PRINTED: 02/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPL		COMPLETED			
	345013	B. WING _			C 01/28/2016
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - CHARLO	TTE		STREET ADDRESS, CITY, STATE, ZIP COD 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	PE	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 000 INITIAL COMMEN	TS	F 0	00		
Complaint Investig 483.10(b)(5) - (10) 8S=C RIGHTS, RULES, The facility must in and in writing in a l understands of his regulations govern responsibilities dur facility must also p notice (if any) of th §1919(e)(6) of the	ere cited as a result of the lation. Event #41WB11. , 483.10(b)(1) NOTICE OF SERVICES, CHARGES If orm the resident both orally language that the resident or her rights and all rules and ing resident conduct and ring the stay in the facility. The rovide the resident with the e State developed under Act. Such notification must be been admission and during the	F 1	56		2/26/16
any amendments t writing. The facility must in	eceipt of such information, and to it, must be acknowledged in aform each resident who is d benefits, in writing, at the time				
of admission to the resident becomes items and services facility services unwhich the resident other items and se and for which the r the amount of char inform each reside the items and serv (i)(A) and (B) of this	e nursing facility or, when the eligible for Medicaid of the sthat are included in nursing der the State plan and for may not be charged; those excices that the facility offers resident may be charged, and rges for those services; and ent when changes are made to ices specified in paragraphs (5) is section.				
at the time of admi the resident's stay, facility and of charg including any charg	ofform each resident before, or ission, and periodically during to services available in the ges for those services, ges for services not covered		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/15/2016

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.

Electronically Signed

		(X3) DATE COMP	SURVEY PLETED			
	345013	B. WING				C 28/2016
			322	3 CENTRAL AVENUE	1 017	20/2016
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		x	•		(X5) COMPLETION DATE
under Medicare or by The facility must furni legal rights which incl A description of the m funds, under paragraph A description of the refor establishing eligibit the right to request and 1924(c) which determ non-exempt resource institutionalization and spouse an equitable secannot be considered toward the cost of the medical care in his or down to Medicaid eligible. A posting of names, an umbers of all pertine groups such as the Stagency, the State lice ombudsman program advocacy network, and unit; and a statement complaint with the Stagency concerning refacility, and non-complaint with the Stagency concerning refacility, and non-complaint with the Stagency concerning refacility, and non-complaint with the Stagency concerning refacility must infor name, specialty, and physician responsible	sh a written description of udes: lanner of protecting personal oh (c) of this section; equirements and procedures lity for Medicaid, including a assessment under section lines the extent of a couple's at the time of a attributes to the community share of resources which available for payment institutionalized spouse's her process of spending libility levels. Inddresses, and telephone ent State client advocacy tate survey and certification ensure office, the State in the protection and and the Medicaid fraud control that the resident may file a late survey and certification ensident abuse, neglect, and esident property in the oliance with the advance tts. In each resident of the late of the	F	156			
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page under Medicare or by The facility must furni legal rights which incl A description of the re for establishing eligibit the right to request ar 1924(c) which determ non-exempt resource institutionalization and spouse an equitable s cannot be considered toward the cost of the medical care in his or down to Medicaid elig A posting of names, a numbers of all pertine groups such as the S agency, the State lice ombudsman program advocacy network, ar unit; and a statement complaint with the Sta agency concerning re misappropriation of re facility, and non-comp directives requiremen The facility must infor name, specialty, and physician responsible	TOORRECTION TO DENTIFICATION NUMBER: 345013 ROVIDER OR SUPPLIER SOURCES - CHARLOTTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: 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 inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 under Medicare or by the facility's per diem rate. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NO. 28205 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) FREGULATORY OR LSO IDENTIFYING INFORMATION) Continued From page 1 under Medicare or by the facility's per diem rate. 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The facility must prominently display in the facility The facility must prominently display in the facility	A BUILDING 345013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this 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. 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	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	1 01120/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	O BE COMPLETION
