system and verifying the medication in the drawer. She further explained that the off going nurse would be at the computer screen and the oncoming nurse would be in the drawer verifying the number of each narcotic medication for each resident. The number of pills was entered into the computer until all the medications had been counted and then each nurse would electronically sign that the count had been complete. Nurse #2 stated the computer system would tell you if there were any discrepancies or not. She added that during this count on 07/20/21 at 7:00 AM Nurse #1 (off going nurse) was at the computer system and was calling out names and she (Nurse #2) was at the drawer calling out the amount and then Nurse #1 would enter the number into the system. Nurse #2 stated that Nurse #1 did not call out Resident #3's name and there were no medications for him in the drawer. Nurse #2 stated she did not question this at the time because she assumed that the DON had removed them from the drawer since Resident #3 had been discharged from the facility. Nurse #2 stated that she proceeded to work her shift and at 3:00 PM on 07/20/21 Nurse #3 reported to work, and they began to count the narcotics on the 700-hall medication cart. This time Nurse #2 (off going nurse) was at the computer calling out 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 12/09/2021

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 602	Continued From page 4	F 602		

names and Nurse #3 (on coming nurse) was at the drawer verifying the number of medications. Nurse #2 stated that Resident #3's name appeared on the screen and Nurse #3 stated that he had no medication in the drawer. Nurse #2 recalled that at 7:00 AM Nurse #1 did not call out Resident #3's name and she again confirmed that he had no medication in the drawer at that time. Nurse #2 stated that she and Nurse #3 searched the medication cart and room and when they could not locate the missing narcotics, they notified the DON. She added that according to the computer system Resident #3 was supposed to have 12 hydrocodone 5/325 mg and 20 Tylenol #3 in the narcotic drawer and neither could be located.

The DON was interviewed on 12/07/21 at 4:44 PM. The DON stated that 2 nurses were counting the 700-hall medication cart on 07/20/21 and they noted some missing narcotics and reported that to me. The DON stated he went to the cart and searched the medication cart and medication room, but the medication could not be located. He explained that Resident #3 had 2 narcotic medications hydrocodone and Tylenol #3 that were listed on the tracking log, but the physical medications could not be located. He explained that when he could not locate the medication, he began his investigation and began obtaining statements from the involved staff members. The DON stated that on 07/19/21 Nurse #1 was going to be late for work and when she arrived at work, she failed to count the medication cart with another nurse and assumed responsibility of the medication without verifying that the count was accurate. He stated that the expected 2 nurses to count the medication cart at the change of every shift and anytime there was a transfer of

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 12/09/2021

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 602	Continued From page 5	F 602		

responsibility. He added that each nurse was expected to verify the name on the computer screen and each nurse was to verify the amount of medication that was in the cart and both nurses were expected to verify that the correct number of medications was entered into the computer during the medication reconciliation. The DON stated he would go around to the medication carts and collect the medication that needed to be returned to the pharmacy and if one of the nurses reported that something needed to be returned, he would go and return the medication.

An attempt to speak to Nurse #1 was made on 12/08/21 at 8:57 AM without success.

Nurse #3 was interviewed on 12/08/21 at 8:58 AM. Nurse #3 confirmed that she was working on 07/19/21 3:00 PM to 11:00 PM but not on the 700 hall. She stated that Nurse #1 was scheduled to work the 700-hall medication cart but was going to be late, so she and Nurse #2 counted the 700-hall medication cart. Nurse #3 confirmed that on 07/19/21 at 3:00 PM when she counted the 700-hall cart with Nurse #2 Resident #3 narcotic medications were accounted for on the cart. Nurse #3 stated that when Nurse #1 arrived at work on 07/19/21 at around 4:00 PM she offered to count the cart with her, but Nurse #1 declined and stated she wanted to get started with her shift. Nurse #3 stated she handed her the keys and went down her hall to begin her shift. Nurse #3 stated she did not question Nurse #1 when she did not want to count because Nurse #1 was a supervisor, and she was a new nurse and did not feel like she should question her superior. On 07/20/21 at 3:00 PM Nurse #3 stated she returned to the facility to work and was scheduled to work the 700 hall and proceed to count with

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 12/09/2021

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 602	Continued From page 6	F 602		

Nurse #2. Nurse #3 explained that Nurse #2 (off going nurse) was at the computer screen and she (on coming nurse) was at the drawer and Nurse #2 was calling out the resident name and then I would call out how many pills they had, and Nurse #2 would enter them in the system. Nurse #2 called out Resident #3's name and I stated that there was no medication for Resident #3 in the narcotic drawer. Nurse #2 then stated to Nurse #3 that at the 7:00 AM count Nurse #1 had not called out Resident #3's name. Nurse #3 stated that they both searched the medication cart and room and none of the missing narcotics could be found so they immediately went and reported to the DON. Nurse #3 stated that the facility's procedure for removing narcotic that had been discontinued or the resident had discharged to the hospital was to let the DON know that the medication needed to be removed from the medication cart and he would come to the cart and remove it and fill out the appropriate paperwork and return the medication to the pharmacy. Nurse #3 stated that she and Nurse #2 had discussed on 07/19/21 that Resident #3 had been gone for almost a week and they probably needed to let the DON know that the medications needed to be returned to the pharmacy. She added she did not know why they did not notify the DON of the medications but stated they did discuss it.

