PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345013	B. WING _				C <b>20/2017</b>
	ROVIDER OR SUPPLIER  SOURCES - CHARLOTTE	<b>E</b>		32	TREET ADDRESS, CITY, STATE, ZIP CODE 223 CENTRAL AVENUE HARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224 SS=D	\$483.12 The resident abuse, neglect, misar property, and exploits subpart. This includes freedom from corpora seclusion and any ph not required to treat the 483.12(b) The facility implement written pole (b)(1) Prohibit and preexploitation of resident resident property,  (b)(2) Establish policitinvestigate any such (b)(3) Include training \$483.95,  This REQUIREMENT by:  Based on observation interviews the facility care to 3 existing preexidents reviewed for the findings included Based on observation interviews the facility changes as ordered to 3 sampled resident (Resident # 5).  The findings included	chas the right to be free from propriation of resident ation as defined in this is but is not limited to all punishment, involuntary ysical or chemical restraint the resident's symptoms.  must develop and icies and procedures that:  event abuse, neglect, and into and misappropriation of as required at paragraph  is not met as evidenced  in, record reviews, and staff neglected to perform wound issure ulcers for 1 of 3 in wound care (Resident #5).  in, record reviews, and staff failed to complete dressing of treat pressure ulcers for 1 is with wound care		2224	All wounds for Resident #5 were assessed by ADON and administrator of 6/20/2017 to assess for wound deterioration as a result of the missed treatment to sacrum and bilateral heels 6/18/2017.  No deterioration was observed as a result of the missed treatment.  Observation and comparison of Vohra wound physician notes dated 6/13/17 a 6/20/17 showed no significant change if wounds with actual slight improvement noted to Right heel and sacrum.  Nurse #4 received counseling and 1:1 education by regional corporate nurse	s on sult and in	7/12/17  (X6) DATE

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

07/11/2017

**Electronically Signed** 

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.

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCT			X3) DATE SURVEY COMPLETED		
		345013	B. WING			C <b>06/20/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		00:20:20:1
				3223 CENTRAL AVENUE		
PEAK RES	SOURCES - CHARLOTTI	Ē		CHARLOTTE, NC 28205		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION				RRECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
F 224	Continued From page	e 1	F 22	14		
	Resident #5 admitted	to the facility on 03/17/17		consultant on the importance	of and	
	with diagnoses that ir	ncluded pressure ulcer of the		facility expectation of complete	ing	
	sacrum and non- Alzi	neimer's dementia.		treatments as ordered by the	physician.	
		n order dated 03/21/17 read		All residents with pressure uld	ers have the	
	in part, clean sacral wound cleanser, pat	wound with normal saline or dry, apply anasept		potential to be affected.		
	(medicated gel) gel, o	cover with sterile gauze, and		All residents with pressure ulc	ers were	
	dry dressing daily and			assessed by clinical team on 6		
				assure treatments were appro	priate with	
	Review of the most re	ecent comprehensive		interventions in place to prome		
	minimum data set (M	DS) dated 03/23/17		healing and that treatments w	ere being	
	revealed that Resider	nt #5 was severely		completed as ordered. Team	consisted of	
	cognitively impaired f	or daily decision making and		Administrator, Tx nurse, Custo	omer	
	required extensive as	ssistance of 2 staff members		Relations nurse and dietary m	ıanager.	
	with bed mobility. The	e MDS further revealed that		Weekly QAPI wound meetings	s were	
		age 4 pressure ulcer (PU)		initiated to review wound prog	ress as well	
	and 2 Unstageable P	Us on admission.		as treatment records and result audits in place.	ılts of daily	
	Review of a physiciar	n order dated 05/30/17 read				
		d left heel ulcer with normal		Mandatory in-service was con		
	I .	nser, pat dry, apply wet		7/5,7/6,7/7,7/8,7/9, and 7/10 b		
		kin (medicated wound		Clinical consultant and admini		
		ver with dry dressing and		nurse designee. Emphasis wa	•	
	wrap with kerlix daily	and as needed.		importance and facilities expe		
				complete treatments as ordere	ed by MD.	
	I .	1, 2017 through June 30,				
		inistration Record (TAR)		Audits Initiated:		
		g changes for the sacrum,		DON, Customer Relations nur		
	left heel, and right he			weekend administrative nurse	-	
		completed on 06/17/17 by		will audit treatment records da		
	Nurse #3. None of the			treatments were completed as		
		d right heel) had been		weeks, then 3x a week x 4 we	eks then	
	changes had not bee	indicating that the dressing n completed.		weekly x 4 weeks.		
	_	•		Customer Relations nurse wil	•	
		d care with Resident #5 was		findings of audits to the Facilit	•	
		11:05 AM. The wound nurse		Assurance /Performance Impr		
	was observed to don	gloves and remove the		Committee monthly x 3 month	IS.	

