	-	ID HUMAN SERVICES			FORM APPROVED
		MEDICAID SERVICES		E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					с
		345013	B. WING		03/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
	SOURCES - CHARLOTTE	=		3223 CENTRAL AVENUE	
	SOURCES - CHARLOTT	-		CHARLOTTE, NC 28205	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	
				DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
	A complaint investiga	ation was conducted from			
		Event ID # 4HJV11. The			
	-	e investigated NC00197539,			
		98665, NC00198242,			
		C00197186. 1 of the 13 resulted in deficiency.			
F 600		-	F 600		3/20/23
SS=G		8	1 000		5/20/25
	§483.12 Freedom fro	m Abuse, Neglect, and			
	Exploitation				
		right to be free from abuse,			
		ation of resident property, efined in this subpart. This			
	includes but is not lim	•			
		involuntary seclusion and			
		ical restraint not required to			
	treat the resident's m	edical symptoms.			
	§483.12(a) The facilit	v must-			
	3+00.12(a) The labilit	y must-			
		e verbal, mental, sexual, or			
	physical abuse, corpo				
	involuntary seclusion	; is not met as evidenced			
	by:	is not met as concented			
	-	ns, record reviews, and		F600	
		er and Physician interviews		Affected Resident:	
		otect the resident's right to		Resident #3 currently resides in the	
		is injury for 1 of 3 residents		facility. She is being monitored by facil	
		Resident #3. Resident #3		staff to prevent any additional injuries t	
		ve a red area below her right ng on 1/22/2023 at 6:46 am		her. Resident #3 careplan interventions were reviewed by the Corporate Nurse	
		bruising under both eyes and		Manager to ensure appropriate	
	bruising in left ear on			interventions were in place. This was	
				completed on 3/16/23. Resident #3 did	L L
	Findings included:			not suffer any persistent adverse effect	ts
)=		(X6) DATE
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	
Electron	cally Signed				03/16/2023

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: 03/20/2023

						OMB NO		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			· · ·	SURVEY PLETED	
		345013	B. WING			C 03/08/2023		
AME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			03/06/2023		
		_			TRAL AVENUE			
EAK RE	SOURCES - CHARLOTTE	1		CHARLO	DTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETIO DATE	
F 600	Continued From page	e 1	F 60					
					the alleged deficient practice.			
	-	sh speaking resident, was		Desir	dents with the Potential to be			
		y on 12/30/2020 and her hronic pain, arthritis, heart		Affec				
	disease and dementia	-		All re	sidents have the potential to be			
		#0			ted by the alleged deficient prac			
		#3 medical record revealed or Aspirin 81 milligrams			facility Administrator and Directo ing reviewed the careplans of ar			
		but no other anticoagulant			ent who wanders into resident ro	•		
	medications were ord	lered.			sure that there are appropriate			
	Posidont #2's Modica	tion Administration Record			ventions in place to prevent resid sident altercations. Careplan	dent		
	was reviewed, and a			ventions were reviewed and revis	sed			
	shift indicated she dic			opropriate. This was completed o	on			
	-	3/2023 when she discharged			23. In addition, the Director of	المسل		
	to the hospital.				ing or designee interviewed all a priented residents regarding any			
	Resident #3's Care P	lan dated 3/10/2022			ents of injuries of unknown origin			
	indicated she had a b				ent to resident or staff to resider			
	Plan included an inter	lue to dementia. The Care			e. This will completed by 3/18/20 esident reported any incidents. A			
		in supervised area when out			ssment was completed on any	A SKIII		
	of bed. The Care Pla	in further included Resident		resid	ent that was unable to be intervi			
		e was Spanish with impaired			termine if there were any injuries			
	cognitions and require participating in activiti				own origin or any signs of physic e. There were no identified	Jai		
		ervention of encourage			icious injuries or other signs of			
	resident to interact wi			abus	e.			
	residents, volunteers,	, family and staff and on in activities that rely less		Sveta	emic changes:			
	• • •	ition such as exercise and			Corporate Compliance Manager			
	musical activities.			educ	ated the Administrator, Director			
		Data Set (MDS) assessment			ing and Assistant Director of			
	dated 12/5/2022 indic moderately cognitive	cated Resident #3 was v impaired. The			ing/Infection Preventionist on /2023 and 3/17/2023 on the follo	wina		
		idicated Resident #3 did not			Director of Nursing and Corporat	-		
		rbally abusive behaviors		Nurs	e Manager educated all facility s	staff		
	towards others or reje	ect care but did wander daily.			e following. This will be comple 19/2023.	ted		