The Consultant Pharmacist (CP) was interviewed via phone on 12/08/21 at 9:21 AM. The CP stated that he visited the facility monthly and while he was in the facility, he conducted medication pass observations. He explained that he was not generally in the building at change of shift so he would not observe the narcotic counting that occurred during shift change. The CP stated that

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 12/09/2021

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 602	Continued From page 7 it was policy that the narcotic medications be kept under double lock and always secured and should be counted or accounted for by 2 licensed nurses. He added that when the narcotic medication would be counted would be up to the facility that was not included in their policy. An attempt to speak to the local law enforcement officer who responded on 07/21/21 was made on 12/08/21 at 11:02 AM without success. The Administrator and DON were interviewed on 12/08/21 at 2:53 PM. When the DON was asked why he had not removed the narcotic medication for Resident #3 for a week the Administrator stated that at the time they had a vacancy in Assistant Directive of Nursing role, and it was workload issue and the DON just did not have the time to remove the medications. The DON stated when he was notified of the missing narcotic, he immediately began his investigation which included obtaining statements from involved staff, notifying the appropriate agencies, and searching for and trying to locate the missing narcotic. He added that he educated the 3 involved nurses on the expectation of how to count and when to count the narcotics and since this incident they have no issues with any further diversions of narcotic medications.	F 602		
F 684 SS=E	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	F 684		1/12/22

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 12/09/2021

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 684	Continued From page 8 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 observations, interviews with a resident, family, nurse practitioner (NP) and staff and record review, the facility failed to provide daily wound care per physician order to a resident with a diagnosis of peripheral vascular disease (PVD). Resident #6 did not receive wound care for 10 days to 2 wounds, an unstageable necrotic wound of the right lateral ankle and an unstageable necrotic wound to the right lateral heel. This occurred for 1 of 2 sampled residents reviewed for wound care (Resident #6). The findings included: Resident #6 was admitted to the facility on 10/04/21. Diagnoses included, diabetes mellitus type 2, osteomyelitis, cerebral infarction with right sided weakness, mild to moderate PVD of right lower extremity (RLE), moderate PVD of left lower extremity (LLE), acute embolism and thrombosis of deep veins of left upper extremity (LUE), localized edema, and vitamin D deficiency, among others. An admission Minimum Data Set assessment dated 10/11/21, assessed Resident #6 with impaired cognition, clear speech, able to be understood and to understand others, at risk for changes in skin integrity, and no venous/arterial ulcers on admission. A wound nurse (WN) progress note dated 11/10/21 documented Resident #6 was noted with a wound to his right lateral ankle measuring 2	F 684	The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #6 continues to reside at facility with no adverse effects. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 12/8/2021 the Director of Nursing (DON) reviewed current residents in the facility with physician orders for wound care to ensure that wound care was provided as ordered. All wound care was completed as ordered. No other residents were adversely affected by the alleged deficient practice. On 12/8/2021 the Wound Care Nurse (WCN) stocked each medication room and a supplemental treatment cart so that wound care supplies would be always available to nursing staff. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/8/2021, the Staff Development	

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 12/09/2021

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 684	Continued From page 9 centimeters (cm) by 2.5 cm and a wound to his right lateral heel measuring 2 cm by 3 cm. The WN documented that both wounds would be treated with betadine-soaked gauze and wrapped with kerlix daily with a referral to the wound doctor (WD) for weekly assessments of these wounds. Review of a care plan, revised 11/11/21, documented Resident #6 had wounds to his right lateral ankle and right lateral heel and that he was at risk for further breakdown due to decrease mobility. Approaches included to treat wounds to the right lateral ankle and right lateral heel per physician orders. A Wound Evaluation and Management Summary (WEMS) by the WD dated 11/16/21 documented Resident #6 had an unstageable necrotic (dead tissue) wound to the right lateral ankle that measured 2 cm by 2 cm by 0.1 cm and an unstageable necrotic wound to the right lateral heel that measured 1.5 cm by 3 cm. The depth was not measurable. The wounds were debrided to remove the necrotic tissue. The WD ordered Leptospermum honey with a gauze island border dressing applied once daily for 30 days. An arterial leg study, dated 11/20/21, for Resident #6 of his bilateral legs assessed Resident #6 with mild to moderate PVD of RLE, moderate PVD of LLE, and acute embolism and thrombosis of deep veins of LUE. The WD documented weekly assessments of the unstageable necrotic wound to the right lateral ankle and right lateral heel on 11/23/21, 11/30/21 and 12/7/21 and noted wound progress as improved with each assessment. The 11/23/21 WEMS documented the results of the 11/20/21	F 684	Coordinator (SDC) and WCN educated all licensed nurses on their responsibility to complete wound care according to physician orders as well as where to locate wound care supplies. Any licensed nurse that was not educated on 12/8/2021 were educated prior to their next scheduled shift. Newly hired licensed nurses will be educated during clinical orientation. The SDC is responsible for tracking completion of the education. The Administrator informed the SDC of this responsibility on 1/7/2022. To ensure that this alleged noncompliance will not recur, the wound care nurse (WCN); nursing supervisor; or designee will review physician orders for wound care and confirm that all wound care has been completed as ordered daily. The Administrator notified the WCN and nursing supervisors of this responsibility on 1/7/2022. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 1/7/2022 an audit tool was developed by the Quality Assurance and Performance Improvement Committee consisting of the Administrator, DON, SDC and Regional Nurse. The DON will use the audit tool to monitor whether wound care has been completed in accordance with physician orders. Monitoring three times a week for 4 weeks; then two times a week for 4 weeks; then one time a week for 4 weeks.	