Facility ID: 923280

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '		, ,	(X3) DATE SURVEY COMPLETED		
	345013	B. WING			C 06/20/2017		
	E		STREET ADDRESS, CITY, STATE, ZIP CODE  3223 CENTRAL AVENUE  CHARLOTTE, NC 28205				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE		
dressing from Reside bilateral heels, all 3 d 06/17/17 and contain drainage. The wound clean all 3 PU's and a ordered. When the dieach was dated and a 06/18/17 revealed that for Resident #5's unit. An interview with Nur 06/20/17 at 11:24 AN she was the nurse re unit on 06/18/17. Nur couple of treatment of did not recall perform care. Nurse #4 confir care would be her reserved in the resident #5.  An interview was con Nursing (DON) on 06 stated that she expect responsible for the unwound care during hithe wound care was a have been notified so the situation. The DO unaware that the wound completed.  An interview with the the 500 unit was cone PM. The Clinical Care	ent #5's sacral area and dressings were dated ed moderate amount of a nurse was observed to apply new dressings as ressings were completed initialed by the wound nurse.  assignment sheet dated at Nurse #4 was responsible to on 06/18/17.  The se # 4 was conducted on 1. Nurse #4 confirmed that sponsible for Resident #5's rese #4 stated that she did a changes on the 500 unit but sing Resident #5's wound med that the ordered wound sponsibility but she could not ordered dressing changes  adducted with the Director of 6/20/17 at 1:30 PM. The DON confirmed that if not complete the ordered sher shift. She added that if not completed she should on she could have corrected by confirmed she was und care had not been  Clinical Care Coordinator for ducted on 06/20/17 at 3:45 to Coordinator stated that if	F 2.	QAPI team will review findings evaluate need for any addition	nal			
	ROVIDER OR SUPPLIER  SOURCES - CHARLOTTI  SUMMARY ST (EACH DEFICIENCE REGULATORY OR  Continued From page dressing from Reside bilateral heels, all 3 d 06/17/17 and contain drainage. The wound clean all 3 PU's and a ordered. When the di each was dated and  A review of the daily 06/18/17 revealed the for Resident #5's unit  An interview with Nur 06/20/17 at 11:24 AM she was the nurse re unit on 06/18/17. Nur couple of treatment of did not recall perform care. Nurse #4 confir care would be her res recall performing the to Resident #5.  An interview was con Nursing (DON) on 06 stated that she expect responsible for the ur wound care during hi the wound care was have been notified so the situation. The DO unaware that the wor completed.  An interview with the the 500 unit was con- PM. The Clinical Care there was not a wour	ROVIDER OR SUPPLIER  SOURCES - CHARLOTTE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 dressing from Resident #5's sacral area and bilateral heels, all 3 dressings were dated 06/17/17 and contained moderate amount of drainage. The wound nurse was observed to clean all 3 PU's and apply new dressings as ordered. When the dressings were completed each was dated and initialed by the wound nurse.  A review of the daily assignment sheet dated 06/18/17 revealed that Nurse #4 was responsible for Resident #5's unit on 06/18/17.  An interview with Nurse # 4 was conducted on 06/20/17 at 11:24 AM. Nurse #4 confirmed that she was the nurse responsible for Resident #5's unit on 06/18/17. Nurse #4 stated that she did a couple of treatment changes on the 500 unit but did not recall performing Resident #5's wound care. Nurse #4 confirmed that the ordered wound care would be her responsibility but she could not recall performing the ordered dressing changes to Resident #5.  An interview was conducted with the Director of Nursing (DON) on 06/20/17 at 1:30 PM. The DON stated that she expected the nurse who was responsible for the unit to complete the ordered wound care during his/her shift. She added that if the wound care was not completed she should have been notified so she could have corrected the situation. The DON confirmed she was unaware that the wound care had not been	ROVIDER OR SUPPLIER  SOURCES - CHARLOTTE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 dressing from Resident #5's sacral area and bilateral heels, all 3 dressings were dated 06/17/17 and contained moderate amount of drainage. The wound nurse was observed to clean all 3 PU's and apply new dressings as ordered. When the dressings were completed each was dated and initialed by the wound nurse.  A review of the daily assignment sheet dated 06/18/17 revealed that Nurse #4 was responsible for Resident #5's unit on 06/18/17.  An interview with Nurse #4 was conducted on 06/20/17 at 11:24 AM. Nurse #4 confirmed that she was the nurse responsible for Resident #5's unit on 06/18/17. Nurse #4 stated that she did a couple of treatment changes on the 500 unit but did not recall performing Resident #5's wound care. Nurse #4 confirmed that the ordered wound care would be her responsibility but she could not recall performing the ordered dressing changes to Resident #5.  An interview was conducted with the Director of Nursing (DON) on 06/20/17 at 1:30 PM. The DON stated that she expected the nurse who was responsible for the unit to complete the ordered wound care was not completed she should have been notified so she could have corrected the situation. The DON confirmed she was unaware that the wound care had not been completed.  An interview with the Clinical Care Coordinator for the 500 unit was conducted on 06/20/17 at 3:45 PM. The Clinical Care Coordinator stated that if there was not a wound nurse in the facility then it	ROUNDER OR SUPPLIER  SOURCES - CHARLOTTE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 2 dressing from Resident #5's sacral area and bilateral heels, all 3 dressings were dated 06/18/17 revealed that Nurse #4 was responsible for Resident #5's unit on 06/18/17. Nurse #4 stated that she was the nurse responsible for Resident #5's unit on 06/18/17. Nurse #4 stated that she did a couple of treatment changes on the 500 unit but did not recall performing Resident #5's wond care. Nurse #4 confirmed that the ordered wound care was conducted with the Director of Nursing (DON) on 06/20/17 at 1:30 PM. The DON stated that she expected the situation. The DON confirmed she was unaware that the wound care had not been completed.  An interview with the Clinical Care Coordinator for the 500 unit was conducted on officed.  An interview with the Clinical Care Coordinator for the 500 unit was conducted on officed on one of the complete of the nurse who was responsible for the unit to complete the ordered wound care was conducted with the Director of Nursing (DON) on 06/20/17 at 1:30 PM. The DON stated that she expected the nurse who was responsible for the unit to complete the ordered wound care was not completed she should have been notified so she could have corrected the situation. The DON confirmed she was unaware that the wound care had not been completed.  An interview with the Clinical Care Coordinator for the 500 unit was conducted on 06/20/17 at 3:45 PM. The Clinical Care Coordinator stated that if the the wound care wound nurse in the facility then it	ROWDER OR SUPPLIER  345013  ROWDER OR SUPPLIER  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  Continued From		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	COMPLETED
		345013	B. WING _		06/20/2017
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	1 00/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPRODE	JLD BE COMPLETION
F 282 SS=D	Coordinator added the responsible for the 50 completed the ordered 483.21(b)(3)(ii) SERV PERSONS/PER CAPT (b)(3) Comprehensive The services provide as outlined by the comustation of the coordinate with each care.  This REQUIREMENT by:  Based on observation record review the fact in a resident 's control on the care plan for 10 a contracture (Resided The findings included Resident #7 was re-203/21/13 with diagnoral brain injury, hemipled recent Minimum Data	care. The Clinical Care that if Nurse #4 was 00 unit then she should have ed wound care.  VICES BY QUALIFIED RE PLAN  The Care Plans dor arranged by the facility, mprehensive care plan,  The is not met as evidenced and, staff interviews and fility failed to place a hand roll facted right hand as specified and of 3 sampled residents with ment #7).  The dimitted to the facility on ses that included traumatic gia and others. The most a Set (MDS) dated 03/16/17	F 2	Resident #7 was evaluated by PT for positioning and contracture management. A new splint was init for residents right hand contracture Resident is trialing new splint and on therapy caseload at this time. Residents Care plan was updated reflect changes in his treatment plate. All Residents with contractures and splinting devices have the potential affected.  All residents with contractures and splinting devices have the potential affected.	tiated e. remains to an. d Il to be
	impaired, he did not in identified behaviors to assistance from staff. The MDS also specified and lower extremity in impaired to the impaired	t's cognition was severely reject care and had no put required extensive for activities of daily living lied the resident had upper mpairment on one side, was a services or restorative		splinting devices were screened by therapy to evaluate for any change needed in their contracture manag treatment plan. Residents were platherapy case load if needed and Comprehensive care plan was upon reflect any changes in treatment plan.	es ement aced on dated to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345013	B. WING		C 06/20/2017
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE  3223 CENTRAL AVENUE  CHARLOTTE, NC 28205	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 282	nursing services.  A care plan updated of Resident #7's risk for hand roll was to be plan of Resident #7 in bed clenched in a fist. The place. The friend ask open his right fist, he unable to open the clean of Resident #7 was clenched in a fist place.  On 06/20/17 at 10:55 made of Resident #7 was clenched in a fist place.  On 06/20/17 at 2:55 For Resident #7 in bed clenched in a fist and  On 06/20/17 at 2:58 Finterviewed and state nurse aide. She explain for the resident a few nurses and nurse aide required specialized or rolls. The NA stated sin Resident #7's right unable to use his right	on 06/19/17 to minimize further decline specified a faced in his right hand.  PM observations were made and his right hand was ere was no hand roll in ed Resident #7 if he could held up his right fist but was enched fist.  AM observations were in bed and his right hand and no hand roll was in  PM observations were made and his right hand and no hand roll was in place.  PM nurse aide (NA) #5 was dishe was Resident #7's ained that she had only care times but relied on other es to report if a resident eare such as splints or hand she "never" placed anything hand and knew he was	F 28	Audits Initiated: Customer Relations nurse,DON and weekend administrative nurse design will audit splints and resident Comprehensive Care plans daily to assure splints are applied per treatmed plan and as ordered x4 weeks, then 3 week x 4 weeks then weekly x 4 weeks.  Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months.  QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.	ent Bx a ks.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345013	B. WING _		06/20/2017
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	1 00/20/2017
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 282	Continued From pag		F 2	82	
	(DON) was interview	PM the Director of Nursing ed and reported that nurse to follow the interventions on			
F 312 SS=D	483.24(a)(2) ADL CA DEPENDENT RESID		F 3	12	7/13/17
	activities of daily livin services to maintain personal and oral hypersonal personal hypersonal hy	is unable to carry out g receives the necessary good nutrition, grooming, and giene. Γ is not met as evidenced ons, record review and staff failed to render incontinence (Resident #6) and failed to ident's toenails (Resident #7) ampled for activities of daily		Resident #6 received ADL/Incont care on 6/19/17 as soon as it was to the charge nurses attention. Recatheter was also found to be leak changed.	bought esidents
	05/19/17 with diagno	eadmitted to the facility on ses that included onia, wound infection,		CNA #1 received counseling and education on providing appropriat timely ADL care per residents Tx p facilities expectation.  Resident #7 had toenails trimmed charge nurse on 6/20/2017. He was placed on the list to be seen by resident #7.	e and plan and by as also
	data set (MDS) dated Resident #6 was sev daily decision making assistance of two sta The MDS further revolved required an indwellin incontinent of bowel.	ecent quarterly minimum d 05/23/17 revealed that erely cognitively impaired for g and required total ff members with toileting. ealed that Resident #6 g catheter and was always esident #6 was made on		placed on the list to be seen by potential month. Resident denied company pain due to nail care.  All Residents have the potential to affected.  All residents had nails checked ar care was given as needed and appropriate on 6/20/17 and 6/21/14 A mandatory in-service for Nursing	obe nd nail

