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 01/28/2016

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 No deficiencies were cited as a result of the Complaint Investigation. Event #41WB11.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156		2/26/16

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

Electronically Signed | 02/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and	F 156		

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F 156	Continued From page 2 applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with Resident Council President and staff and review of the facility's admission packet, the facility failed to provide residents with accurate contact information for the State Agency. The findings included: An observation on 01/25/16 at 3:17 PM of the facility's main hallway which led to each nursing station revealed advocacy contact information was posted above the water fountain. Further review of the contact information revealed the Division of Health Service Regulation, Licensure and Certification Section (DHSR L&C) was listed as "Division of Facility Services Certification Section and Licensure Section" and the Complaints Intake Unit (CIU) was listed as "Disability of Facility Services Complaints Branch". A review of the facility's admission packet, revised May 2015, revealed DHSR L&C was listed as "Division of Facility Services." An interview occurred on 01/26/16 at 10:44 AM with the President of Resident Council and revealed he was elected President of Resident Council in October 2015, but he was not aware of	F 156	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements. F156 • Resident affected: The president of Resident Council was met with and was updated on state agency contact information. 2/11/2016 • Other residents with the potential: A meeting was accomplished with resident council to review the updated state agency information. 2/16/2016 • Other measures: The Advocacy contact information was updated/corrected on 1/28/2016. The Complaints Intake Unit was corrected to read “Division of Health Service Regulation“ on 1/28/2016. The Admission packet was updated to reflect corrected information i.e. “Division	

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F 156	Continued From page 3 where State Advocacy contact information was posted in the facility. An interview with Social Worker #1 (SW #1) occurred on 01/27/16 at 4:06 PM and revealed she coordinated Resident Council (RC) meetings since September 2015. SW #1 stated during each meeting, she read the prior RC minutes to the residents and reviewed 2 of their rights during each meeting, but she could not recall advising the residents of where advocacy contact information was posted in the facility. ; An interview with the Administrator occurred on 01/27/16 at 4:43 PM and revealed he was the facility's Administrator for the last 7 weeks. The Administrator stated that when he came he checked the advocacy contact information to make sure the right information was posted, but he did not notice that the wrong contact name for the DHSR L&C and the CIU was posted. An interview with the Admissions Coordinator occurred on 01/28/2016 at 11:14 AM and revealed that facility's corporate office provided the contents of the admission packet and revised any documents included. The Admissions Coordinator stated she was not aware that the State Agency contact information was incorrectly listed in the admissions packet, but that she would correct this for any new admissions going forward until the corporate office could update the admission packet.	F 156	of Health Service Regulation" on 1/28/2016. • Continued Compliance: Reviewed state agency information with the resident council president on 2/11/2016. Review state agency information on 2/16/2016 and quarterly thereafter at the resident council meetings. Facility staff will be educated regarding the regulation (F158) referencing "Notice of Rights, Rules and Service changes". Education will be conducted by Administrative nursing, Staff development nurses and/or Administrator. 2/15/2016 An audit tool was developed to evaluate ongoing compliance. The audit will be completed 2x week over the next 3 months. Ongoing audits will be determined by the results of the prior 3 months of auditing. • QA: The updated state agency information will be reviewed at the QAPI committee meeting scheduled for 2/26/2016.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by	F 167		2/26/16

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F 167	Continued From page 4 Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with the Resident Council President and the Administrator, the facility failed to post a sign to notify residents of the location of the State Agency survey results. The findings included: An observation on 01/25/16 at 3:17 PM of the facility's main hallway which led to each nursing station revealed postings of advocacy contact information, but a notice of the location of the State Agency survey results was not included. A notebook was observed in the front lobby which included the State Agency survey results, but there was no sign to indicate its location. An interview occurred on 01/26/2016 at 10:44 AM with the President of Resident Council and revealed he was elected President of Resident Council in October 2015 and that he was told by a staff member that the location of the State Agency survey results would be posted, but he had not seen this posted yet. The President of Resident Council further stated that there was a bulletin board in the main lobby, but a sign to indicate the location of the State Agency survey results was included.	F 167	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements. F167 Resident affected: The resident council president was made aware of the location of the State Agency Survey results on 2/11/2016. The resident council president was also informed of the location of the postings to direct residents, families, etc. to the State Agency Survey results. 2/11/2016 Other residents with potential: During the resident council meeting held on 2/16/2016 the residents were made aware of where to find the State Agency Survey results. Other Measures:	

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	345013	A. BUILDING _____ B. WING _____	C 01/28/2016