Facility ID: 923280

If continuation sheet Page 2 of 21

	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION		E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	• •				PLETED	
			A. BUILDING	G		с		
		345013	B. WING				6/08/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			00/00/2020		
0.002 01 1					23 CENTRAL AVENUE			
PEAK RE	SOURCES - CHARLOTTI	E			HARLOTTE, NC 28205			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIO	
F 600	Continued From page	e 2	F 60	00				
	On 3/8/2023 at 9:38 a	am an interview was			Education included:			
	conducted by phone	with Nurse #5 and she			• A review of the Abuse Policy:			
		n 1/21/2023 on the 7:00 am			Prevention and Reporting of Abuse	э,		
		pm to 11:00 pm shifts and			Neglect, Misappropriation of resident			
	cared for Resident #3	Nurse #5 stated Resident			property, and exploitation; injuries of			
		discoloration or swelling to			unknown origin.			
		She stated Resident #3			 Signs and symptoms of abuse, 			
		she would go into other			neglect, misappropriation of resident			
		she does not remember if			property and exploitation;			
	she went into anothe			How/When & to Whom to report				
		stated when Resident #3			suspected cases of abuse, neglect,			
		tempted to stop her, she			misappropriation of resident property a			
		Nurse #5 indicated Resident			exploitation, injuries of unknown origin	ă.		
	-	en she walks, and she did rvation on 1/21/2023 as it			reasonable suspicion of crimes.Abuse Reporting Tool, which include	doo		
		r she returned from the			a review of interventions to prevent	162		
	hospital on 1/27/2023				resident to resident altercations.			
					This education was provided to ensure			
	Nurse Aide #3 was in	terviewed by phone on			residents are kept free from abuse and			
		and she stated she took			neglect, and to ensure allegations or			
		on 1/21/2023 and worked			suspicions of abuse and neglect are			
		pm. Nurse Aide #3 stated			thoroughly investigated and documente	ed		
		sident #3 frequently and the			with appropriate and timely reporting.			
		anders on the unit and walks			Any staff out on leave or PRN status wi	ill		
	without any problems	 Nurse Aide #3 stated 			be educated by the ADON/IP, Corporat	te		
	Resident #3 will go in	to another resident's room			Nurse Manager, or Director of Nursing			
	and when you try to r	edirect her, she becomes			prior to returning to duty. Any newly hire			
		ed she did not remember			staff will be educated by the ADON/IP of	or		
		to another resident's room			Human Resources Coordinator during			
		was in other rooms caring			orientation. All staff will continue to be			
		may have. Nurse Aide #1			educated on the above annually.			
	stated she did not ob							
	swelling to Resident	#3's face on 1/21/2023.			Monitoring:			
	A				An audit tool was developed which			
	-	en by Nurse #1 dated			included the following:			
		n stated Resident #3 was			Progress notes reviewed			
		ed area below her right eye			Point of Care Documentation –			
		The note further stated the			Behaviors	-		
	I inurse Practitioner Wa	as notified and the oncoming		- 1	 Care Plan Approaches – Wanderer 	IS	1	