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	<u>J. 0930-0391</u>	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ` ′		CONSTRUCTION		SURVEY PLETED	
							С	
		345013	B. WING				/20/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
				32	223 CENTRAL AVENUE			
PEAK RE	SOURCES - CHARLOTTI	E		С	HARLOTTE, NC 28205			
(V4) ID	QUMMADV QT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Continued From page	<u> </u>		312				
. 0.2			'	312	was siven on ADI sers on			
		Resident #6 was lying in t bedside. Upon entering			was given on ADL care on 7/5,7/6,7/7,7/8,7/9 and 7/10/17 by			
		here was odor of feces.			Regional Clinical Consultant and or			
		vas soiled with fecal matter,			Administrative nurse designee.			
		w between Resident #6's			Emphasis was placed on nail care			
		large yellow ring on the			incontinent care and facilities expectati	on		
	pillowcase. The yello				of timely and appropriate care in	0		
	-	the pillow case and was half			accordance to Residents plan of care.			
		ightly wet. Resident #6's			Nurses were educated on their role to			
		ated that she had come to			assure their assigned residents are			
	I -	approximately 10:32 AM			receiving timely ADL care by CNA's an	d		
	and found her family	member in this condition.			that they also assist when needed with			
	The family member s	tated that the pillowcase			ADL care.			
	was solid and was we	et through to the pillow and						
	she was just going to	throw the pillow away.			Audits Initiated:			
					Customer Relations nurse ,DON and			
		ontinence care was made			weekend administrative nurse designe			
	I .	AM with Nursing Assistant			will complete audits of ADL care to ass			
	` '	observed to enter Resident			appropriate and timely incontinent care			
		esident #6 to her right side			and nail care is received daily x4 week			
	· ·	the soft formed fecal matter			then 3x a week x 4 weeks then weekly	X 4		
		ottom. When all the fecal oved from Resident #6, the			weeks.			
	soiled pad and gown	•			Customer Relations nurse will report			
		aced with clean ones.			findings of audits to the Facility Quality			
	resident #0 and repr	acca with cican ones.			Assurance /Performance Improvement			
	An interview with NA	#1 was conducted on			Committee monthly x 3 months.			
		1. NA #1 confirmed that she			Tanana manana kao manana			
		Resident #6 on first shift. She			QAPI team will review findings and			
		ot changed or rendered any			evaluate need for any additional			
		since arriving at the facility			monitoring or modification of this			
	I .	M. NA #1 explained that she			requirement.			
		:00 AM and started bathing						
	another resident and							
		resident's bath the breakfast						
	1	I and she did not have time						
	to render any care to	any other residents before						
		breakfast meal. NA #1						
	explained that Reside	ent #6 did not wear a brief						

MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) A. BUILDING  (X8) MULTIPLE CONSTRUCTION (X9) MUL		(X3) DATE SURVEY COMPLETED		
	345013	B. WING		C 06/20/2017
VIDER OR SUPPLIER  URCES - CHARLOT	TE	3	223 CENTRAL AVENUE	1 00/20/2017
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
ue the wound on han interview with N. 6/19/17 at 4:09 PN yorked third shift are resident #6. NA #2 are to Resident #6. NA #2 are to Resident #6 the added that she pproximately every nd each time that she had a small amer. She added that resident #6 had the er up and place a small and place a she had been in 6/20/17 at 10:47 A he was the nurse rest shift on 06/19/17 hat she had been in 6/19/17 at approximate the heck to see if Resident #6's medication of the she had been in 6/19/17 at approximate with the she had been in 6/19/17 at approximate with the she had been in 6/19/17 at approximate with the she had been in 6/19/17 at approximate with the she had been in 6/19/17 at approximate with the she had been in 6/19/17 at approximate with the she had been in and found her so the she had been in an interview with the she conducted on (1/19/19/19/19/19/19/19/19/19/19/19/19/19	A #2 was conducted on M. NA #2 confirmed that she and was responsible for a stated that she last rendered at a approximately 5:45 AM. A checked Resident #6 by two hours through the night she had checked Resident #6 bount of soft formed stool on a teach time she discovered a stool on her she would clean new pad under her.  Inducted with Nurse #1 on M. Nurse #1 confirmed that responsible for Resident #6 on 7 and 06/20/17. She stated in Resident #6's room on mately 9:30 AM to administer cations. Nurse #1 stated she cal matter but she did not ident #6 had been incontinent. A did not know that Resident waned up until her family came ided. Nurse #1 stated that she dent including Resident #6 to intinence before each meal then to be cleaned up.  Be Director of Nursing (DON) 26/20/17 at 1:30 PM. The asident #6 was checked for	F 312		
	SUMMARY:  (EACH DEFICIEN REGULATORY O  Continued From pa ue the wound on harmonic with No. 6/19/17 at 4:09 PN corked third shift and desident #6. NA #2 are to Resident #6. he added that she pproximately every and each time that he had a small am er. She added that he had a small am er. She added that he had a small am er. She added that her up and place a  an interview was co. 6/20/17 at 10:47 A he was the nurse in rest shift on 06/19/17 hat she had been in 6/19/17 at approxi desident #6's medic id not smell any fee heck to see if Resi lurse #1 stated she for needed to be cle in and found her so in the control of the control in interview with	JORRECTION  JASO13  JORNAM STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  JOINT AT 4:09 PM. NA #2 confirmed that she worked third shift and was responsible for desident #6. NA #2 stated that she last rendered are to Resident #6 at approximately 5:45 AM. The added that she checked Resident #6 proximately every two hours through the night and a small amount of soft formed stool on the had a small amount of soft formed stool on the she added that each time she discovered desident #6 had the stool on her she would clean the up and place a new pad under her.  In interview was conducted with Nurse #1 on 6/20/17 at 10:47 AM. Nurse #1 confirmed that the was the nurse responsible for Resident #6 on the she had been in Resident #6's room on 6/19/17 at approximately 9:30 AM to administer desident #6's medications. Nurse #1 stated she did not smell any fecal matter but she did not sheck to see if Resident #6 had been incontinent. The last she had been in great matter but she did not sheck to see if Resident #6 had been incontinent. The stated she did not know that Resident 6 needed to be cleaned up until her family came in and found her soiled. Nurse #1 stated that she expected each resident including Resident #6 to be checked for incontinence before each meal and if found soiled then to be cleaned up.  In interview with the Director of Nursing (DON) has conducted on 06/20/17 at 1:30 PM. The ion stated that Resident #6 was checked for	DIAMETER OF SUPPLIER  JURCES - CHARLOTTE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Tontinued From page 7  Jue the wound on her bottom.  In interview with NA #2 was conducted on 6/19/17 at 4:09 PM. NA #2 confirmed that she worked third shift and was responsible for lesident #6. NA #2 stated that she last rendered are to Resident #6 at approximately 5:45 AM. The added that she checked Resident #6 proximately every two hours through the night and each time that she had checked Resident #6 proximately every two hours through the night and each time that she had been she discovered lesident #6 had the stool on her she would clean the up and place a new pad under her.  In interview was conducted with Nurse #1 on 6/20/17 at 10:47 AM. Nurse #1 confirmed that the was the nurse responsible for Resident #6 on rest shift on 06/19/17 and 06/20/17. She stated that she had been in Resident #6's medications. Nurse #1 stated she did not smell any fecal matter but she did not heck to see if Resident #6 had been incontinent. The last she had been in Resident #6 had been incontinent. The last she had been resident #6's medications. Nurse #1 stated she did not know that Resident 6 needed to be cleaned up until her family came and found her soiled. Nurse #1 stated that she expected each resident including Resident #6 to echecked for incontinence before each meal and if found soiled then to be cleaned up.  In interview with the Director of Nursing (DON) was conducted on 06/20/17 at 1:30 PM. The	A BUILDING  345013  A BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  323 CENTRAL AVENUE  CHARLOTTE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TOTAL  TAG  PREFIX TAG  PREFIX TAG  PREFIX CROSS-REFERENCED TO THE APPROPRIATION  ORDITION AND ALL STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TOTAL  TAG  PREFIX TAG  PREFIX CROSS-REFERENCED TO THE APPROPRIATION  ORDITION AND ALL STATEMENT OF DEFICIENCY)  F 312  TOTAL  TOTAL 1-09 PM. NA #2 was conducted on 6/19/17 at 4-09 PM. NA #2 confirmed that she orked third shift and was responsible for desident #6. NA #2 stated that she last rendered are to Resident #6 at approximately 5:45 AM. He added that she checked Resident #6 are to Resident #6 at approximately 5:45 AM. He added that she had checked Resident #6 he had a small amount of soft formed stool on Her.  The interview was conducted with Nurse #1 on 6/20/17. She stated that she had been in Resident #6 no not follow the state of the sta

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  LAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345013	B. WING		C 06/20/2017
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	1 00/20/2017
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 312	should have rendered sometime earlier in the should have clear 2. Resident #7 was ready of the severely impaired, he no identified behavior assistance from staff. The MDS also specificand lower extremity in not receiving therapy nursing services.  A care plan updated of Resident #7 needed personal hygiene and Further review of the Resident #7 had not be considered and explain the facility for almo accident and was deposited that she will be should be considered and explain the facility for almo accident and was deposited that she will be considered that sh	d care to Resident #6 the morning and if soiled then and her up. e-admitted to the facility on sees that included traumatic place and others. The most mum Data Set (MDS) dated the resident's cognition was a did not reject care and had are, but required extensive for activities of daily living and the resident had upper mpairment on one side, was services or restorative  on 06/19/17 specified total care from staff for a grooming.  The medical record revealed total care seen by a Podiatrist.  PM Resident #7's friend was a sined the resident had been set 9 years following an ordendent on staff for care are had observed Resident is toenails to be long.	F 31		

	$\Gamma$		' '	DATE SURVEY COMPLETED			
		345013	B. WING				C 20/2017
	ROVIDER OR SUPPLIER			S'	TREET ADDRESS, CITY, STATE, ZIP CODE  223 CENTRAL AVENUE  CHARLOTTE, NC 28205	1 06/	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314 SS=D	(DON) observed Res stated she would get the length. The DON were responsible for toes) on shower days resident was a Diabetrim them. The DON Resident #7 was a Di length of the nails she them.  On 06/20/17 at 1:35 Finterviewed and state supposed to trim nails Diabetic. She reporter Resident #7 but was had his toenails trimm needed to be trimmed giving showers to res length and trimmed the 483.25(b)(1) TREATM PREVENT/HEAL PRIVENT/HEAL PRIVENT/HE	AM the Director of Nursing ident #7's toenails and a nurse to trim them due to explained that nurse aides trimming nails (fingers and and as needed unless the tic and then the nurse would stated she didn't know if abetic or not, but due to the ewanted a nurse to trim  PM nurse aide (NA) #5 was d nurse aides were sunless the resident was a ed she was assigned to unaware when he had last need and did not know they d. She explained that when idents she checked nail nem as needed.  MENT/SVCS TO ESSURE SORES  Based on the esment of a resident, the		312			7/13/17

