STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conduced on 11/4/19 through 11/5/19. Eight of the ten complaint allegations were unsubstantiated. Event ID: DP7711.	F 000		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on a lunch meal tray line observation, interviews with 2 residents (Residents #4 and #8), 4 family members and staff and a test tray, the facility failed to provide foods per resident's preferences for taste and temperature (Residents #1, 2, 3, 4, 8, and 9). The findings included: 1a. Resident #1 was admitted to the facility on 9/24/19. Diagnoses included in part, Alzheimer's dementia, nutritional deficiency and anorexia. Review of a comprehensive Minimum Data Set (MDS) assessment dated 10/7/19 assessed Resident #1 with severely impaired cognition and required staff assistance with eating. A family interview occurred on 11/5/19 at 10:12 AM and revealed that Resident #1 often received cold food.	F 804	Resident #1 did not suffer any adverse outcome related to the alleged deficiency. Resident #1 is no longer a resident of the facility. On 11/22/2019 the Certified Dietary Manager affirmed with Residents #2, #3, #4, #8 and #9 or their family member that meals were being delivered according to their palatability preferences. There were no concerns reported at that time. On 11/27/2019 all residents that could communicate whether they received meals that met their palatability preferences were interviewed. Concerns identified were addressed at that time by the Certified Dietary Manager. On 11/26/2019 the Certified Dietary Manager educated the dietary staff on the proper use of menu cards and preparing	12/3/19

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

Electronically Signed | 11/27/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 1 1b. Resident #2 was admitted to the facility on 3/24/18. Diagnoses included in part, severe dementia and iron deficiency anemia. Review of a quarterly MDS assessment dated 10/9/19 assessed Resident #2 with severely impaired cognition and able to feed herself after staff set up her meal tray. A family interview occurred on 11/4/19 at 9:56 AM. The interview revealed that on 10/10/19 Resident #3 received ham for dinner that was thick, tough and difficult to cut. 1c. Resident #3 was admitted to the facility 3/12/19. Diagnoses included in part, dementia, diabetes mellitus type 2, and hyperlipidemia. Review of an annual MDS assessment dated 3/25/19 assessed Resident #3 with impaired cognition and dependent on staff for eating assistance. A family interview occurred on 11/5/19 at 11:42 AM. The interview revealed that the supper meal he received the night before was ice cold. 1d. Resident #4 was admitted to the facility 7/27/18. Diagnoses included in part, hypertension and hyperlipidemia. A quarterly MDS assessment dated 10/8/19 assessed Resident #4 with clear speech, able to be understood/understand, intact cognition and that he ate independently. Resident #4 was interviewed on 11/5/19 at 10:11 AM. The interview revealed that he always received cold food, rice was hard as a rock and the milk was served warm. He further stated that he had spoken to the Administrator and the Certified Dietary Manager (CDM), but that his dietary concerns were not resolved. 1e. Resident #8 was admitted to the facility	F 804	meals to meet the palatability preferences of residents. On 11/26/2019 the Staff Development Coordinator began educating all licensed nursing staff and certified nursing assistants on timely tray delivery to ensure that residents received meals that meet their palatability preference. All nursing and dietary staff will be educated by 12/6/2019. Staff that are on a leave of absence must complete the education with the Staff Development Coordinator or designee prior to being placed on the schedule. An audit tool has been developed. The Certified Dietary Manager/designee will conduct audits to ensure that residents are receiving meals that meet their palatability preference. The audit will be conducted for five residents on each hall weekly for four weeks, then for two residents on each hall weekly for four weeks, then for one resident on each hall weekly for four weeks. The Certified Dietary Manager will report the results of the audits to the Quality Assurance and Process Improvement Committee monthly for three months for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 2	F 804		

8/7/19. Diagnoses included in part, diabetes mellitus 2, anemia, hypertension, hyperlipidemia, coronary artery disease, and a history of a stroke. A quarterly MDS assessment dated 10/7/19 assessed Resident #8 with clear speech, able to be understood/understand, intact cognition, able to feed himself, but required encouragement with meals. Resident #8 was observed eating his lunch meal on 11/4/19 at 12:40 PM. He stated that his food was not hot and that he rarely received hot food.

1f. Resident #9 was admitted to the facility on 5/16/13. Diagnoses included in part, coronary artery disease, diabetes mellitus 2, hyperlipidemia, and dementia. A quarterly MDS assessment dated 10/24/19 assessed Resident #9 with severely impaired cognition and required limited staff assistance with meals. A family interview occurred on 11/4/19 at 9:53 AM. The interview revealed that Resident #9's food was often cold when it was received.