Facility ID: 923280

If continuation sheet Page 3 of 21

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE C	CONSTRUCTION	· /	ESURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		COM	PLETED	
							С	
		345013	B. WING			03/08/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
PEAK RE	SOURCES - CHARLOTTI	E	3223 CENTRAL AVENUE CHARLOTTE, NC 28205					
0(0)15					PROVIDER'S PLAN OF CORRECTION		(1/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 600	Continued From page	e 3	F 60	00				
	shift would notify the				The Administrator, Director of Nursing	or		
		emorgeney contact.			designee will review progress notes,	01		
	On 3/6/2023 at 1:30 p	om Nurse #1 was			behavior monitoring documentation and	d		
	interviewed by phone	and stated she worked the			care plans of residents who wander inte			
		shift on 1/21/2023 and			other residents' rooms to ensure that			
		made her aware Resident			there are appropriate interventions in			
		r her right eye that looked he stated she went to check			place to prevent any potential resident resident altercation. The audits will be	10		
		she had a red area under her			done weekly x 12 weeks in morning			
		lightly swollen. Nurse #1			clinical meeting. The results of these			
		Il the Director of Nursing			audits will determine the need for furthe	ər		
		ed what she observed and			monitoring.			
	put the information in	an incident report the DON			QAPI			
	would see when she	came to work.						
					All audits will be brought to Quality			
		y Nurse #2, which was /'s investigation file, stated			Assurance and Performance Improvement (QAPI) Committee meeting	20		
	-	3 on the 7:00 am to 3:00 pm			monthly x 3 months by the Administrate	-		
		tement indicated Nurse Aide			for review and further recommendation			
		#2 it looked like Resident #3			to ensure compliance with the plan of	-		
		her eyes. Nurse #2 indicated			correction.			
		tion under both eyes and the						
		ave come from Resident #3						
	lying on her face beca	ause she had just woken up.			Compliance date 3/20/23			
	During an interview b	y phone with Nurse #2 she						
		e 7:00 am to 3:00 pm shift						
		rse Aide #1 told her during						
		shift that Resident #3 had						
		er eyes, and she went to #2 stated Resident #3 had a						
		#2 stated Resident #3 had a oth eyes but they were not						
		so stated Resident #3 had						
	been lying on the side							
		he redness. Nurse #2						
	stated she did know a	a few words in Spanish but						
		#3 if someone had hurt her.						
		Resident #3 had wandered						
	on 1/22/2023 during l	her shift but she was not on						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/20/2023 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345013	B. WING			(03/(C 08/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI	E, ZIP CODE		
				223 CENTRAL AVENUE			
PEAK RES	SOURCES - CHARLOTTE			CHARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
	Continued From page 1 to 1 observation unt the hospital on 1/27/2 did not see Resident a rooms that day but sh constantly. On 3/7/2023 at 9:42 a conducted by phone w stated she worked on to 3:00 pm shift and F her. Nurse Aide #1 st #3 that Resident #3 w under her eye, but it of Nurse Aide #1 stated her when she was not providing care but Re wandered into a room another resident. An interview was cond 3/8/2023 at 1:53 pm a from 7:00 am until 11: 1/22/2023. Nurse #3 eye was swollen and not bruised. She state what time it was wher under Resident #3's e looked like Resident # caused the swelling a stated Resident #3 wa resident's rooms and belongings. Nurse #3 residents had been ag	 4 il after she came back from 023. Nurse #2 stated she #3 go into any other resident e was not with her m an interview was with Nurse Aide #1 and she 1/22/2023 on the 7:00 am Resident #3 was assigned to ated she reported to Nurse ras red and slightly swollen lid not look like a bruise. she kept Resident #3 with tin another resident's room 		DEF		TE	DATE
	her. Nurse #3 stated little English but she v Nurse #3 stated she t	ght on for staff to redirect Resident #3 does speak a vill not use English, and hinks some of her s from Resident #3 not					

Facility ID: 923280

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CENTER STATEMENT C	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		FORM OMB NO (X3) DATE	0: 03/20/2023 1 APPROVED 0: 0938-0391 SURVEY LETED
		345013	B. WING			(
		545015				03/	08/2023
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PEAK RES	SOURCES - CHARLOTTE	1		223 CENTRAL AVENUE CHARLOTTE, NC 28205	5		
(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 CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	12:13 pm, while an of Resident #3, and stat Resident #3 on 1/23/2 pm shift. Nurse Aide Nurse #4 that Reside bruises to both her ey checked on her at the 1/23/2023. She state weekend before and I since the Friday befor During the interview a sat in her wheelchair attempt to get up and Nurse Aide #2 stated English except to say speaks Spanish is no #3 smiles when spoke Spanish. Nurse Aide on 1 on 1 observation the hospital on 1/27/2 on 1 observation befor on 1/23/2023. During an interview w 3/7/2023 at 9:04 am f 1/23/2023 and when I Nurse Aide #2 reports bruising to her eyes a went to look at Reside she had bruising on h and blue and a darke ear. He stated it look	ff. terviewed on 3/6/2023 at beervation was made of ed she was assigned to 2023 on the 7:00 am to 3:00 #2 stated she reported to int #3 had black and blue res and her left ear when I beginning of the shift on d she had not worked the had not seen Resident #3 re which was 1/20/2023. Ind observation Resident #3 in her room and did not did not have any behaviors. Resident #3 does not speak hello and the person that t working today. Resident en to but speaks only #2 stated Resident #3 was is since she returned from 023 but had not been on 1 re she went to the hospital ith Nurse #4 by phone on he stated he worked his shift began at 7:00 am ed that Resident #3 had nd left ear. He stated he ent #3's face and found that er eyes that were dark black r black bruise on her left	F 600		DEFICIENCY)		
	like it had been there	l not look new but looked a few days. Nurse #4 ied the Director of Nursing					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 03/20/2023 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345013	B. WING		_	03/	C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PEAK RE	SOURCES - CHARLOTTE	E		223 CENTRAL AVENUE CHARLOTTE, NC 28205	i		
(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 CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	at work, and the Direc incident report and ca He stated he had also to notify her of the bru and ear. On 3/7/2023 at 2:07 p conducted by phone v she stated she saw R 1/21/2023, and she d She stated on Monda call from Nurse #4 an marks under her eyes had hit her face. She facility and when she doorway she could se blackened. The Fam asked Resident #3 wl and Resident #3 state at me, but Resident # was or what they had Member stated she to what Resident #3 had On 3/7/2023 at 11:42 was held with the pre Administrator, who no facility, and she state by nursing that Resid her eyes and in her e Resident #3 had redm before and they thoug something else and d Assistant Administrato	d 9:00 am when she arrived ctor of Nursing had done the alled the Family Member. to called the Family Member using to Resident #3's face of an interview was with the Family Member, and tesident #3 on Saturday, id not have any injuries. y, 1/23/2023, she received a d he stated Resident #3 had s and he thought someone to stated she came to the got to Resident #3's ee that her eyes were ily Member stated she hat happened to her face ed the girl threw something 3 could not tell her who it thrown. The Family old the Director of Nursing told her. am a telephone interview vious Assistant o longer worked at the d it was reported to the DON ent #3 had bruising under ar on 1/23/2023. She stated tess under her eyes the day ght the redness was from id not suspect abuse. The	F 600				