F 156	Medicare and Medicar receive refunds for prosuch benefits. This REQUIREMENT by:		F 15	Preparation, submission and	
	Council President and facility's admission pays provide residents with information for the St. The findings included An observation on 01 facility's main hallway station revealed advowas posted above the review of the contact Division of Health Se and Certification Sections as "Division of Facility Section and Licensur Complaints Intake Ur "Disability of Facility Seranch". A review of the facility Seranch". A review of the facility Seranch and Certification Section and Licensur Complaints Intake Ur "Disability of Facility Seranch". A review of the facility Seranch and Certification of Facili	d staff and review of the acket, the facility failed to a accurate contact ate Agency. 1: 1/25/16 at 3:17 PM of the which led to each nursing acacy contact information e water fountain. Further information revealed the rvice Regulation, Licensure tion (DHSR L&C) was listed by Services Certification e Section" and the ait (CIU) was listed as Services Complaints 1/25/16 at 3:17 PM of the revealed the review of the section		implementation of this Plan of Correctoes not constitute an admission of agreement with the facts and concluset forth on the survey report. Our F Correction is prepared and executed means to continuously improve the cofficare and to comply with all applicated State and Federal regulatory requirements. F156 Resident affected: The president of Resident Council we met with and was updated on state agency contact information. 2/11/20. Other residents with the potential A meeting was accomplished with resident council to review the updates state agency information. 2/16/2016 Other measures: The Advocacy contact information we updated/corrected on 1/28/2016. The Complaints Intake Unit was correct to read "Division of Health Service Regulation" on 1/28/2016. The Admission packet was updated reflect corrected information i.e. "Div	or sions Plan of I as a quality able as 16 al: ed as rected

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345013	B. WING			C 01/28/2016
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		01/20/2016
	10 715 211 011 001 1 21211			3223 CENTRAL AVENUE		
PEAK RES	SOURCES - CHARLOTTE			CHARLOTTE, NC 28205		
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F 156	Continued From page	÷ 3	F 1	56		
	posted in the facility. An interview with Soc	y contact information was ial Worker #1 (SW #1)		of Health Service Regulation" on 1/28/2016. Continued Compliance: Reviewed state agency informations.	ion with	1
	she coordinated Residual Since September 201	at 4:06 PM and revealed dent Council (RC) meetings 5. SW #1 stated during		the resident council president on 2/11/2016. Review state agency information	n on	
	the residents and revi during each meeting,	ad the prior RC minutes to sewed 2 of their rights but she could not recall sof where advocacy contact and in the facility.		2/16/2016 and quarterly thereafted resident council meetings. Facility staff will be educated regulation (F158) referencing of Rights, Rules and Service cha	garding g "Notic	ce
	01/27/16 at 4:43 PM a	Administrator occurred on and revealed he was the for the last 7 weeks. The		Education will be conducted by Administrative nursing, Staff dev nurses and/or Administrator. 2/1 An audit tool was developed to e	15/2016	6
	Administrator stated t checked the advocac make sure the right in	hat when he came he y contact information to formation was posted, but		ongoing compliance. The audit w completed 2x week over the nex months.	vill be tt 3	
	the DHSR L&C and the	the wrong contact name for ne CIU was posted.		Ongoing audits will be determine results of the prior 3 months of a • QA:	-	
	occurred on 01/28/20 revealed that facility's the contents of the ad	corporate office provided Imission packet and revised		The updated state agency inform be reviewed at the QAPI commit meeting scheduled for 2/26/2016	ttee	will
	State Agency contact listed in the admission	e was not aware that the information was incorrectly as packet, but that she any new admissions going				
	forward until the corporation packet.	orate office could update the				
F 167 SS=C	483.10(g)(1) RIGHT TREADILY ACCESSIB	TO SURVEY RESULTS - LE	F 1	67		2/26/16
	_	ht to examine the results of ey of the facility conducted by				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ENTIFICATION NUMBED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D		343013	B. WING _	0.71		01/	/28/2016
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RES	SOURCES - CHARLOT	TE			23 CENTRAL AVENUE		
				CH	HARLOTTE, NC 28205		
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F 167	Continued From pa	ge 4	F 1	167			
		rveyors and any plan of with respect to the facility.					