The CDM was interviewed on 11/4/19 at 12:29 PM and stated that he tasted the food daily, spoke to residents about the food, and that he was aware of resident concerns related to their food being served cold. The CDM stated that he noticed that the meal cart remained on the units for a while before nursing staff distributed the meal trays and that he had encouraged nursing staff to distribute meal trays as soon as the meal cart arrived on the unit so that residents would receive hot food.

An interview with the Administrator occurred on 11/5/19 at 3:20 PM and revealed he expected the dietary department to maintain/serve hot food and for nursing staff to distribute meal trays timely to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 3 provide residents with palatable/hot food. 2. An observation of the lunch meal tray line occurred on 11/4/19 at 11:30 AM. The menu included salisbury steak, sugar snap peas, mashed potatoes, a biscuit and cake. Temperature monitoring by the CDM, with a calibrated thermometer, occurred at 11:54 AM and revealed the following temperatures: Mashed potatoes, 142.2 degrees Fahrenheit (F); 109.2 degrees F when sampled. Per the recipe either cream or half and falf was an ingredient. Sugar snap peas, 179 degrees F; 128.1 degrees F when sampled Salisbury steak, 184 degrees F; 113.4 degrees F when sampled The test tray was delivered at 12:03 PM and sampled at 12:29 PM (26 minutes). There was no visible steam observed coming from the foods and the margarine required excessive mixing into the food to melt. The CDM agreed that all foods were mildly warm but not hot and stated that he did not like his foods hot. The CDM also agreed that the sugar snap peas had a good flavor, but a very soft/mushy texture. He also agreed that the biscuit was hard and dry. The CDM stated that the mashed potatoes were bland and could use more seasoning. He further stated that although the recipe for the mashed potatoes suggested to add cream or half and half, he advised the cook to use whole milk instead to use inventory. CDM further stated that he tasted the food daily, spoke to residents about the food, and that he was aware of resident concerns related to their food being served cold. The CDM stated that he noticed that the meal cart remained on the units for a while before nursing staff distributed the	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 4 meal trays and that he had encouraged nursing staff to distribute meal trays as soon as the meal cart arrived on the unit so that residents would receive hot food. An interview with Dietary Staff #1 (DS #1) occurred on 11/4/19 at 1:00 PM. The interview revealed that she did not follow the recipes when she prepared the mashed potatoes. DS #1 stated that she made the mashed potatoes using milk instead of cream as per the recipe. She also stated that she did not add spices that she knew residents liked to the foods as she usually did, like garlic and pepper, because those spices were not available. An interview with the Administrator occurred on 11/5/19 at 3:20 PM and revealed he expected the dietary department to follow recipes, maintain/serve hot food and for nursing staff to distribute meal trays timely to provide residents with palatable/hot food.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		12/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 5	F 842		