	MENT OF HEALTH AN					FORM	: 03/20/2023 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345013	B. WING			03/	; 08/2023
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
			3	223 CENTRAL AVENUE			
PEAK RE	SOURCES - CHARLOTTE		C	CHARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	stated when she cam 1/23/2023, she review report from the weeke Nurse #1 wrote on 1/2 went to look at Reside #4 with her. The DON redness and swelling and she thought Resi against the bed rail ar DON stated she spok working in the facility Resident #3 on Sunda indicated that Nurse A redness under Reside thought the redness a way she sleeps on he checked on Resident and 3:00 pm and state had changed to a blue blue area in her left er Resident #3 went to th The DON indicated on was asked to go to Re Resident #7 stated th wandered into her roo roommate, Resident # and hit Resident #3. reported the injury of 1/23/2023 when Reside began to be blue and resident to resident al Resident #7 reported thrown something at F stated Resident #3 ha and had gone into oth but she did not do it ro Resident #8 was adm	/2023 at 3:31 pm and she e to work on Monday, red the 24 hour activity and and saw the note that 22/2023 and immediately ent #3 and she had Nurse N stated there was a little under Resident #3's eyes dent #3 may have been and caused the redness. The e to Nurse #2 who was and was assigned to ay, 1/22/2023, and Nurse #2 hide #1 had reported ent #3's eyes but the she and swelling was from the r face. The DON stated she #3 again between 1:00 pm ed the areas under her eyes e color and she also had a ar. The DON stated he hospital that evening. In Tuesday, 1/24/2023, she esident #7's room and the at Resident #3 had of and Resident #7's 48, had thrown something The DON stated she unknown origin on dent #3's discoloration reported the incident as buse on 1/24/2023 when	F 600				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY MPLETED
			A. BUILDING	G		С
		345013	B. WING			
	ROVIDER OR SUPPLIER	040010		STREET ADDRESS, CITY, STATE, ZIP CO		3/08/2023
	NOVIDER OR SOLT EIER			3223 CENTRAL AVENUE	DE	
PEAK RES	SOURCES - CHARLOTTE	E		CHARLOTTE, NC 28205		
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETIO DATE
F 600	Continued From page	28	F 60	0		
		not been able to interview	1.00			
	her. The DON stated					
	-	is on Resident #3's face on				
	1/23/2023 she tried to					
	application on her pho	one but Resident #3 was not				
	able to communicate	with it, the DON stated the				
	two staff members wh	no could translate were not				
	working.					
		om the Director of Nursing				
		e Aide who spoke Spanish				
		room with her on Monday,				
		her if she was in pain and				
	what happened to he					
		om the Restorative Aide was d the Director of Nursing				
		ak with Resident #3 on				
		spoke Spanish and she				
		in pain and what happened				
		torative Aide stated Resident				
	#3 stated she was no	t in pain and was incoherent				
	when she asked what	t happened to her face, her				
		and did not make sense.				
		er (NP) was interviewed by				
		1:27 pm and she saw				
		2023 between 9:00 am and				
		g had reported she had es, she did not remember				
		es, she did not remember e NP stated there was a very				
		n to Resident #3's middle,				
		zed bruised area below each				
		black area to her left inner				
		was swollen under her eyes				
		ne NP stated she questioned				
		not know of any injuries.				
		ike Resident #3 had run into				
	-	and eyes, and the injuries				
		the resident had been				
	abused The NP stat	ed that it would be out of				