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 06/20/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		7072072077
DE 414 DE 4		_		3223 CENTRAL AVENUE		
PEAK RES	SOURCES - CHARLOTTI			CHARLOTTE, NC 28205		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 314	Continued From page	e 10	F 3	14		
		essure ulcers receives				
	1	and services, consistent with				
	-	ls of practice, to promote				
		ction and prevent new ulcers				
	from developing.					
	· ·	is not met as evidenced				
	by:					
		n, record reviews, and staff		All wounds for Resident #5 w		
		failed to complete dressing		assessed by ADON and admi		
	_	to treat pressure ulcers for 1		6/20/2017 to assess for woundeterioration as a result of the		
	of 3 sampled resident (Resident # 5).	is with wound care		treatment to sacrum and bilat		
	(INCSIDENT # 5).			6/18/2017.	ciai ficcis dii	
	The findings included	Ŀ		No deterioration was observe	ed as a result	
		-		of the missed treatment.		
	Resident #5 admitted	to the facility on 03/17/17		Observation and comparison	of Vohra	
	with diagnoses that ir	ncluded pressure ulcer of the		wound physician notes dated	6/13/17 and	
	sacrum and non- Alzi	neimer's dementia.		6/20/17 showed no significan		
	Dovious of a physician	a order dated 02/21/17 read		wounds with actual slight imp		
		n order dated 03/21/17 read wound with normal saline or		noted to Right heel and sacru Nurse #4 received counseling		
	wound cleanser, pat			education by regional corpora		
		cover with sterile gauze, and		consultant on the importance		
	dry dressing daily and			facility expectation of complet		
	,			treatments as ordered by the	-	
	Review of the most re	ecent comprehensive				
	minimum data set (M	DS) dated 03/23/17		All residents with pressure uld	cers have the	
	revealed that Resider	nt #5 was severely		potential to be affected.		
		or daily decision making and				
		ssistance of 2 staff members		All residents with pressure uld		
	_	e MDS further revealed that		assessed by clinical team on		
		age 4 pressure ulcer (PU)		assure treatments were appro	-	
	and 2 Unstageable P	us on admission.		interventions in place to prom		
	Povious of a physician	a order dated 05/20/17 read		healing and that treatments w	-	
		n order dated 05/30/17 read d left heel ulcer with normal		completed as ordered. Team Administrator, Tx nurse, Cus		
		o leit neel uicer with normal nser, pat dry, apply wet		Relations nurse and dietary n		
		kin (medicated wound		Troiduona nuise and dietaly II	iailayei.	
	_	over with dry dressing and		Weekly QAPI wound meeting	s were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345013	B. WING _				C <b>20/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2017	
				322	23 CENTRAL AVENUE			
PEAK RES	SOURCES - CHARLOTT	Έ		CH	HARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 314	Continued From pag		F3	314	initiated to review wound progress as v	vell		
	Review of the June ( 2017 Treatment Adn	01, 2017 through June 30, ninistration Record (TAR) ng changes for the sacrum,			as treatment records and results of dai audits in place.	ly		
	left heel, and right he	eel had been initialed, completed on 06/17/17 by			Mandatory in-service was conducted o 7/5,7/6,7/7,7/8,7/9, and 7/10 by Regior Clinical consultant and administrative nurse designee. Emphasis was placed	ıal		
	(sacrum, left heel an	d right heel) had been , indicating that the dressing			importance and facilities expectation to complete treatments as ordered by MD	1		
	made on 06/19/17 at was observed to dor dressing from Reside bilateral heels, all 3 of 06/17/17 and contain drainage. The wound	nd care with Resident #5 was t 11:05 AM. The wound nurse in gloves and remove the ent #5's sacral area and dressings were dated ned moderate amount of d nurse was observed to apply new dressings as			Audits Initiated: Customer Relations nurse ,DON and weekend administrative nurse designer will audit treatment records daily to ass treatments were completed as ordered weeks, then 3x a week x 4 weeks, then weekly x 4 weeks.  Customer Relations nurse will report	ure x4		
	ordered. When the deach was dated and	ressings were completed initialed by the wound nurse.			findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months.			
	on 06/19/17 at 11:30 indicated that he wor and Nurse #3 was th weekends. He added wound nurse present	e wound nurse was conducted AM. The wound nurse rked Monday through Friday he wound nurse on the d that if there was not a t in the facility then the hall sible for completing the			QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.			
	06/19/17 at 2:43 PM she was the weeken worked on 06/17/17 She added that the r would be responsible	rse #3 was conducted on . Nurse #3 confirmed that d treatment nurse and she but did not work on 06/18/17. hurse responsible for the hall e for completing the ordered besence. Nurse #3 confirmed						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345013	B. WING _			C 06/20/2017
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205		0/20/2017
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	changes to her sacru	e 12 ed Resident #5's dressing m, left, and right heels on d initialed and dated each	F 3	14		
	O6/18/17 revealed that for Resident #5's unit An interview with Nur O6/20/17 at 11:24 AN she was the nurse re unit on O6/18/17. Nur couple of treatment of did not recall perform care. Nurse #4 confir care would be her res	assignment sheet dated at Nurse #4 was responsible				
	Nursing (DON) on 06 stated that she expect responsible for the ur wound care during hit he wound care was that have been notified so the situation. The DO unaware that the wou completed.  An interview with the the 500 unit was cone PM. The Clinical Care there was not a wour was the responsibility	care. The Clinical Care				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345013	B. WING		06/20/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3223 CENTRAL AVENUE  CHARLOTTE, NC 28205	1 06/20/2017
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 314	Continued From page	e 13	F 31	4	
F 315 SS=D	completed the ordere 483.25(e)(1)-(3) NO ( RESTORE BLADDER	CATHETER, PREVENT UTI,	F 31	5	7/13/17
	continent of bladder a receives services and continence unless his or becomes such that to maintain.  (2)For a resident with on the resident's comfacility must ensure the continuous catheter is resident's clinical concatheterization was not indwelling catheter or is assessed for remove	ers the facility without an not catheterized unless the dition demonstrates that			
	and  (iii) A resident who is receives appropriate prevent urinary tract i continence to the extension of the resident with on the resident's comfacility must ensure the incontinent of bowel resident.	n fecal incontinence, based prehensive assessment, the nat a resident who is			

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SU COMPLE	
		345013	B. WING _			C 06/20/2017
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		70/20/2011
				3223 CENTRAL AVENUE		
PEAK RES	SOURCES - CHARLOTTE	Ē		CHARLOTTE, NC 28205		
(X4) ID			ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI		(X5) COMPLETION
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF		DATE
F 315	Continued From page		F 3	15		
	bowel function as pos This REQUIREMENT by:	ssible. is not met as evidenced				
	_	n, record review, and staff		A catheter leg strap was put into	o place for	
		failed to anchor a urinary		resident #5 on 6/19/17 to ancho		
	catheter tubing to a re	esident's thigh to prevent nt of the catheter for 1 of 1		tubing and prevent pulling on ca		
	resident sampled (Re			All residents with catheters have potential to be affected	e the	
	The findings included	:		All residents with catheters were	e.	
	Review of a facility po	olicy titled "Catheter Care,		assessed on 6/19/17 by DON a		
		t 2015 read in part, "ensure		to assure catheter leg straps we		
	that the catheter rema	ains secured with a leg strap		place to anchor and secure cath		
	to reduce friction and	movement at the insertion		tubing.		
		r tubing should be strapped				
	to the resident's inner	thigh)."		In-service training was conducted 7/5/17-7/10/17 on facilities police	y and	
		nitted to the facility on		procedure for securing Foley ca		
	03/17/17 with diagnos			tubing and facilities expectation		
	hypertension, non-Alz			residents with catheter tubing ha		
	pressure ulcer of the	sacrum, and others.		catheters secured by leg straps		
	D : (1)			times unless other directive is n		
	Review of the most re			securing catheter tubing in their	treatment	
	minimum data set (Mi revealed that Resider			plan.		
		or daily decision making and		Audits Initiated:		
	required extensive as	-		Customer Relations nurse, DON	d and	
	members with activitie			weekend administrative nurse d		
				will audit catheters for placemer	nt of tubing	
		sident #5 was made on		and to assure tubing is anchore		
		I. Resident #5 was resting in		by leg strap daily x4 weeks, the		
		There was an indwelling		week x 4 weeks then weekly x 4	1 weeks.	
		n the side of the bed in a				
		nspection of the catheter		Customer Relations nurse will re	•	
		neter tubing was under		findings of audits to the Facility		
		g and was not secured to		Assurance /Performance Improv		
		rauma or dislodgement. g was resting on top of the		Committee monthly x 3 months.  QAPI team will review findings a		