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 12/09/2021

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 684	Continued From page 10 arterial study completed for Resident #6. The wounds were assessed on 12/7/21 by the WD and measured, right lateral heel, 0.8 cm by 1.1 cm by 0.1 cm and right lateral ankle, 2.1 cm by 2.3 cm, by 0.6 cm. Review of the November 2021 Medication Administration Record (MAR) for Resident #6 revealed there was no documentation of wound care on Saturday/Sunday, 11/12/21, 11/13/21, 11/20/21, 11/21/21, 11/25/21, 11/26/21, and 11/28/21. Review of the December 2021 MAR, for Resident #6 revealed there was no documentation of wound care on 12/5/21 and 12/6/21. The December 2021 MAR documented wound care for Resident #6 on 12/4/21. Resident #6 was observed on 12/7/21 at 12:20 PM in bed with a dressing to his right foot dated, 12/7/21. A family member was present and stated that when she arrived that day, Resident #6 had a dressing to his right foot that was dated 12/3/21, but that the dressing had been changed earlier that day by the WN and WD. Resident #6 stated in interview that the dressing to his right foot was last changed on Friday, 12/3/21. Resident #6 further stated that he usually received daily wound care, but that sometimes he did not receive wound care on the weekends. An interview with the WN occurred on 12/7/21 at 12:28 PM. The WN stated in interview that she provided wound care to residents Monday through Friday and that the charge nurse was responsible for providing wound care when the WN was off. The WN stated that she and the WD provided wound care that morning to Resident #6	F 684	The DON will report the results of the audit to the Quality Assurance and Performance Committee for tracking and trending monthly x 3 months. Include dates when corrective action will be completed. The date when the corrective action will be completed is, January 12, 2022.	

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 12/09/2021

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 684	Continued From page 11	F 684		

and during the care, she removed a dressing dated 12/3/21 from the right foot of Resident #6. The WN stated it was the same dressing she applied on Friday, 12/3/21 when she provided wound care and she was off over the weekend and Monday, and returned to work that day, Tuesday, 12/7/21. The WN stated she could not explain why Resident #6 did not receive wound care on Saturday, 12/4/21, Sunday, 12/5/21 or Monday, 12/6/21. The WN stated wound care should be provided by the charge nurse when the WN was off and that supplies were available, one cart was kept in the medication room on one unit and another cart was kept outside the door to the WN office. The WN stated that she stocked both carts with supplies and that the nursing assignment sheet documented when the WN was off. The WN further stated that Resident #6 had 2 wounds to his right foot and that both wounds were improving as evidenced by smaller measurements. The WN also stated that the WD ordered daily treatments to these wounds.

A phone interview with Nurse #5 occurred on 12/8/21 at 4:37 PM. During the interview, Nurse #5 stated that she was the nurse assigned to care for Resident #6 on Saturday/Sunday, 12/4/21 and 12/5/21, 3 PM to 11 PM shift. Nurse #5 stated that she documented the MAR in error that she provided wound care on 12/4/21 to Resident #6. Nurse #5 stated that she did not provide wound care to Resident #6 that weekend because she did not receive report from Nurse #8, the previous nurse, that wound care had not been provided. Nurse #5 stated that she only worked with Resident #6 on the 3 PM to 11 PM shift on weekends and only provided wound care to him if the nurse told her that wound care was not provided on the previous shift or the dressing

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 12/09/2021

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 684	Continued From page 12	F 684		

became soiled or was no longer intact. Nurse #5 stated that if wound care was not documented on the MAR on other weekends, that was the reason why the care was not provided.

An interview with Nurse #6 occurred on 12/7/21 at 4:15 PM. Nurse #6 stated in interview that she was the assigned nurse for Resident #6 on Monday 12/6/21 on the 3 PM to 11 PM shift. Nurse #6 stated that she was not able to provide wound care to Resident #6 that day because she was responsible for 23 residents and she would not know that wound care was needed unless the previous nurse told her or if she was notified that the WN was off. Nurse #6 further stated that wound care was usually provided by the WN or the 7 AM to 3 PM charge nurse and if the charge nurse did not advise that wound care was not provided, the oncoming nurse would not know to provide the care because the nurses were not always notified when the WN was off.

A phone interview with Nurse #7 occurred on 12/8/21 at 4:59 PM. Nurse #7 stated in interview that she was the assigned nurse for Resident #6 on the 7 AM to 3 PM shift on Saturday/Sunday, 12/4/21 and 12/5/21, but that she did not get a chance to provide wound care to Resident #6 on her shift. Nurse #7 stated that she let the oncoming nurse know. Nurse #7 stated that since she did not document wound care on the MAR, that would also have let the oncoming charge nurse know to provide the wound care. Nurse #7 further stated, "Sometimes we just run out of time."