Facility ID: 923280

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/20/2023 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345013	B. WING					C 08/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
				32	223 CENTRAL AVENUE			
PEAK RES	SOURCES - CHARLOTTE			С	HARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
TAG F 600	Continued From page of throwing something anything at another re- never had behaviors b During an interview w on 3/7/2023 at 3:18 p Resident #3 on Mond pm. She stated she h under her left eye and the bruising did not lo had happened recentil that it was abuse. The questioned staff to see had been hit and they An interview was cond Administrator on 3/8/2 stated he was partially investigation of Resid stated Resident #3 and had walked into some gotten fatigued and fa know what had happen when the redness und bruising. The Adminis went to the hospital at request and the next of reported to him that h woman. The Adminis not name Resident #3 she just stated that wo	 9 9 at Resident #3, to throw seident and Resident #8 had before. iith the Physician by phone m she stated she saw ay, 1/23/2023, around 12:00 had dark black, blue bruising in her left ear. She stated ok old and it looked like it by and she was concerned e Physician stated she had e if she had a fall or if she did not know at that time. cucted with the 2023 at 2:20 pm and he y involved with the ent #3's facial bruising. He nbulates and they felt she thing, or she could have fillen, and they really didn't ened to her on 1/23/2023 der her eyes changed to strator stated Resident #3 the Family Members morning another resident er roommate had hit that trator stated the resident did a st he person that was hit, oman. The Administrator 		600				
	back and interview the to have an eyewitness On 3/7/2023 at 2:07 p Family Member revea send her mother to th	the bruises we did not go e staff because we seemed s. In an interview with the led she asked the facility to e hospital when she came ter Nurse #4 notified her of						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/20/2023 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345013	B. WING _				C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PEAK RES	OURCES - CHARLOTTE	E			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 PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page Resident #3's injuries		F	300			
	stated the circumstan bruising to Resident # and the facility had sta into something as she The hospital History a the hospital Physician abuse however the Ph	I Physical dated 1/24/2023 ces surrounding the f3's eyes was not apparent, ated she may have walked e is able to walk on her own. and Physical further stated n could not rule out elder hysician felt it was less likely bility to walk unassisted.					
	1/27/23 indicated she 1/23/2023 when her of noticed she had two b complaining of genera Summary further indic Computed Tomograph for facial fractures, ce fractures, no abdomin pelvic fractures. Resi	alized pain. The Discharge					
	Resident #7's annual assessment date 1/23 mildly cognitively impa	3/2023 indicated she was					
F 610 SS=G	cognitively intact. Investigate/Prevent/C	2023 indicated she was correct Alleged Violation	F	610			3/20/23
		se to allegations of abuse, or mistreatment, the facility					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345013	B. WING			C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RES	SOURCES - CHARLOTTE	E		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 PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 610	Continued From page	e 11	F 61	10		
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged hly investigated.				
		t further potential abuse, or mistreatment while the gress.				
	designated represent	the results of all administrator or his or her ative and to other officials in e law, including to the State				
	incident, and if the all appropriate corrective This REQUIREMENT	n 5 working days of the eged violation is verified e action must be taken. is not met as evidenced				
	Nurse Practitioner, ar facility failed to compl to determine the poss	ns, record review, and staff, nd Physician interview the lete a thorough investigation sible cause of a suspicious ents reviewed for abuse		F610 Affected Resident: Resident #3 currently resides in the facility. Upon re-admission to facilit resident remained on one on one c	ty,	
	(Resident #3). A red right eye and facial sv 1/22/2023 at 6:46 am	area below Resident #3's welling was identified on which progressed to black ler both eyes and left ear on		until 3/15/2023. No known and/or witnessed events noted during this Resident continues being closely monitored by facility staff to prevent additional adverse events. Residen	time. t any t #3	
	Findings included:			did not suffer any persistent advers effects from the alleged deficient pr		
	Resident Property, ar on 1/19/2023 stated t responsible to ensure including injuries of u investigated. The pol investigation staff me	e complaints of abuse, nknown origin are licy further stated during the mbers on all shifts who have resident during the period of		Residents with the Potential to be Affected: All residents have the potential to b affected by the alleged deficient pra The facility Administrator and Direct Nursing reviewed 100% of the repo injuries of unknown origin to ensure they were fully investigated. These investigations included interviews w	actice. tor of rted e that	