Facility ID: 923280

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345013	B. WING				C <b>20/2017</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205		1 06/	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		EFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	catheter tubing and we catheter from the insection of 19/17 at 10:40 AM bathed Resident #5 as he did not want to go offer again later to ge stated that Resident # always be on top her she must have misse providing care to the Resident #5 during the that the catheter tubin insertion site. She metop of Resident #5's rileg. She added that strap that secured the resident's leg but it juton and interview was con 06/19/17 at 10:50 AM NAs provided the catheter with the catheter was not anchaptlied the anchor.  An observation of Nu 06/19/17 at 11:02 AM apply a leg band to Risecuring the catheter with the catheter was not anchaptlied the anchor.	ducted with NA #3 on I. NA #3 stated she had Ind changed her gown but et up. She added she would it Resident #5 up. NA #3 #5's catheter tubing should leg to prevent pulling and d that when she was resident. NA #3 observed e interview and confirmed ing was pulling against the oved the catheter to lay on ight leg instead of under her ome residents had a leg e catheter tubing to the st depended on the resident.  ducted with Nurse #1 on I. Nurse #1 stated that the neter care and she followed s done properly and to vas not leaking. Nurse #1 resident was up in a er was placed in a privacy it remained in bed the inchored to the resident's if she was aware that the incred she would have  rese #1 was made on I. Nurse #1 was observed to esident #5's right leg,	F3	315	evaluate need for any additional monitoring or modification of this requirement.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
	345013	B. WING		06/20/2017
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - CHARLOTT	'E		STREET ADDRESS, CITY, STATE, ZIP CODE  3223 CENTRAL AVENUE  CHARLOTTE, NC 28205	1 00/20/2011
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
stated the facility use catheter tubing to the that if Resident #5's tugging then the tubin anchored to Resider 483.25(c)(2)(3) INCF DECREASE IN RAN (c) Mobility.  (2) A resident with lir receives appropriate increase range of modecrease in range of decrease in range of modecrease in range of mode	6/20/17 at 1:30 PM. The DON ed leg straps to secure the ersident's leg. She added catheter tubing was pulling or ing should have been at #5's leg. REASE/PREVENT IGE OF MOTION  mited range of motion at treatment and services to obtion and/or to prevent further f motion.  mited mobility receives a equipment, and assistance we mobility with the maximum dence unless a reduction in ably unavoidable.  T is not met as evidenced ons, visitor interview, staff d review the facility failed to a resident's contracted right ther decline in range of motion esidents with a contracture	F 3:		nitiated re. I remains d to lan. nd ial to be

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED
		345013	B. WING			C <b>06/20/2017</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3223 CENTRAL AVENUE  CHARLOTTE, NC 28205		00/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	DATE
F 318	specified the resident impaired, he did not ridentified behaviors be assistance from staff. The MDS also specified and lower extremity in not receiving therapy nursing services.  A care plan updated of Resident #7's risk for hand roll was to be plant of the facility for almost accident. She explain the facility for almost accident. She explain right sided weakness a hand roll in his right from becoming stiff. visited the hand roll wadded that nurse aided didn't know to place a hand. She stated she ob/18/17 and stayed Resident #7 and durin place. During the resident's hand and heresident's hand was soon of the friend ask of Resident #7 in bed clenched in a fist. The place. The friend ask	eject care and had no but required extensive for activities of daily living and the resident had upper impairment on one side, was services or restorative.  On 06/19/17 to minimize further decline specified a laced in his right hand.  On Resident #7's friend was ained the resident had been st 9 years following an ined the resident suffered and was supposed to have thand to prevent the hand She added that when she was never in place. She is caring for the resident on throughout the day with ing the day, no hand roll was visit she tried to open the hand difficulty because the	F 3	therapy to evaluate for needed in their contrateratment plan. Reside therapy case load if not comprehensive care reflect any changes in Audits Initiated: Customer Relations in weekend administrative will audit splints and in Comprehensive Care assure splints are appulan and as ordered in week in a 4 week in the Assurance in the	acture manageme lents were placed leeded and plan was updated in treatment plan.  The plans designed resident plans daily to plied per treatment plans daily to plied per treatment at weeks, then 3x weekly x 4 weeks the plans daily ince Improvement 3 months.  In the plans daily to plied per treatment at weeks, then 3x weekly x 4 weeks the plans daily a daily and plans daily and pl	e at a a.s.

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	COMPLETED	
		345013	B. WING		C <b>06/20/2017</b>	
	ROVIDER OR SUPPLIER  SOURCES - CHARLOT	TE	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	1 00/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 318	Continued From pa	ge 18	F 318	3		
		0 AM a restorative aide was orted Resident #7 was not on I.				
	made of Resident #	5 AM observations were 7 in bed and his right hand st and no hand roll was in				
	(OT) #1 was intervied 1 of 3 occupational in facility. The OT state Resident #7 and was an OT caseload. The medical record and dated 04/01/13 for right hand daily as the Resident #7 had not for over a year and in the state of	PM Occupational Therapist ewed and explained she was therapists employed at the ed she was not familiar with s unaware of he was ever on the OT reviewed Resident #7's noted a physician's order nursing to apply hand roll to olerated. The OT stated that the been on therapy caseload therapy would rely on nursing hange in Resident #7's				
	of Resident #7 in be	PM observations were made and his right hand was d no hand roll was in place.				
	interviewed and stat nurse aide. She exp for the resident a fer nurses and nurse ai	PM nurse aide (NA) #5 was ted she was Resident #7's plained that she had only care w times but relied on other des to report if a resident care such as splints or hand				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
			7 50.125.			С
		345013	B. WING			06/20/2017
	ROVIDER OR SUPPLIER  SOURCES - CHARLOTTE	<b>.</b>		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 .SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 318	rolls. The NA stated sin Resident #7's right unable to use his right	she "never" placed anything hand and knew he was	F	318		
F 431 SS=D	(DON) was interviewed		F	431		7/13/17
	drugs and biologicals them under an agree §483.70(g) of this par	t. The facility may permit to administer drugs if State under the general				
	that assure the accuration dispensing, and admit	cility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident.				
	(b) Service Consultati employ or obtain the s pharmacist who					
	disposition of all conti	em of records of receipt and rolled drugs in sufficient curate reconciliation; and				
	(3) Determines that d that an account of all	rug records are in order and controlled drugs is				