A phone interview with Nurse #8 on 12/8/21 at 5:03 PM revealed that she was not the assigned nurse for Resident #6 often and that she was

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 12/09/2021

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 684	Continued From page 13	F 684		

occasionally assigned as the nurse for Resident #6 on Sundays. Nurse #8 stated that when she worked on Sundays, she could not always provide wound care because she did not always have the wound care supplies or the wound care supplies were locked in the wound care cart. Nurse #8 stated that the Director of Nursing (DON) was aware of the concern with available wound care supplies and that the wound care supply cart was often scarcely supplied. Nurse #8 stated that she advised the oncoming charge nurse, Nurse #5, that she did not provide wound care to Resident #6 on Sunday, 12/6/21 because she did not have the supplies to provide the care.

An interview occurred with the Nurse Practitioner (NP) on 12/7/21 at 1:04 PM. During the interview, the NP stated that Resident #6's diagnosis of moderate PVD and moderate stenosis in the arteries in his bilateral LE were definitely contributing factors to the development of these wounds. The NP stated that wound care was ordered by the WD as daily treatments for a reason and that the order for daily dressing changes to these wounds should be followed. The NP also stated that if access to supplies was an issue, supplies could be ordered that were more readily available, but whatever was causing the challenge with meeting the order should be addressed and that the WD order for wound care should be followed.

A phone interview occurred with the WD on 12/7/21 at 1:17 PM. During the interview, the WD stated that it was possible that he had been made aware of a resident that was not receiving dressing changes over the weekends, but that he was not sure if it was Resident #6 that he was notified about. The WD stated that he ordered

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 12/09/2021

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 684	Continued From page 14	F 684		

daily dressing changes to the wounds on Resident #6's right foot to control infection because of the diagnosis of PVD and decreased blood flow. The WD stated that the wounds to the right foot of Resident #6 were initially assessed by the WD on 11/16/21 with an etiology of pressure, but after the results of the arterial study returned on 11/20/21, the WD updated his notes on the 11/23/21 assessment with the results of the arterial study. The WD stated that he was now certain that the etiology of these wounds was arterial. The WD further stated that the greatest problem with severe vascular disease was that it did not take much pressure to develop wounds under these conditions. The WD stated he expected Resident #6 to receive wound care daily as ordered, but that for this Resident, surprisingly the arterial wounds to his right foot were improving as the measurements were currently smaller and the wounds were without signs of infection.

An interview with the DON occurred on 12/7/21 at 3:24 PM. The DON stated that when the WN was off, he expected the charge nurse to provide the wound care. The DON stated that if the charge nurse on the 7 AM - 7 PM shift did not provide the wound care, the charge nurse should report to the oncoming charge nurse so that the wound care could be provided on the next shift. The DON stated that he had been made aware that some residents were not receiving wound care on the days the WN was off, but he could not recall when this was identified. The DON stated that when this was brought to his attention, the nurses identified as not providing wound care received verbal re-education and that he had not continued to see this as a problem.

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 12/09/2021

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 689	Continued From page 15	F 689		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with a resident and staff and record review, the facility failed to transfer a resident to bed without injury. Resident #2 was transferred to bed and after complaints of pain, Resident #2 was assessed with an acute fracture of the distal fibula (ankle). Resident #2 was referred to an orthopedist and received an order for an orthotic boot. This affected 1 of 2 sampled residents reviewed for supervision to prevent accidents (Resident #2). The findings included: Resident #2 was re-admitted to the facility on 2/26/16. Diagnoses included, in part, vascular dementia, peripheral neuropathy, and chronic pain syndrome, among others. The care plan for Resident #2, revised 9/28/21 documented she required staff assistance for transfers using a mechanical lift. A quarterly Minimum Data Set, dated 10/13/21, assessed Resident #2 with clear speech, able to understand and be understood, intact cognition, she did not ambulate, required extensive staff	F 689	Past noncompliance: no plan of correction required.	1/5/22

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 12/09/2021

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 689	Continued From page 16	F 689		

assistance with bed mobility and ambulation on the unit and total staff assistance for transfers and ambulation off the unit.

Review of the facility's investigative report revealed a written statement dated 10/17/21 which documented that at 3:20 PM, Resident #2 was observed by Nurse Aide (NA) #1 in her room, seated in her wheelchair. Moments later NA #1 heard Resident #2 calling out and stating, "my leg, my leg." NA #1 entered the Resident's room and observed Resident #2 lying in bed saying, "my leg, my leg." When questioned who put her to bed and what happened to her leg, Resident #2 stated "That girl put me to bed and did not use my machine and my leg hurts." Resident #2 was unable to give the name or any details about who put her to bed. Resident #2 was assessed by Nurse #4 and noted her left leg was bruised and swollen and she complained of pain. The physician was notified, an x-ray was ordered, and results dated 10/18/21 revealed an acute fracture of the left distal fibula. Resident #2 was referred to an orthopedist and her left leg was placed in an orthotic boot.

Review of a progress note dated 10/17/21 and a written statement dated 10/21/21 by Nurse #4 revealed NA #1 reported to her that Resident #2 complained that her leg hurt and that someone transferred her without using a mechanical lift. Nurse #4 assessed Resident #2 with complaints of pain to her left shin, swelling and discoloration to her left lower leg. Resident #2 was medicated for pain, the Nurse Practitioner (NP) was notified, and an x-ray was ordered. Resident #2 stated to Nurse #4 that someone transferred her without using a mechanical lift and hurt her leg. Attempts to interview Nurse #4 were unsuccessful.