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PRINTED: 03/20/2023

				LE CONSTRUCTION		NO. 0938-03	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · /			(X3) DATE SURVEY COMPLETED		
			A. BUILDING	3		С	
345013		B. WING	B WING				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		03/08/2023		
NAME OF P	ROVIDER OR SUPPLIER			3223 CENTRAL AVENUE	CODE		
PEAK RE	SOURCES - CHARLOTTE	E		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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 610	Continued From page	e 12	F 61	0			
				alert and oriented resident	s. Skin		
	Resident #3 was adm	nitted to the facility on		assessment will be comple	eted for those		
		liagnoses included chronic		residents who were not at			
		isease and dementia.		interviewed or who were r	ot alert and		
				oriented. This will be com	pleted by		
	On 3/8/2023 at 9:38 a	am an interview was		3/19/2023. All injuries of u	nknown origin		
		with Nurse #5, and she		have been fully investigate	ed. No other		
	stated she worked on	1/21/2023 on the 7:00 am		resident suffered any adve	erse effects		
	to 3:00 pm and 3:00 p	om to 11:00 pm shifts and		related to the alleged defic	cient practice.		
		Nurse #5 stated Resident					
		liscoloration or swelling to		Systemic changes:			
		She stated Resident #3		The Corporate Complianc	-		
		she would go into other		educated the Administrato			
		she did not remember if she		Nurse Manager, the Direc	-		
		ident's room on 1/21/2023.		and Assistant Director of N	-		
		n Resident #3 wandered and		Preventionist, on 3/10/202			
	you attempted to stop	-		3/17/2023. Corporate Nurse	-		
		indicated Resident #3 was valked. Nurse #5 stated no		educated facility Nurse Pr Medical Director on 3/16/2			
	one had interviewed l			Physician on 3/17/2023.	S and Allending		
		Resident #3's demeanor or if		The Corporate Nurse Mar	ager the		
		n she cared for her on		Director of Nursing, the Co	-		
	1/21/2023 from 7:00 a			Reimbursement Manager			
				Administrator educated all			
	Nurse Aide #3 was in	terviewed by phone on		be completed by 3/19/202			
		and she stated she took					
		on 1/21/2023 and worked		Education included:			
		pm. Nurse Aide #3 stated		" A review of the Abuse	Policy;		
		dent #3 frequently and she		" Prevention and Repo	•		
		on the unit and walked		Neglect, Misappropriation			
	-	. Nurse Aide #3 stated		property, and exploitation;			
		o into another resident's		unknown origin;			
		ried to redirect her, she		" Signs and Symptoms	of Abuse,		
		She stated she did not		including suspicious bruis			
	remember Resident #	#3 going into another		lacerations, cuts and swel	ling;		
		21/2023 but she was in		" How/When & to Who			
	other rooms caring fo	r residents so she may		suspected cases of abuse	-		
		stated she did not observe		misappropriation of reside			
	any bruising or swelli	ng on Resident #3's face on		exploitation, injuries of unl	(nown origin 8	1	

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		MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	COMPLETED			
	345013		A. BOILDING	A. BUILDING		
			B. WING		C 03/08/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	-		
NAME OF FROVIDER OR SOFFLIER				3223 CENTRAL AVENUE		
PEAK RE	SOURCES - CHARLOTTI	E		CHARLOTTE, NC 28205		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETIN O THE APPROPRIATE DATE	
F 610	Continued From page	e 13	F 61	0		
		e had asked her if Resident	_	reasonable suspicion of	crimes:	
		r injuries before she went		" Abuse Reporting To		
	out to the hospital on	-		a step-by-step algorithm		
				and reporting injuries of		
	A progress note writte	en by Nurse #1 dated		" Investigations include	de: interviews	
		n stated Resident #3 was		regarding any allegation		
		ed area below her right eye		injuries with all alert and		
		The note further stated the		residents (either on a pa		
		as notified and the oncoming		assignment or facility wi		
	shift would notify the	emergency contact.		appropriate); skin asses		
	$O_{\rm D} 2/6/2022$ at 1.20 r	om Nuroo #1 woo		residents who are unable		
	On 3/6/2023 at 1:30 p	ed she worked the 11:00 pm		interviewed to assess fo or other injuries of unkno	-	
		21/2023 and stated Nurse		on a particular unit or fac		
		are Resident #3 had an		appropriate);		
		eye that looked like an insect		" Keeping resident sa	fe durina	
		went to check on Resident		investigation		
		l area under her right eye,		Abuse Policy and Abuse	Reporting Tool	
		ollen. Nurse #1 stated she		have been posted in bre		
	did not call the Direct	or of Nursing (DON) but		medication rooms and n	ursing stations to	
	documented what she	e observed and put the		assist staff in identifying	reporting abuse	
	information in an incie	dent report the DON would		allegations and injuries of	of unknown origin.	
		to work. Nurse #1 stated the		This education was prov		
		DON) did talk to her about		residents are kept free fi		
		2023 when the bruising was		neglect, and to ensure a		
		#3's face. Nurse #1 stated		suspicions of abuse and		
		vhat her face looked like and		thoroughly investigated a		
		used it but did not ask her out how she acted that night		with appropriate and tim	ery reporting.	
		ed or wandering that night.		Monitoring:		
		ed of wandering that hight.		The Corporate Nurse Ma	anager will review	
	A signed statement b	y Nurse #2, which was		all investigations of injur	-	
	-	's investigation file, stated		origin and allegations of		
		3 on the 7:00 am to 3:00 pm		a complete and thorough		
		tement indicated Nurse Aide		conducted. The audits w		
		#2 it looked like Resident #3		x 12 weeks and will be s	-	
		ner eyes. Nurse #2 indicated		Administrator and Direct	or of Nursing.	
		tion under both eyes and the		The Administrator will co		
	discoloration could ha	ave come from Resident #3		all investigations of injur	ies of unknown	