	examination and mi	ake the results available for ust post in a place readily ents and must post a notice of					
	by: Based on observat Resident Council Pi the facility failed to	ions and interviews with the resident and the Administrator, post a sign to notify residents e State Agency survey results.			Preparation, submission and implementation of this Plan of Correcti does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Pla Correction is prepared and executed a	ons In of	
	An observation on (facility's main hallwant station revealed pos information, but a n	01/25/16 at 3:17 PM of the ay which led to each nursing stings of advocacy contact otice of the location of the			means to continuously improve the qu of care and to comply with all applicab State and Federal regulatory requirements.	ality	
	notebook was obse included the State A	y results was not included. A rved in the front lobby which agency survey results, but o indicate its location.			F167 Resident affected: The resident council president was ma aware of the location of the State Ager Survey results on 2/11/2016. The resi	псу	
	with the President of revealed he was electronical in October 2	ed on 01/26/2016 at 10:44 AM of Resident Council and ected President of Resident 2015 and that he was told by a ne location of the State			council president was also informed of location of the postings to direct reside families, etc. to the State Agency Surv results. 2/11/2016	ents,	
	Agency survey result had not seen this portion Resident Council furbulletin board in the	olts would be posted, but he osted yet. The President of rther stated that there was a main lobby, but a sign to not the State Agency survey			Other residents with potential: During the resident council meeting he on 2/16/2016 the residents were made aware of where to find the State Agenc Survey results. Other Measures:	;	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLET COMPLETE CONSTRUCTION (X3) DATE S COMPLETE CONSTRUCTION (X4) DATE S COMPLETE CONSTRUCTION (X5) DATE S COMPLETE CONSTRUCTION (X6) DATE S COMPLETE CONSTRUCTION (X7) DATE S COMPLETE						
		345013	B. WING _			l .	28/2016
NAME OF PR	ROVIDER OR SUPPLIER	1 23333		S1	TREET ADDRESS, CITY, STATE, ZIP CODE	J 017.	20/2010
PFAK RES	SOURCES - CHARLOTT	F		32	223 CENTRAL AVENUE		
	- STIARLOTT	_		C	HARLOTTE, NC 28205		
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F 167	01/27/16 at 4:43 PM facility's Administrator Administrator stated checked the advocace make sure the right in that he did not know notified residents of the Agency survey result surveyor walked to be main lobby of the fact stated that he did not residents of the locater than the stated that he did not residents of the locater than the stated that he locater than the stated than t	Administrator occurred on and revealed he was the or for the last 7 weeks. The that when he came he exp contact information to information was posted, but if there was a sign which he location of the State is. The Administrator and oth nursing units and to the ility and the Administrator at see a sign posted to notify ion of the State Agency at a sign should be posted.	F 1	167	The location of where to find the State Agency Survey results was also posted the following locations: Main Hallway (Front), Nursing Station for Hallways 100-400, Nursing Station for Hallways 500-900, on 1/28/2016. Continued Compliance: Facility staff will be educated/in-service to the location of the State Agency survey results. 2/15/2016 Facility staff will be educated/in-service regarding the regulation requiring the residents right to State Agency survey results and that these they are to be readily accessible. Staff will be educated by Administrative nurses, staff development nurse and/or the Administrator. 2/15/2016 Daily rounds by the administrator initiat on 2/11/2016 will include the observation of signage directing residents, families etc. to the State Agency Survey results An audit tool was developed to evaluationgoing compliance with F167, this will completed 2x a week for the next 3 months. Ongoing audits will be determined by the prior 3 months of auditing. QA: The right to survey results (F167) requiring the accessibility to State Ager survey results and compliance with this regulation will be reviewed at the QAPI committee meeting on 2/26/2016.	s ed ed ed ed ed bn e el be	
F 323 SS=D	483.25(h) FREE OF A HAZARDS/SUPERV		F 3	323	•		2/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345013	B. WING			C 01/28/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205		0172072016	
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F 323	as is possible; and ea	ure that the resident as free of accident hazards	F 32	23			
	by: Based on observation facility record review, multipurpose disinfect shaving cream in a lot housed 4 residents with 2 of 9 halls (Resident #90). The findings included The Material Safety In the Material Safety In the Multi-Surface Distribution of the following caution Moderately irritation. The MSDS or swallow. Avoid conclothing. Store in well OF REACH OF CHILL The MSDS for shaving following health haza	Data Sheet (MSDS) for Alpha infectant Cleaner, recorded "Harmful if swallowed. o the eyes. Mild skin also recorded "Do not taste intact with skin, eyes and l-ventilated area. KEEP OUT		Preparation, submission and implementation of this Plan of does not constitute an admiss agreement with the facts and set forth on the survey report. Correction is prepared and exmeans to continuously improv of care and to comply with all State and Federal regulatory requirements. F 323 Residents # 234, #155, #200 a were not affected by unsecured disinfectant cleaner and shaving Those with Potential: The cabinets in all Spa areas locks placed to secure any pothazardous items. 1/29/2016. No resident has had access to hazardous items. 1/2	cion of or conclusions Our Plan of ecuted as a re the quality applicable and # 90 ed ng cream. have had tentially		