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 12/09/2021

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 689	Continued From page 17	F 689		

Review of x-ray results dated 10/18/21 documented Resident #3's left ankle was assessed with an acute fracture of the distal fibula.

An orthopedist consult dated 10/19/21 documented Resident #2's left leg was placed in an orthotic boot because of a non-displaced fibula fracture.

The facility completed a Brief Interview for Mental Status (BIMS) assessment dated 10/20/21, which assessed Resident #2 with severely impaired cognition.

Resident #2 was observed on 12/07/21 at 1:30 PM in her room seated in her wheelchair. Her left leg was observed in an orthotic boot. A lift pad for a mechanical lift was observed underneath Resident #2 in her wheelchair. When asked what happened to her leg, Resident #2 stated that she was getting help from staff to go to the bathroom and the staff told her to hold onto her neck. Resident #2 further stated that while the staff was transferring her to her wheelchair, "She threw me onto my bed and ever since then my leg started hurting. I told her to use the machine, but she told me to hold onto her neck." Resident #2 stated she had not seen the staff member before or since this incident occurred. When asked to give the staff member's name or to describe the staff, Resident #2 stated "I can't, it all happened so fast."

An interview occurred on 12/07/21 at 4:25 PM with NA #1. During the interview, NA #1 stated that she was assigned to care for Resident #2 on Saturday, 10/16/21 and Sunday, 10/17/21, 3:00

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 12/09/2021

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 689	Continued From page 18	F 689		

PM to 11:00 PM shift. NA #1 stated that she came on shift on 10/17/21 and during her rounds she observed Resident #2 in her room in her wheelchair beside her bed. NA #1 stated she then provided care to two residents and while coming back up the hall, she heard Resident #2 calling out "my leg", she went to her room and Resident #2 was in the bed. NA #1 stated that Resident #2 could not put herself in the bed, so she asked her how she got in the bed and Resident #2 said "That girl put me to bed and did not use my machine and my leg hurts." NA #1 asked Resident #2 to describe the person who put her to bed, and she could not give a name or description. NA #1 stated that she was unaware of how Resident #2 hurt her leg, but she reported the incident and complaints of leg pain to Nurse #4.

A phone interview occurred on 12/08/21 at 11:59 PM with NA #2. During the interview, NA #2 stated that she was the assigned NA for Resident #2 on the 7AM - 3PM shift on 10/16/21 and 10/17/21 and that she was assigned to care for Resident #2 regularly. NA #2 stated that she transferred Resident #2 both days, 10/16/21 and 10/17/21 from her bed to her wheelchair with staff assistance from NA #3 and used a mechanical device for the transfer. NA #2 further stated that Resident #2 did not have complaints of pain during the transfers, and she was not aware of any concerns. NA #2 stated that Resident #2 could not transfer alone and required staff assistance with transfers.

A phone interview occurred on 12/09/21 at 12:20 PM with NA #3. During the interview, NA #3 stated that he regularly worked the 3 PM to 11 PM, but that on 10/17/21, he worked 7AM -

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 12/09/2021

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 689	Continued From page 19	F 689		

11PM. NA #3 stated that he did not work with Resident #2 that day and did not assist with transferring her. NA #3 further stated that he was familiar with Resident #2 and had assisted staff to transfer Resident #2 with a mechanical lift in the past, but that he did not assist with her transfers on 10/17/21. NA #3 also stated that the mechanical lift staff used to transfer Resident #2, belonged to Resident #2, remained in her closet and that Resident #2 would remind staff to use the mechanical lift when she was transferred.

A phone interview with NA #4 occurred on 12/09/21 at 12:30 PM. During the interview, NA #4 stated that he worked on 10/17/21 on the 3 PM to 11 PM shift and that he spoke to Resident #2 on 10/17/21 after 3:00 PM and observed her in bed. NA #4 stated that he asked Resident #2 why she was in bed because she was typically up in her wheelchair at that time, and she complained that her leg hurt. NA #4 stated he asked Resident #2 what happened to her leg and she stated that the night before, 2 ladies came into her room and transferred her from her wheelchair to the bed without using the lift. NA #4 stated he asked her to name the staff, but Resident #2 stated she could not recall who they were. NA #4 stated he reported this to Nurse #4 who stated she was already aware of the incident and was taking care of it.

An interview with NA #5 occurred on 12/08/21 at 12:25 PM and revealed she did not work with Resident #2 on 10/17/21, but that she assisted Resident #2 with transfers in the past using a mechanical lift because Resident #2 could not transfer alone.

An interview occurred on 12/08/21 at 12:40 PM

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 12/09/2021

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 689	Continued From page 20	F 689		

with NA #6, the interview revealed she did not provide care to Resident #2 on 10/17/21, but that when she was assigned to care for Resident #2 in the past, the Resident required 2 people to transfer her using a mechanical lift.

An interview occurred on 12/09/21 at 12:15 PM with NA #7, the interview revealed that she had not been assigned to care for Resident #2, but that whenever she transferred a resident, she always did so with another staff member to assist.