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						<u>O. 0938-039</u>		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				С				
345013		B. WING			8/08/2023			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE				
PEAK RESOURCES - CHARLOTTE				3223 CENTRAL AVENUE CHARLOTTE, NC 28205				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
F 610	Continued From page	e 14	F 61	0				
				 origin and allegations of abus timely reporting. The results audits will determine the neer monitoring. QAPI All audits will be brought to Q Assurance and Performance Improvement (QAPI) Commit monthly x 3 months by the Ad for review and further recomm to ensure compliance with the correction. COMPLIANCE DATE: 3/20/2 	of these d for further Quality ttee meeting dministrator mendations e plan of			
	3/8/2023 at 1:53 pm a from 7:00 am until 11 1/22/2023. Nurse #3 eye was swollen and not bruised. She stat what time it was when under Resident #3's e looked like Resident # caused the swelling a	ducted with Nurse #3 on and she stated she worked :00 pm on 1/21/2023 and stated Resident #3's right red on Sunday, but it was red she did not remember in she found the redness eye. Nurse #3 stated it #3 had rubbed her eye and and redness. Nurse #3 andered and went into other						

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/20/2023 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345013	B. WING		_	(03/) 08/2023
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	SOURCES - CHARLOTTE		3	3223 CENTRAL AVENUE			
PEAN RES	SOURCES - CHARLOTTE			CHARLOTTE, NC 28205	5		
(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	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Resident #3 when she before, and they would to redirect Resident # not report to the Direct Resident #3's eye bei DON did not interview #3's demeanor or if sh bruising was identified stated she did not knot to Resident #3's left e bruising until she retu following weekend, w work. Nurse Aide #2 was int 12:13 pm, while an of Resident #3, and stat Resident #3 on 1/23/2 pm shift. Nurse Aide Nurse #4 that Residen bruises under both he when she checked on shift on 1/23/2023. S worked the weekend Resident #3 since Frie interview and observat wheelchair in her roor up and did not have a #2 stated Resident #3 except to say hello. F spoken to but speaks During an interview w 9:04 am he stated he when his shift began a reported that Residen eyes and ear. He stated	d been aggressive with e wandered into their rooms d put their light on for staff 3. Nurse #3 stated she did for of Nursing (DON) about ng red and swollen and the v her regarding Resident he saw any injury after the d on 1/23/2023. Nurse #3 bw the redness and swelling ye had progressed to rned to the facility on the hen she was scheduled to to servation was made of ed she was assigned to 2024 on the 7:00 am to 3:00 #2 stated she reported to ht #3 had black and blue er eyes and her right ear her at the beginning of the he stated she had not before and had not seen day, 1/20/2023. During the tion Resident #3 sat in her n and did not attempt to get ny behaviors. Nurse Aide d did not speak English Resident #3 smiles when only Spanish. ith Nurse #4 on 3/7/2023 at worked 1/23/2023 and at 7:00 am Nurse Aide #2 t #3 had bruising under her ted he went to look at	F 610		JEFICIENCY)		
	eyes and ear. He sta Resident #3's face an	ted he went to look at					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/20/2023 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345013	B. WING			03/	C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
			32	223 CENTRAL AVENUE			
PEAK RES	SOURCES - CHARLOTTE		с	HARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 610	blue and a darker black He stated it looked likk with an open hand. No bruising did not look re been there a few days had notified the Direct around 9:00 am when stated he had called the her of the bruising to 10 On 3/7/2023 at 2:07 pt conducted with the Fas stated she saw Resid 1/21/2023, and she di She stated on Monda call from Nurse #4, ar had marks under her someone had hit her fa to the facility and whe doorway she could se blackened. The Fami asked Resident #3 wh and Resident #3 state at me, but Resident # was or what they had Member stated she to what Resident #3 had On 3/7/2023 at 11:42 with the previous Assi longer worked at the fa- reported to the DON the had bruising under her 1/23/2023. She state under her eyes the dat the redness was from suspect abuse. The A	ck bruise on her right ear. e someone had slapped her lurse #4 also stated the new but looked like it had s. Nurse #4 indicated he tor of Nursing of the bruising a she arrived at work. He he Family Member to notify Resident #3's face and ear. om an interview was amily Member, and she ent #3 on Saturday, id not have any injuries. y, 1/23/2023, she received a nd he stated Resident #3 eyes and he thought face. She stated she came in she got to Resident #3's be that her eyes were ly Member stated she nat happened to her face ed the girl threw something 3 could not tell her who it thrown. The Family old the Director of Nursing	F 610				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/20/2023 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345013	B. WING			_		C 08/2023
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	00,	00,2020
					223 CENTRAL AVENUE	,		
PEAK RES	SOURCES - CHARLOTTE				HARLOTTE, NC 28205	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page Resident #3.	: 17	F	510				
	An interview was com Nursing (DON) on 3/6 stated when she cam 1/23/2023, she review report from the week Nurse #1 wrote on 1/2 went to look at Reside #4 with her. The DON redness and swelling and she thought Resid against the bed rail ar DON stated she spok working in the facility Resident #3 on Sunda indicated that Nurse A redness under Reside thought the redness a way she sleeps on he checked on Resident and 3:00 pm and state had changed to a blue blue area in her left ea Resident #3 went to the The DON indicated on was asked to go to Re Resident #7 stated the wandered into her roor roommate, Resident #3. reported the injury of 1/23/2023 when Reside began to be blue and resident- to- resident Resident #7 reported	ved the 24-hour activity and and saw the note that 22/2023 and immediately ent #3 and she had Nurse N stated there was a little under Resident #3's eyes dent #3 may have been nd caused the redness. The e to Nurse #2 who was and was assigned to ay, 1/22/2023, and Nurse #2 aide #1 had reported ent #3's eyes but she und swelling was from the r face. The DON stated she #3 again between 1:00 pm ed the areas under her eyes e color and she also had a ar. The DON stated he hospital that evening. n Tuesday, 1/24/2023, she esident #7's room and the at Resident #3 had om and Resident #7's #8, had thrown something The DON stated she unknown origin on dent #3's discoloration reported the incident as a abuse on 1/24/2023 when that Resident #8 had						
	stated Resident #3 ha	Resident #3. The DON ad a history of wandering er residents' rooms before,						