	unlocked spa on the	/25/16 at 1:03 PM of an 700/800 halls revealed 2 ses of shaving cream which		In-service education was initia 1/29/16 for facility staff, includ housekeeping, dietary and nur	ing		

A. BUILDING		SURVEY PLETED					
		345013	B. WING				C 28/2016
	ROVIDER OR SUPPLIER	<u> </u>		32	TREET ADDRESS, CITY, STATE, ZIP CODE 223 CENTRAL AVENUE HARLOTTE, NC 28205	<u> </u>	20/2010
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F 323	Continued From page were stored on the locabinet. The cabinet of ambulatory residents ambulated via wheel warnings to avoid spread the reach of children appendix open flame. An observation on 01 the same spa on the funlocked and the 2 castill in an unlocked cadescribed. An observation on 01 the spa on the 700/80 and the 2 cans of shate The unlocked cabinet Alpha HP Multi-Surfatthe lower shelf which ambulatory residents ambulated via wheel warning to keep out of the spa on the 700/80 and the spray bottle of and the spray bottle of ambulation on 01 the spa on the 700/80 and the spray bottle of ambulation on 01 the spa on the 700/80 and the spray bottle of ambulation on 01 the spa on the 700/80 and the spray bottle of the spa on	wer shelf of an unlocked was accessible to and residents who chairs. The cans recorded aying in eyes, keep out of and not to spray toward an 1/25/16 at 3:41 PM revealed 1/20/800 halls was still ans of shaving cream were binet as previously 1/26/16 at 08:38 AM revealed 1/20 halls was still unlocked aving cream were removed. It stored a spray bottle of the Disinfectant Cleaner on was accessible to and residents who chairs. The label recorded a 1/27/16 at 09:21 AM revealed 1/27/		323		ally vill nent e ed nd d	
	09/12/14. Diagnoses and mental disorder. care plan and nurses revealed a quarterly N dated 01/18/16 which with severely impaired	dmitted to the facility on included vascular dementia Review of assessments, notes for Resident #234 Minimum Data Set (MDS) assessed Resident #234 d cognition, required a quired redirection from					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 323	from 01/26/16 - 01/27 her wheel chair proper the facility, including the facility, including the facility, including the facility. Resident #155 was an 11/26/14. Diagnoses behaviors. Review of nurses notes for Resiannual MDS dated 12 Resident #155 with surequired a wander guithe facility. Resident #01/26/16 - 01/27/16 owheel chair propelling the 700/800 unit. Resident #200 was an 02/04/15. Diagnoses disease and dementian assessments, care places and required redirection. Resident #200 reveale 01/08/16 which assessed and required redirection. Resident #90 was and 11/30/15. Diagnoses of assessments, care Resident #90 reveale 12/07/15 which assessing impaired cognition, reguired frequent redirection. Resident #90 reveale 12/07/15 which assessing impaired cognition, reguired frequent redirection. Resident #90 reveale 12/07/15 which assessing impaired cognition, reguired frequent redirection. Resident #90 reveale 12/07/15 which assessing impaired cognition, reguired frequent redirection. Resident #90 reveale 12/07/15 which assessing impaired cognition, reguired frequent redirection. Resident #90 reveale 12/07/15 which assessing impaired cognition, reguired frequent redirection. Resident #90 reveale 12/07/15 which assessing impaired cognition, reguired frequent redirection. Resident #90 reveale 12/07/15 which assessing impaired cognition, reguired frequent redirection.	lent #234 was observed (716 on multiple occasions in elling independently about the 700/800 unit. Idmitted to the facility on included dementia with assessments, care plan and dent #155 revealed an (2/03/15 which assessed everely impaired cognition, and and self propelled about #155 was observed from an multiple occasions in her grabout the facility, including (about the facility, including dimitted to the facility on included Alzheimer's a with behaviors. Review of an and nurses notes for ed a quarterly MDS dated (seed Resident #200 with graition, wandering behavior on from unsafe places. Imitted to the facility on included dementia. Review plan and nurses notes for d an admission MDS dated (seed Resident #90 with equired a wander guard and irection out of unsafe was observed from (an multiple occasions in her graindependently about the	F	3323			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	I	01/20/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 323	interview revealed s rooms on the 800/90 700/800 halls. The intimes she returned purse aide that were stated that a spray be disinfectant was left cabinet for nurse aide care. An interview with the	ge 9 016 at 09:23 AM. The he typically cleaned resident 00 halls and the spa for the interview also revealed that at bersonal hygiene items to the left in the spa. HS #1 also bottle of a multi-purpose in the spas in a locked les to use between resident e contract company's dry Account Manager	F 3:	23			