must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 6 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain a complete and accurate medical record of wound assessments for 1 of 3 residents reviewed for pressure ulcer care (Resident #1). The finding included: Resident #1 admitted to the facility on 09/26/19 and discharged from the facility on 10/22/19. Resident #1's diagnoses included: history of pressure ulcer of sacrum, nutritional deficiency, anorexia, and others. Review of a Resident Skin Integrity Review dated 09/26/19 revealed that on admission Resident #1 had an old scar to her coccyx area and her bilateral heels were soft. The form was completed by Nurse #1. Review of a nurses note dated 09/26/19 at 10:42 PM read in part, noted a scar on sacral area, both heels were soft with black discoloration, heel boots on while in bed. The note was signed by Nurse #1.	F 842	Resident #1 did not experience any adverse effect from documentation inaccuracy. Resident #1 was d/c from facility on October 22, 2019 and did not return to this facility. The Skin Integrity forms were audited on all new admissions for the 30 days prior to 11/4/19 to ensure accuracy of documentation. There were no additional discrepancies noted. Facility□s Initial Skin Integrity form was revised on 11/11/19 to clearly identify if the information gathered is admission, readmission, or other. The revision clearly identifies the licensed nurse completing the form and clearly identifies the date the form was completed. Education was provided to all licensed nurses by the Director of Nursing and Staff Development Coordinator. Education included power point presentation titled Documentation □ Your Best Friend □ 2019. This presentation included but was not limited to a focus on documentation accuracy. Example: Never sign a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 7 Review of a Resident Skin Integrity Review with no date provided revealed that Resident #1 had a scar to her sacrum along with dark purple or black skin discoloration that measured 6.5 centimeters (cm) by 6.6 cm. The back of the form read in part, unstageable black/purple discoloration to sacrum. The form indicated it was completed by Nurse #2. Review of a comprehensive Minimum Data Set (MDS) dated 10/07/19 revealed that Resident #1 had long and short-term memory loss and was severely impaired for daily decision making. The MDS further revealed that she required total assistance with activities of daily living and had no pressure ulcers. Review of a nurses note dated 10/04/19 at 12:16 PM read in part, skin assessment done and observed an open area to this resident's sacrum that had no bleeding noted. Loose skin around the open area was intact. Nurse in room and zinc-oxide based hydrophilic cream applied to area. The note was signed by Nurse #3. Review of a nurses note dated 10/04/19 at 12:47 PM read in part, resident has an open area on sacrum. No drainage noted. Area cleaned with normal saline or wound cleanser, pat dry and zinc-oxide based hydrophilic paste applied daily. The note was signed by Nurse #2. An interview was conducted with Nurse #1 on 11/04/19 at 10:39 AM. Nurse #1 confirmed that she had admitted Resident #1 to the facility on 09/26/19 and completed the Resident Skin Integrity Review that revealed she had an old scar on her sacrum and both of her heels had	F 842	document you did not complete; Never use another nurses name to complete a document; always date entries. Inservice training began with all licensed nurse on 11/11/2019 and will be completed by November 25, 2019. Licensed nursing staff on Leave of Absence, vacation, or PRN staff will be in serviced prior to returning to assignment. An audit tool was developed to monitor the accuracy of the revised skin integrity form. The audit was started on 11/13/19 by the DON to include all information is completed with licensed nurse signature and date of completion. Administrative nursing staff to include DON, ADON, SDC, and Unit Managers will continue to audit new up to 10 new admission revised skin integrity forms weekly for 4 weeks, then 5 a week for 4 weeks, then 5 per month x 2 months. DON will report the data from the audit to the Quality Assurance and Performance Improvement committee monthly x 3 months. The QAPI team will evaluate the data and need for any additional monitoring or modification of the requirement if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 8	F 842		

some discoloration to the them. She added that they did not normally stage or measure any wounds because the Wound Doctor visited the facility weekly and he did that. Nurse #1 confirmed that she had documented her findings of the skin assessment in the nurses note.

An interview was conducted with Nurse #2 on 11/04/19 at 11:15 AM. Nurse #2 explained that she was covering for the wound nurse for 2 weeks in late September to the first of October because the regular wound nurse was out of work. Nurse #2 stated that she mainly did treatments on a daily basis and added that she never measured wounds because the Wound Doctor would do that when he visited on a weekly basis. She stated that the Resident Skin Integrity Review form was only used on admission and confirmed she had not admitted Resident #1 to the facility on 09/26/19. Nurse #2 reviewed the Resident Skin Integrity Review form that had no date and indicated she had completed and stated, "that is not my document and I did not complete this form." Nurse #2 was unable to explain how the form was completed or why it stated she had completed it because she had not.

An interview was conduced with Nurse #3 on 11/05/19 at 2:10 PM. Nurse #3 stated that on 10/04/19 a Nurse Aide (NA) came to her and reported an open area to Resident #1's sacral area. Nurse #3 stated that when she looked at the wound it was the size of a dime, but she did not measure the wound because the wound nurse and wound doctor generally did that. She added that she notified Nurse #2 who was filling in and doing treatments while the wound nurse was out of work. She added that Nurse #2 had come to Resident #1's room and ordered and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 11/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 9	F 842		

completed the treatment of zinc-oxide based hydrophilic paste.

A follow up interview was conducted with Nurse #2 on 11/05/19 at 2:45 PM. Nurse #2 again stated that Resident Skin Integrity Review that had no date and indicated she had completed was not her documentation or hand writing. She stated that she did not ever measure wounds and stated she was only filling in for a few days as the treatment nurse.

An interview was conducted with the Director of Nursing (DON) on 11/05/19 at 4:15 PM. The DON could not explain the discrepancy in the Resident Skin Integrity Review form completed by Nurse #1 and then by Nurse #2. She stated that she expected Resident #1's medical record to be complete and accurate.

An interview was conducted with the Administrator on 11/05/19 at 4:45 PM. The Administrator stated that he expected Resident #1's medical record to be accurate and all assessments should be accurate and timely with no discrepancies. He added if we have discrepancies then as a team, we need to figure them out and decide which assessment was an accurate depiction of the resident at the time.