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345013	B. WING			06/	
	ROVIDER OR SUPPLIER			32	TREET ADDRESS, CITY, STATE, ZIP CODE  223 CENTRAL AVENUE  CHARLOTTE, NC 28205	<u>  U6//</u>	20/2017
(X4) ID PREFIX TAG			ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	labeled in accordance professional principle appropriate accessor instructions, and the capplicable.  (h) Storage of Drugs (1) In accordance with the facility must store locked compartments controls, and permit controls, and permit controls, and permit controlled drugs listed controlled drugs listed controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distributed quantity stored is min be readily detected. This REQUIREMENT by:  Based on observation facility failed to secure which contained diabout when the cart was left "diabetic carts."	and Biologicals. Sused in the facility must be with currently accepted is, and include the yand cautionary expiration date when  and Biologicals. In State and Federal laws, all drugs and biologicals in under proper temperature only authorized personnel to eys.  In ovide separately locked, compartments for storage of it in Schedule II of the Abuse Prevention and and other drugs subject to the facility uses single unit tion systems in which the simal and a missing dose can is not met as evidenced and staff interviews the experiment in the insulin products in a cart enter the insulin products in a cart enter medication and supplies it unattended for 1 of 9	F	431	700 hall nurse received counseling and 1;1 education on drug storage. Emphas was placed on locking med carts and Diabetic carts when not in view and secure storage of all medications in locked carts when not in view.  No Residents were affected by deficient practice.  Mandatory in-service training was	sis	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345013	B. WING _			1	<b>20/2017</b>
	ROVIDER OR SUPPLIER			32	TREET ADDRESS, CITY, STATE, ZIP CODE 223 CENTRAL AVENUE HARLOTTE, NC 28205	1 00/	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	was unattended. Dur were housekeeping shallway close to the unadditional observation plastic tray on top of the and 3 insulin vials.  On 06/19/17 at 4:07 Funlocked medication interviewed and state nurse went on to explorientation and working had the key to the carnulocked while she wourse confirmed that were left unsecured worder.  On 06/20/17 at 3:30 F(DON) was interviewed expect a nurse to lock unattended and ensursecured.  483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMBIQUARTERLY/PLANS)	the 700 hallway. The cart ing the observation there taff and residents in the nlocked medication cart. In so of the cart revealed a he cart with 8 insulin pens.  PM nurse #2 approached the cart. The nurse was dishe forgot to lock it. The ain that she was in nog with another nurse who are to she decided to leave it as away from the cart. The insulin pens and insulin vials while she was away from the penson of the cart when left are all medications were  PM the Director of Nursing and and stated she would are a medication cart when left are all medications were  (i)(ii)(h)(i) QAA ERS/MEET  Int and assurance.  Intain a quality assessment ittee consisting at a		520	provided daily from 7/5-7/10 on Medication storage. Emphasis was pla on securing all meds appropriately in locked cart before leaving med cart or diabetic cart. Medications are never to left unattended on top of carts.  Audits Initiated: Customer Relations nurse,DON and weekend administrative nurse designer will complete rounds with audits daily x weeks, then 3x a week x 4 weeks then weekly x 4 weeks.  Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months.  QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.	be e .4	7/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345013	B. WING _			C 06/20/2017
	ROVIDER OR SUPPLIER	<b>.</b>	•	STREET ADDRESS, CITY, STATE, ZIP CO 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	DE .	39/20/2011
(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 C ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 520	(iii) At least three other staff, at least one of wadministrator, owner, individual in a leaders (g)(2) The quality assessment and evaluate identifying issues with assessment and assencessary; and  (ii) Develop and impleaction to correct identifying issues with assessment and assencessary; and  (ii) Develop and impleaction to correct identifying issues with assessment and assencessary; and  (ii) Develop and impleaction to correct identifying issues with assessment and assencessary; and  (ii) Disclosure of information to correct identifying issues with assence in the information to correct identifying issues with assentiation.  (i) Sanctions. Good factor committee to identifying deficiencies will not be sanctions.  This REQUIREMENT by:  Based on observation record review, the fact and Assurance Commitmelemented procedure.	er members of the facility's who must be the a board member or other ship role; and essment and assurance erly and as needed to ate activities such as a respect to which quality urance activities are ement appropriate plans of tified quality deficiencies; emation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this eith attempts by the and correct quality	F	All QAPI committee membe in-service training on QAPI pexpectations on 7/11/17. Nereviewing QAPI plans was in and in-serviced.	process and w process of	
	December 2016 and	March 2017. This was for 4 riginally cited in December		A new position was created a	and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345013	B. WING		C 06/20/2017	,
NAME OF PE	ROVIDER OR SUPPLIER	0.00.0		STREET ADDRESS, CITY, STATE, ZIP CODE	06/20/2017	
TO UNIC OF TH	TO VIDEN ON OUT FEIEN			3223 CENTRAL AVENUE		
PEAK RES	OURCES - CHARLOTTE			CHARLOTTE, NC 28205		
			CHARLOTTE, NC 20203			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLE	ETION
F 520	Continued From page	e 23	F 52	0		
	2016 on an annual re	certification survey and in		implemented for a Customer Relati	ons	
	March 2017 on a com			nurse to assist with quality improve		
	deficiencies were in the	· ·		and customer service.		
		ties of daily living, services				
		notion, provide care in		F282		
	accordance with the o	care plan and drug storage.		Resident #7 was evaluated by PT a	and OT	
	The continued failure	of the facility during two		for positioning and contracture		
		ord show a pattern of the		management. A new splint was init		
		stain an effective Quality		for residents right hand contracture		
	Assessment and Assu			Resident is trialing new splint and r	emains	
	(Resident #7 and #6).	. The findings are included.		on therapy caseload at this time.		
				Residents Care plan was updated		
	This tog is arous refer	rad to:		reflect changes in his treatment pla	n.	
	This tag is cross refer	red to.		All Residents with contractures and	1	
				splinting devices have the potential		
	1. F 282 Based on ob	servations, staff interviews		affected.		
		e facility failed to place a				
		's contracted right hand as		All residents with contractures and		
		plan for 1 of 3 sampled		splinting devices were screened by		
	residents with a contr	acture (Resident #7).		therapy to evaluate for any change	S	
	The facility was cited	in March 2017 for F 282		needed in their contracture manage	ement	
		ovide restorative nursing		treatment plan. Residents were pla	ced on	
	services as identified	on the care plan.		therapy case load if needed and		
				Comprehensive care plan was upd		
	0 F 040 Pagada:!	aconvotione stoff interviews		reflect any changes in treatment pla	an.	
		oservations, staff interviews		A. dita laitiatad.		
		e facility failed to render the day shift (Resident #6)		Audits Initiated: Customer Relations nurse, DON a	and	
		ependent resident 's toenails		weekend administrative nurse desi		
	(Resident #7) for 2 of	•		will audit splints and resident	grico	
	reviewed for activities			Comprehensive Care plans daily to		
		- · · · · · · · · · · · · · · · · · · ·		assure splints are applied per treat		
				plan and as ordered x4 weeks, the		
	The facility was cited	in March 2018 for F 312 for		week x 4 weeks then weekly x 4 we		
	failing to provide nail					
				Customer Relations nurse, will repo		
				findings of audits to the Facility Qua		
	3. F 318 Based on ob	servations, visitor interview,		Assurance /Performance Improven	nent	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345013	B. WING		_	C <b>06/20/2017</b>	
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - CHARLOTTE				STREET ADDRESS, CITY, STA 3223 CENTRAL AVENUE CHARLOTTE, NC 28205		00/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	DATE	
F 520	failed to place a hand contracted right hand range of motion for 1 a contracture (Reside The facility was cited failing to provide restorable 1. F 431 Based on obtainterviews the facility products in a cart white medications and suppurattended for 1 of 9. The facility was cited for failing to remove of the facility's Administrator was aware of the presand complaint investion Administrator explaint been incorporated into Assurance program to Administrator stated to effective auditing tool	ecord review the facility roll in a resident's to prevent further decline in of 3 sampled residents with ent #7).  in March 2017 for F 318 for prative nursing services.  eservations and staff failed to secure insuling the contained diabetic olies when the cart was left "diabetic carts."  for F 431 in December 2016 expired medications.  PM the Administrator was ained she had been the for less than 3 months but vious annual recertification	F 52	Committee monthly  QAPI team will revie evaluate need for an monitoring or modifir requirement.  F312 Resident #6 received care on 6/19/17 as a to the charge nursed catheter was also for changed.  CNA #1 received conduction on providition timely ADL care perfacilities expectation.  Resident #7 had too charge nurse on 6/20 placed on the list to this month. Resident any pain due to nail.  All Residents have the affected.  All residents had not care was given as an appropriate on 6/20. A mandatory in-service was given on ADL of 7/5,7/6,7/7,7/8,7/9 and Regional Clinical Conduction of timely and appropriate on 6/20. Administrative nursed Emphasis was placed incontinent care and of timely and appropriate on 6/20.	ew findings and ny additional ication of this ed ADL/Incontinent soon as it was boug attention. Resider bund to be leaking a bunseling and 1:1 ling appropriate and residents Tx plan and residents Tx plan and the eded and leeded and	nts and and so ist of	