During an interview on 12/07/21 at 10:15 AM with the Administrator and Director of Nursing (DON) revealed that the facility completed an Initial Allegation Report for Resident #2 due to a fracture she sustained. Resident #2 alleged that she was transferred without a mechanical lift and that her leg was hurt during the transfer. The DON stated that NA #1 was assigned to care for Resident #2 on Sunday, 10/17/21, on the 3:00 PM to 11:00 PM shift. The DON further reported that sometime around 3:30 PM that day, NA #1 reported to Nurse #4 that Resident #2 was complaining of pain to her left leg and reported to NA #1 "That girl put me to bed and did not use my machine and my leg hurts." The DON stated he interviewed NA #1 on 10/17/21 and she stated that she walked by the room of Resident #2 that day around 3:20 PM and observed Resident #2 in her room, seated in her wheelchair. NA #1 then stated that moments later she heard Resident #2 calling out and stating, "My leg, my leg." And observed Resident #2 lying in bed saying, "My leg, my leg." NA #1 stated she asked Resident #2 who put her to bed and what happened to her leg? Resident #2 stated "That girl put me to bed and did not use my machine and my leg hurts." The DON stated he also asked Resident #2 what

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 12/09/2021

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 689	Continued From page 21	F 689		

happened, and her report was the same, but that she could not provide further details about the person who put her to bed. The Administrator stated that he also interviewed Resident #2 and she reported to him a description of the person who transferred her to bed on 10/17/21 and hurt her leg, but the description Resident #2 provided did not match a description of the staff assigned to care for her on the 7 AM - 3 PM or 3 PM to 11 PM shifts on 10/17/21. The DON further stated that the investigation resulted in substantiating the allegation of abuse but that the investigation did not identify a specific staff member responsible nor the specific details regarding how the fracture occurred.

The facility provided a plan of correction with a correction date of 10/27/21. The facility's plan of correction included the following information:

1. On 10/17/21, the facility conducted an initial investigation of resident abuse/neglect.
2. On 10/17/21, the facility assessed and interviewed Resident #2. Resident #2 was assessed by Nurse #4 with pain, swelling and discoloration to her left leg. Resident #2 was medicated by Nurse #4 for complaints of pain. The NP was notified and ordered an Xray. Resident #2 was referred to an orthopedist.
3. On 10/17/21, the facility began interviews with all staff who worked 10/15/21 - 10/17/21, as a result from a report from Resident #2 that her leg hurt from being transferred without a mechanical lift.
4. On 10/18/21, Xray results for Resident #2 were received. Resident #2 was diagnosed with an acute fracture of the distal fibula. Resident #2 was referred to an orthopedist and received an order for an orthotic boot.

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 12/09/2021

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 689	Continued From page 22	F 689		

5. On 10/18/21, the facility submitted an initial investigation to the HCPI.
6. On 10/18/21, the facility reviewed medical records to identify residents who required transfers with mechanical lifts, reassessed all residents who required staff assistance with transfers for type of transfers required, updated care plans regarding transfers, interviewed alert and oriented residents regarding abuse and conducted 100% skin audits on residents who could not be interviewed.
7. On 10/19/21 NA #1 was suspended pending the outcome of the investigation.
8. On 10/19/21, Resident #2 was seen by an orthopedist and returned to the facility with an orthotic boot to her left leg.
9. On 10/21/21 the facility submitted an Investigative Report to HCPI which substantiated resident abuse for Resident #2. The facility's investigation was unable to identify specific staff or the specific cause of the fracture.
10. On 10/22/21 the facility provided re-education on transfers with mechanical lifts and abuse/neglect.
11. On 10/22/21, the facility began twice weekly rounds to monitor for implementation of staff re-education on transfers and preventing abuse/neglect.
12. On 10/27/21, the facility's QAPI met to review monitoring and revise the QAPI plan.

The facility alleged correction on 10/27/21.

On 12/07/21 to 12/09/21, the facility's corrective action plan with correction date of 10/27/21 was validated. To validate the corrective action plan, the following was reviewed: staff in-services, skin assessment, resident interviews, audit tools and monitoring tools regarding abuse/neglect and

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 12/09/2021

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 689	Continued From page 23 transfers conducted per the care plan. Interviews with staff revealed they were re-educated per the documentation of in-services provided. Interviews with management staff revealed they completed audits and monitoring per the audit tools and monitoring documentation provided. Observations of transfers for sampled residents were conducted while the survey team was onsite with no concerns noted.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		1/12/22