	occurred on 01/27/1 that her department sanitizer in an unloc cabinet for nurse aid care. The Account N rounded routinely to kept in the top cabin Manager stated that resident's personal I sanitizer stored in the unlocked. When this Manager stated she top cabinet and advi (DON) of the items of further stated that slips and the sanitizer stored in the unlocked.	dry Account Manager 6 at 09:52 AM and revealed left a spray bottle of a ked spa in the unlocked top les to use between resident Manager stated that she make sure the sanitizer was let in the spa. The Account in the past she found hygiene products and the le lower cabinet which was soccurred the Account moved the sanitizer to the lised the Director of Nursing found. The Account Manager he had not informed the litems found in an unlocked					
	occurred on 01/27/1 Account Manager at HP Multi-Surface Di in an unlocked lowe accessible to ambul who propelled in wh	e unlocked 700/800 hall spa 6 at 10:24 AM with the nd revealed a spray bottle of sinfectant Cleaner was stored r cabinet which was atory residents and residents eel chairs. The Account the disinfectant cleaner					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	` ') DATE SURVEY COMPLETED	
		345013	B. WING				C	
NAME OF P	ROVIDER OR SUPPLIER	0.00.0			TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	28/2016	
PEAK RES	SOURCES - CHARLOTTE	!			223 CENTRAL AVENUE CHARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	should be stored in the cabinet. The Account the facility had reside behaviors and there were sident could wander remained unlocked. An interview with Nurron 01/27/16 at 11:01 worked on the 700 had cleaner stored in the groom and shower equivalence to the disinfectant because Resident #1 with wandering behave about the facility. An interview with Nurron the stored the disinfectant because Resident #1 with wandering behave about the facility.	we upper cabinet or a locked Manager further stated that Ints with wandering I was a potential that a I into the spa since the spa I se Aide #1 (NA #1) occurred	F	3323				
F 356 SS=C	on the 800 hall and us stored in the spa to ol stated the disinfectan cabinet because of reachinet because of reachinet because of reachinet in the Interim DON nurse aides to store of cabinet in the spa due wandering behaviors. Residents #90, #234, residents with wander supervision and redired 483.30(e) POSTED NINFORMATION	sed the disinfectant cleaner ean the shower bed. NA #2 t should remain in a locked esidents who wandered. I on 01/28/2016 at 4:23 PM revealed she expected shemicals in a locked et to confused residents with The Interim DON identified #155 and #200 as confused ring behaviors who required ection.	F	356			2/26/16	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			E SURVEY IPLETED
		345013	B. WING _			C 1/28/2016
	ROVIDER OR SUPPLIER	I ≣		STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205		1/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 356	o The current date. o The total number as by the following categunlicensed nursing st resident care per shift. Registered nurse. Licensed practic vocational nurses (as - Certified nurse as o Resident census. The facility must post specified above on a of each shift. Data mo Clear and readable o In a prominent plac residents and visitors. The facility must, upon make nurse staffing of for review at a cost no standard. The facility must main staffing data for a min required by State law. This REQUIREMENT by: Based on observation facility failed to update a daily basis in the frost the survey conducted. Findings included: On 1/27/16 at 9:00 All	and the actual hours worked pries of licensed and aff directly responsible for t: es. all nurses or licensed defined under State law). aides. the nurse staffing data daily basis at the beginning ust be posted as follows: format. e readily accessible to	F3	Preparation, submission and implementation of this Plan of C does not constitute an admission agreement with the facts and consect forth on the survey report. Correction is prepared and execute means to continuously improve of care and to comply with all agestate and Federal regulatory.	on of or onclusions Our Plan of cuted as a the quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		345013	B. WING			C 01/28/2016
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - CHARLOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	T	TION SHOULD BE THE APPROPRIA	
F 356	for 1/26/16. At 2:30 for 1/26/16. At 2:30 for evealed the posted still dated for 1/26/16. On 1/28/16 at 8:20 A posted staffing in the for 1/26/16. At 12:30 revealed the posted still dated for 1/26/16. During an interview of staffing coordinator supdating and posting stated there was a moby the time clock. Still daily and posted in the responsible for updat in the front lobby on a Observation on 01/28	PM on 1/27/16, observation staffing in the front lobby was. M, observation revealed the front lobby was still dated PM on 1/28/16, observation staffing in the front lobby was. In 01/28/16 at 12:45 PM, the aid she was responsible for the staffing daily. She aster copy of staffing posted affing changes are done are staffing books at each stated she was also ing the staffing data posted a daily basis as well. B/16 at 2:30 PM revealed the front lobby had been	F3	requirements. F356 No resident was affected be staffing data information not daily. Those with potential: Education was conducted be Development Coordinator regulation F356 i.e.: nurses information must be posted education was provided to Departments. 2/15/2016. Continued compliance: An audit tool was developed the nurse staffing information will be done daily for 2 week week for 4 weeks, then we weeks. Ongoing audits will by the prior 12 weeks of audit the QAPI meeting over the months.	by Staff regarding the s staffing d daily. The All Facility ed to observe ion. The audieks, then 3x ekly for 6 l be determinudits.	e e it ned