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AN SERVICES				FORM	03/20/2023 APPROVED 0.0938-0391
VIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345013	B. WING				C 08/2023
	s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIAT		(X5) COMPLETION DATE
the hospital on Thad reported the n able to interview the facility had done ents in the facility tively intact d on 3/8/2023 at Aide, who spoke Ts room with her on ed her if she was in er face. erviewed on ed the Director of y, 1/23/2023, to ask n and what estorative Aide er head "no" when spoke words that did what happened to ddministrator sent a rector of Nursing poroximately 11:30 Aide #2 and Nurse ted to speak to her sident #7 she stated es bed) did it, she r something at o stated that it her and hit her. was interviewed on saw Resident #3 on	F 610				
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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/20/2023 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345013	B. WING		_		。 08/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PEAK RE	SOURCES - CHARLOTTE	1		223 CENTRAL AVENUE CHARLOTTE, NC 28205	5		
(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	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	eyes; she did not rem The NP stated there was abrasion to Resident peanut sized bruised pea sized black area Resident #3 was swo in her ear. The NP st nursing, and they did She stated it looked li a door and hit her lip did not worry her that abused. The NP state character for Residen of throwing something anything at another re- had behaviors before During an interview wa 3/7/2023 at 3:18 pm s #3 on Monday, 1/23/2 stated she had dark b her left eye and in her bruising did not look of happened recently, an was abuse. The Physical guestioned to see if s been hit and they did A hospital History and stated the circumstan bruising to Resident # and the facility had stati into something as she The hospital Physician abuse however the P	she had bruising under her ember the specific time. vas a very small vertical #3's middle, upper lip, a area below each eye and a to her left inner ear and llen under her eyes but not ated she questioned not know of any injuries. ke Resident #3 had run into and eyes, and the injuries the resident had been ed that it would be out of t #8, the resident accused g at Resident #3, to throw esident and she had never	F 610				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/20/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345013	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PEAK RE	SOURCES - CHARLOTTE	:		223 CENTRAL AVENUE CHARLOTTE, NC 28205			
04015			I	,	PLAN OF CORRECTION		(1/5)
(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	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	20	F 610				
	The Hospital Discharg						
		ent #3 fell at the skilled					
		Discharge Summary further Physician could not rule out					
	-	at it was less likely due to					
	Resident #3's propen						
	diagnoses of dementi	а.					
	An interview was con	ducted with the					
		2023 at 2:20 pm and he					
	stated he was partiall investigation of Resid	ent #3's facial bruising. He					
	stated Resident #3 ar	nbulates and they felt she					
		ething, or she could have Illen, and they really didn't					
		ened to her on 1/23/2023					
		der her eyes changed to					
		trator stated Resident #3 t the Family Members					
	request and the next	morning anther resident					
		er roommate had hit that trator stated the resident did					
		B as the person that was hit,					
	she just stated that w	oman. The Administrator					
		sked staff who worked prior ound anything in the floor					
		oken or if Resident #3 was					
		dministrator stated after					
	-	s they did not go back and ause they seemed to have					
	an eyewitness.						

Facility ID: 923280

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