l' '		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY  COMPLETED	
		345013	B. WING			C 06/20/2047	
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - CHARLOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	•	06/20/2017	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 520	Continued From page	e 25	F 52	accordance to Residents plan of Nurses were educated on their assure their assigned residents receiving timely ADL care by C that they also assist when need ADL care.  Audits Initiated: Customer Relations nurse, DON weekend administrative nurse of will complete audits of ADL car appropriate and timely incontin and nail care is received daily of then 3x a week x 4 weeks then weeks.  Customer Relations nurse will findings of audits to the Facility Assurance /Performance Improce Committee monthly x 3 months.  QAPI team will review findings evaluate need for any additional monitoring or modification of the requirement.  F318  Resident #7 was evaluated by for positioning and contracture management. A new splint was for residents right hand contract Resident is trialing new splint and therapy caseload at this time. Residents Care plan was update reflect changes in his treatment.  All Residents with contractures splinting devices have the pote affected.	role to sare NA's and ded with  Nand designee re to assure rent care x4 weeks, a weekly x 4  report y Quality ovement s.  and all his  PT and OT si initiated cture. and remains related to at plan.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED  C 06/20/2017		
345013			B. WING _						
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - CHARLOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE  3223 CENTRAL AVENUE  CHARLOTTE, NC 28205			06/20/2017		
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE		
F 520	Continued From page	26	F	520	All residents with contractures and splinting devices were screened by therapy to evaluate for any changes needed in their contracture manageme treatment plan. Residents were placed therapy case load if needed and Comprehensive care plan was updated reflect any changes in treatment plan.  Audits Initiated: Customer Relations nurse, DON and weekend administrative nurse designed will audit splints and resident Comprehensive Care plans daily to assure splints are applied per treatment plan and as ordered x4 weeks, then 3x week x 4 weeks then weekly x 4 weeks.  Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months.  QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.  F431  700 hall nurse received counseling and 1;1 education on drug storage. Emphas was placed on locking med carts and Diabetic carts when not in view and secure storage of all medications in locked carts when not in view.  No Residents were affected by deficient practice.	on I to e It ass.			

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 _				С			
		343013				06/2	20/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
DEAK RE	SOURCES - CHARLOTTE	<u>.</u>		3223 CENTRAL AVENUE			
ILANINE	DOUROLO - OFFICEOTTE	-		CHARLOTTE, NC 28205			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 520	Continued From page	27	F 5	Mandatory in-service training of provided daily from 7/5-7/10 of Medication storage. Emphasis on securing all meds appropriately locked cart before leaving mediabetic cart. Medications are left unattended on top of carts.  Audits Initiated: Customer Relations nurse, DO weekend administrative nurse will complete rounds with audit weeks, then 3x a week x 4 we weekly x 4 weeks.  Customer Relations nurse will findings of audits to the Facility Assurance /Performance Improcommittee monthly x 3 month.  QAPI team will review findings evaluate need for any addition monitoring or modification of the requirement.	on s was place ately in d cart or never to seeks then all report provement as.	be e	

CENTERS F	FOR MEDICARE & MEDICAID SERVICES	_		"A" FORM					
STATEMENT C	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY					
	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:					
FOR SNFs ANI	) NFs	345013	B. WING	6/20/2017					
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, (	CITY, STATE, ZIP CODE	•					
PEAK RESOURCES - CHARLOTTE		3223 CENTRAL A CHARLOTTE, N							
ID	<del></del>								
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE	IT OF DEFICIENCIES							
F 153	483.10(g)(2)(3) RIGHT TO ACCESS/PU	JRCHASE COPIES OF	FRECORDS						
	(g)(2) The resident has the right to access	s personal and medical	records pertaining to him or herself.						
	herself, upon an oral or written request, in producible in such form and format (inclumaintained electronically), or, if not, in a by the facility and the individual, within	(i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and							
	(ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:								
	(A) Labor for copying the records reques	(A) Labor for copying the records requested by the individual, whether in paper or electronic form;							
	(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and								
	(C)Postage, when the individual has requ	(C)Postage, when the individual has requested the copy be mailed.							
	(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and family interviews the facility failed to provide a copy of a medical record upon written request to the family member for 1 of 1 resident reviewed for request of medical records (Resident #3).								
	The findings included:								
	Interview on 06/19/17 at 2:05 PM with the responsible party of Resident #3 revealed she submitted a written request for Resident #3's medical records on 05/24/17 to be mailed to her and that she had not yet received the records, nor had anyone at the facility given her an explanation as to why she had not received them.								
	On 06/20/17 at 11:05 AM the Medical Records Director (MRD) provided a form titled "Request for Access to Protected Health Information" which had been completed by the family member of Resident #3. The form included the following notations:								
	Medical records for the time period of 05/01/17 through 05/24/17 for Resident #3.  Family member request for the medical records for Resident #3 to be mailed to them.  Request form signed and dated by family member on 05/24/17.								

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

The above isolated deficiencies pose no actual harm to the residents

CENTERS FOR	MEDICARE & MEDICAID SERVICES	_		A FURIN		
STATEMENT OF	SOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY		
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:		
FOR SNFs AND NFs  NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - CHARLOTTE				COMPLETE.		
		345013	B. WING	6/20/2017		
		3223 CENTRAL	STREET ADDRESS, CITY, STATE, ZIP CODE  3223 CENTRAL AVENUE CHARLOTTE, NC			
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES					
F 153	Continued From Page 1					
	family member with filling out the request The MRD explained that the Administrator member and the MRD left the family merhadministrator what she needed to do about Administrator told her she was still working wanted the medical records or not.  Interview with the Administrator on 06/20 between the MRD and Resident #3's faming member was upset about whether or not Resident #3 could come back to the facilitaterm care unit when a bed became available explanation. The Administrator further start Resident #3's medical records. The administrator request.  Interview with the family member on 06/20.	t for Resident #3's means or intervened in the comber with the Administ the request for Resident with the family means of the request for Paris of the request for Resident #12:05 PM reveally member the morning desident #3 would be a Administrator stated sharp on the rehabilitation ole, then the family means the resident #12:15 PM reveals with the resident #12:15 PM reveals #12:15 PM reve	aled she intervened on the conversation g of 05/24/17 because she felt the family ble to come back to the facility and reques e explained to the family member that unit and could be moved over to the long	th		