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F 167	Continued From page 5 An interview with the Administrator occurred on 01/27/16 at 4:43 PM and revealed he was the facility's Administrator for the last 7 weeks. The Administrator stated that when he came he checked the advocacy contact information to make sure the right information was posted, but that he did not know if there was a sign which notified residents of the location of the State Agency survey results. The Administrator and surveyor walked to both nursing units and to the main lobby of the facility and the Administrator stated that he did not see a sign posted to notify residents of the location of the State Agency survey results, but that a sign should be posted.	F 167	The location of where to find the State Agency Survey results was also posted at the following locations: Main Hallway (Front), Nursing Station for Hallways 100-400, Nursing Station for Hallways 500-900, on 1/28/2016. Continued Compliance: Facility staff will be educated/in-serviced to the location of the State Agency survey results. 2/15/2016 Facility staff will be educated/in-serviced regarding the regulation requiring the residents right to State Agency survey results and that these they are to be readily accessible. Staff will be educated by Administrative nurses, staff development nurse and/or the Administrator. 2/15/2016 Daily rounds by the administrator initiated on 2/11/2016 will include the observation of signage directing residents, families etc. to the State Agency Survey results. An audit tool was developed to evaluate ongoing compliance with F167, this will be completed 2x a week for the next 3 months. Ongoing audits will be determined by the prior 3 months of auditing. QA: The right to survey results (F167) requiring the accessibility to State Agency survey results and compliance with this regulation will be reviewed at the QAPI committee meeting on 2/26/2016.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		2/26/16

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 01/28/2016

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F 323	Continued From page 6 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility record review, the facility failed to secure a multipurpose disinfectant chemical cleaner and shaving cream in a locked cabinet on a unit that housed 4 residents with wandering behaviors for 2 of 9 halls (Residents #234, #155, #200 and #90) . The findings included: The Material Safety Data Sheet (MSDS) for Alpha HP Multi-Surface Disinfectant Cleaner, recorded the following caution "Harmful if swallowed. Moderately irritating to the eyes. Mild skin irritation." The MSDS also recorded "Do not taste or swallow. Avoid contact with skin, eyes and clothing. Store in well-ventilated area. KEEP OUT OF REACH OF CHILDREN." The MSDS for shaving cream, recorded the following health hazards, "At high concentration it is irritating to the eyes. Do not expose to open flame." An observation on 01/25/16 at 1:03 PM of an unlocked spa on the 700/800 halls revealed 2 cans of 1.5 fluid ounces of shaving cream which	F 323	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements. F 323 Residents # 234, #155 ,#200 and # 90 were not affected by unsecured disinfectant cleaner and shaving cream. Those with Potential: The cabinets in all Spa areas have had locks placed to secure any potentially hazardous items. 1/29/2016. No resident has had access to potentially hazardous items 1/29/2016 Other Measures: In-service education was initiated on 1/29/16 for facility staff, including housekeeping, dietary and nursing. The	

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	345013	A. BUILDING _____ B. WING _____	C 01/28/2016

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F 323	Continued From page 7 were stored on the lower shelf of an unlocked cabinet. The cabinet was accessible to ambulatory residents and residents who ambulated via wheel chairs. The cans recorded warnings to avoid spraying in eyes, keep out of the reach of children and not to spray toward an open flame. An observation on 01/25/16 at 3:41 PM revealed the same spa on the 700/800 halls was still unlocked and the 2 cans of shaving cream were still in an unlocked cabinet as previously described. An observation on 01/26/16 at 08:38 AM revealed the spa on the 700/800 halls was still unlocked and the 2 cans of shaving cream were removed. The unlocked cabinet stored a spray bottle of Alpha HP Multi-Surface Disinfectant Cleaner on the lower shelf which was accessible to ambulatory residents and residents who ambulated via wheel chairs. The label recorded a warning to keep out of the reach of children. An observation on 01/27/16 at 09:21 AM revealed the spa on the 700/800 halls was still unlocked and the spray bottle of Alpha HP Multi-Surface Disinfectant Cleaner was still stored on the lower shelf of an unlocked cabinet as previously described. Resident #234 was admitted to the facility on 09/12/14. Diagnoses included vascular dementia and mental disorder. Review of assessments, care plan and nurses notes for Resident #234 revealed a quarterly Minimum Data Set (MDS) dated 01/18/16 which assessed Resident #234 with severely impaired cognition, required a wander guard and required redirection from	F 323	education focus was on keeping the resident environment free from potentially hazardous items. The education was/will continue to be conducted by Administrative nursing, Staff Development Nurse and the Administrator. Continued Compliance: An audit tool was developed to observe the Spa areas for secured potentially hazardous items. The audit was initiated on 1/29/16 and completed daily for 2 weeks. Then 3x a week for 4 weeks, and weekly for the next 6 weeks. Continued audits will be determined by the prior 12 weeks of audits. QA: Audit results will be review at the QAPI meeting over the next 3 months.	