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 12/09/2021

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 755	Continued From page 24 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Consultant Pharmacist interview the facility failed to return controlled medications to the pharmacy when a resident discharged to the hospital for 8 days for 1 of 1 resident (Resident #3) reviewed for misappropriation of resident property which resulted in the controlled medication being diverted from the medication storage cart. The findings included: Review of document titled "Controlled Substance Tracking" dated February 2020 read in part, "Temporary Leave (hospital, therapeutic leave, D/C return expected): When the resident leaves the building, the census must be updated to hospital leave, discharge return expected or therapeutic leave. This will disable the medication from being able to be administered in eMAR but maintain the ability to continue to be counted until it is return to the pharmacy or the resident returns to the facility. If resident does not return after 3 days follow the instructions to return the medication to the pharmacy." Review of a physician order for Resident #3 dated 06/24/21 read, hydrocodone (narcotic pain medication) 5/325 milligrams (mg) by mouth every 6 hours as needed for pain. The order was discontinued on 07/08/21. Review of a physician order for Resident # dated	F 755	The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 discharged from the facility on 7/12/2021 and has not returned to the facility. Resident #3 did not suffer any adverse effects from the alleged deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 1/6/2022, the Administrative Nurse, Staff Development Coordinator; Assistant Director of Nursing and Director of Nursing, searched each medication cart to ensure: the medication cart was free of narcotic medications that were discontinued by the prescriber or discontinued due to the resident□s discharge without an expected return to	

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 12/09/2021

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 755	Continued From page 25 6/28/21 read, Tylenol #3 (narcotic pain medication) 300/30 mg by mouth 4 times a day as needed for pain. Resident #3 was discharged to the hospital on 07/12/21. Review of a Controlled Substance Tracking log dated 07/20/21 and provided by the facility indicated that Resident #3 was supposed to have 12 hydrocodone 5/325 mg and 20 Tylenol #3 on the 700-hall medication cart, but none were found on the medication storage cart. The log was initialed by Nurse #2 and Nurse #3. An interview was conducted with Nurse #2 on 12/07/21 at 1:57 PM. Nurse #2 confirmed she worked on 700 hall on 07/20/21 7:00 AM to 3:00 PM. Nurse #2 stated that at 3:00 PM Nurse #3 reported to work, and they began to count the controlled medication on the medication cart. She stated that she began calling out the names of the residents on the 700 hall and Nurse #3 would say how many pills there were, and that number was entered into the computer system. Nurse #2 stated that Resident #3's name appeared on the computer screen and Nurse #3 stated that there was no medication for Resident #3 on the medication cart. Nurse #2 stated she recalled during the 7:00 AM medication count Resident #3's name was not called out and she was aware that there was no medication for Resident #3 on the medication cart. Nurse #2 stated she did not question this at the time because she assumed that the DON had removed the medication from the drawer since Resident #3 had been discharged from the facility about a week earlier. Nurse #2 stated that she and Nurse #3 searched the medication cart and room and when they	F 755	the facility. The Director of Nursing collected all discontinued narcotic medications that were removed from the cart for return to the pharmacy. No residents were adversely affected by the alleged deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 1/6/2022, the Administrator educated the Director of Nursing (DON) and Assistant Director of Nursing (ADON), on the responsibility to ensure that all discontinued narcotic medications are removed from the medication carts and returned to the pharmacy in a timely fashion (within 3 business days) to prevent misappropriation and diversion. On 1/6/2022, the Staff Development Coordinator (SDC) began educating all licensed nurses and medication aides on the process for tracking and accounting for all narcotic medications to include removing discontinued narcotic medications from the medication cart in a timely manner (within 3 business days). Any licensed nurse or medication aide that was not educated on 1/6/2022 will be educated prior to their next scheduled shift. The SDC is responsible for tracking completion of the education. The Administrator informed the SDC of this responsibility on 1/6/2022. Any newly hired licensed nurses or medication aides will be educated on this process during	

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 12/09/2021

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 755	Continued From page 26 could not locate the missing narcotics, they notified the DON. She added that according to the computer system Resident #3 was supposed to have 12 hydrocodone 5/325 mg and 20 Tylenol #3 in the narcotic drawer and neither could be located. The DON was interviewed on 12/07/21 at 4:44 PM. The DON stated that 2 nurses were counting the 700-hall medication cart on 07/20/21 and they noted some missing narcotics and reported that to me. The DON stated he went to the cart and searched the medication cart and medication room, but the medication could not be located. He explained that Resident #3 had 2 narcotic medications hydrocodone and Tylenol #3 that were listed on the tracking log, but the physical medications could not be located. The DON stated he would go around to the medication carts and collect the medication that needed to be returned to the pharmacy and if one of the nurses reported that something needed to be returned, he would go and return the medication but added he had not returned Resident #3's medication but could not state why. Nurse #3 was interviewed on 12/08/21 at 8:58 AM. Nurse #3 confirmed that she was working on 07/20/21 on the 3:00 PM to 11:00 PM shift on the 700 hall and proceeded to count the controlled narcotic medications with Nurse #2. Nurse #3 explained that Nurse #2 (off going nurse) was at the computer screen and she (on coming nurse) was at the drawer and Nurse #2 was calling out the resident name and then I would call out how many pills they had, and Nurse #2 would enter them in the system. Nurse #2 called out Resident #3's name and I stated that there was no medication for Resident #3 in the narcotic drawer.	F 755	orientation by a licensed nurse. To ensure that this alleged noncompliance will not recur, each business day, the ADON or designee will review facility reports to identify census and/or order changes that might require narcotic medications to be removed from the medication cart. The ADON or designee will retrieve any narcotics from the medication carts that must be returned to the pharmacy. The Administrator notified the ADON of this responsibility on 1/6/2022. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 1/6/2022 an audit tool was developed by the Quality Assurance and Performance Improvement Committee consisting of the Administrator, DON, SDC and Regional Nurse. The DON will use the audit tool to monitor whether narcotics have been removed from the medication carts in a timely manner (within 3 business days). Monitoring will occur three times a week for 4 weeks; then two times a week for 4 weeks; then one time a week for 4 weeks. The DON will report the results of the audit to the Quality Assurance and Performance Committee for tracking and trending. Include dates when corrective action will be completed. The date when the corrective action will	

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 12/09/2021

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 755	Continued From page 27 Nurse #3 stated that they both searched the medication cart and room and none of the missing narcotics could be found so they immediately went and reported to the DON. Nurse #3 stated that the facility's procedure for removing narcotic that had been discontinued or the resident had discharged to the hospital was to let the DON know that they medication needed to be removed from the medication cart and he would come to the cart and remove it and fill out the appropriate paperwork and return the medication to the pharmacy. Nurse #3 stated that she and Nurse #2 had discussed on 07/19/21 that Resident #3 had been gone for almost a week and they probably needed to let the DON know that the medications needed to be returned to the pharmacy. She added she did not know why they did not notify the DON of the medications but stated they did discuss it. The Consultant Pharmacist (CP) was interviewed via phone on 12/08/21 at 9:21 AM. The CP stated that the facility should have a policy on how and when to return controlled medication to the pharmacy, but he was not sure exactly what that policy was without looking it up. The Administrator and DON were interviewed on 12/08/21 at 2:53 PM. When the DON was asked why he had not removed the narcotic medication from the medication cart for Resident #3 for a week and the Administrator stated that at the time they had a vacancy in Assistant Director of Nursing role, and it was a "workload issue" and the DON just did not have the time to remove the medications. The DON stated when he was notified of the missing narcotic, he immediately began to look for the controlled medication but was unable to locate the missing medication.	F 755	be completed is, January 12, 2022.	

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 12/09/2021

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 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with nurse practitioner (NP), wound doctor (WD) and staff and record review, the facility's administration failed to provide effective management of processes implemented to ensure an effective system was in place to provide wound care. This failure had the potential to affect residents with physician orders for wound care. As a result, 1 of 2 sampled residents, reviewed for wound care, did not receive wound care for 10 days to 2 wounds, an unstageable necrotic wound of the right lateral ankle and an unstageable necrotic wound to the right lateral heel (Resident #6). The findings included: This tag is cross referred to: F684 E: Based on observations, interviews with a resident, family, nurse practitioner (NP) and staff and record review, the facility failed to provide daily wound care per physician order to a resident with a diagnosis of peripheral vascular disease (PVD). Resident #6 did not receive wound care for 10 days to 2 wounds, an unstageable necrotic wound of the right lateral ankle and an unstageable necrotic wound to the right lateral heel. This occurred for 1 of 2 sampled residents reviewed for wound care (Resident #6).	F 835	The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #6 continues to reside at facility with no adverse effects. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 12/8/2021 the Director of Nursing (DON) reviewed current residents in the facility with physician orders for wound care to ensure that wound care was provided as ordered. All wound care was completed as ordered. On 12/8/2021 the Wound Care Nurse (WCN) stocked each medication room	1/12/22

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 12/09/2021

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 835	Continued From page 29	F 835		

and a supplemental treatment cart so that wound care supplies would be always available to nursing staff.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
On 12/8/2021, the Staff Development Coordinator (SDC) and WCN educated all licensed nurses on their responsibility to complete wound care according to physician orders as well as where to locate wound care supplies. Any licensed nurse that was not educated on 12/8/2021 were educated prior to their next scheduled shift. Newly hired licensed nurses will be educated during clinical orientation. The SDC is responsible for tracking completion of the education. The Administrator informed the SDC of this responsibility on 1/7/2022.

To ensure that this alleged noncompliance will not recur, the wound care nurse (WCN); nursing supervisor; or designee will review physician orders for wound care and confirm that all wound care has been completed as ordered daily. The Administrator notified the WCN and nursing supervisors of this responsibility on 1/7/2022.
The facility administrator in conjunction with the Corporate Nurse Consultant will monitor the wound care management program in the facility including effective leadership by nursing administration. The facility administrator will review the facility policies, procedures, and QAPI analysis of the wound care management process in

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 12/09/2021

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 835	Continued From page 30	F 835		

the facility. The facility will not tolerate breaches of the wound care management expectations; staff will be disciplined using the progressive discipline process.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

On 1/7/2022 an audit tool was developed by the Quality Assurance and Performance Improvement Committee consisting of the Administrator, DON, SDC and Regional Nurse. The DON will use the audit tool to monitor whether wound care has been completed in accordance with physician orders. Monitoring will occur each business day 4 weeks; then three times a week for 4 weeks; then two times a week for 4 weeks; then one time a week for 4 weeks.

Administrator (or designee) will review wound care audit reports for completion and corrective action weekly x 8 weeks then monthly x 3 months. Corporate Nurse Consultant will monitor a sample of residents during her monthly visit to ensure that wound care was completed according to physician orders.

The Administrator will report the results of the audit to the Quality Assurance and Performance Committee for tracking and trending.

The Administrator is responsible for this plan of correction.

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 12/09/2021

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 835	Continued From page 31	F 835	Include dates when corrective action will be completed. The date when the corrective action will be completed is, January 12, 2022.	