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	345013	A. BUILDING _____ B. WING _____	C 01/28/2016

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PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

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F 323	Continued From page 8	F 323		

unsafe places. Resident #234 was observed from 01/26/16 - 01/27/16 on multiple occasions in her wheel chair propelling independently about the facility, including the 700/800 unit.

Resident #155 was admitted to the facility on 11/26/14. Diagnoses included dementia with behaviors. Review of assessments, care plan and nurses notes for Resident #155 revealed an annual MDS dated 12/03/15 which assessed Resident #155 with severely impaired cognition, required a wander guard and self propelled about the facility. Resident #155 was observed from 01/26/16 - 01/27/16 on multiple occasions in her wheel chair propelling about the facility, including the 700/800 unit.

Resident #200 was admitted to the facility on 02/04/15. Diagnoses included Alzheimer's disease and dementia with behaviors. Review of assessments, care plan and nurses notes for Resident #200 revealed a quarterly MDS dated 01/08/16 which assessed Resident #200 with severely impaired cognition, wandering behavior and required redirection from unsafe places.

Resident #90 was admitted to the facility on 11/30/15. Diagnoses included dementia. Review of assessments, care plan and nurses notes for Resident #90 revealed an admission MDS dated 12/07/15 which assessed Resident #90 with impaired cognition, required a wander guard and required frequent redirection out of unsafe places. Resident #90 was observed from 01/26/16 - 01/27/16 on multiple occasions in her wheel chair propelling independently about the facility, including the 700/800 unit.

An interveiw with Housekeeping Staff #1 (HS #1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 9	F 323		

occurred on 01/27/2016 at 09:23 AM. The interview revealed she typically cleaned resident rooms on the 800/900 halls and the spa for the 700/800 halls. The interview also revealed that at times she returned personal hygiene items to the nurse aide that were left in the spa. HS #1 also stated that a spray bottle of a multi-purpose disinfectant was left in the spas in a locked cabinet for nurse aides to use between resident care.

An interview with the contract company's Housekeeping/Laundry Account Manager occurred on 01/27/16 at 09:52 AM and revealed that her department left a spray bottle of a sanitizer in an unlocked spa in the unlocked top cabinet for nurse aides to use between resident care. The Account Manager stated that she rounded routinely to make sure the sanitizer was kept in the top cabinet in the spa. The Account Manager stated that in the past she found resident's personal hygiene products and the sanitizer stored in the lower cabinet which was unlocked. When this occurred the Account Manager stated she moved the sanitizer to the top cabinet and advised the Director of Nursing (DON) of the items found. The Account Manager further stated that she had not informed the Interim DON of any items found in an unlocked cabinet of the spa.

An observation of the unlocked 700/800 hall spa occurred on 01/27/16 at 10:24 AM with the Account Manager and revealed a spray bottle of HP Multi-Surface Disinfectant Cleaner was stored in an unlocked lower cabinet which was accessible to ambulatory residents and residents who propelled in wheel chairs. The Account Aanager stated that the disinfectant cleaner

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F 323	Continued From page 10 should be stored in the upper cabinet or a locked cabinet. The Account Manager further stated that the facility had residents with wandering behaviors and there was a potential that a resident could wander into the spa since the spa remained unlocked. An interview with Nurse Aide #1 (NA #1) occurred on 01/27/16 at 11:01 AM and revealed she worked on the 700 hall and used the disinfectant cleaner stored in the spa to clean the shower room and shower equipment. NA #1 stated she stored the disinfectant cleaner in a locked cabinet because Resident #155 was a confused Resident with wandering behaviors and self propelled about the facility. An interview with Nurse Aide #2 occurred on 01/27/16 at 11:06 AM and revealed she worked on the 800 hall and used the disinfectant cleaner stored in the spa to clean the shower bed. NA #2 stated the disinfectant should remain in a locked cabinet because of residents who wandered. An interview occurred on 01/28/2016 at 4:23 PM with the Interim DON revealed she expected nurse aides to store chemicals in a locked cabinet in the spa due to confused residents with wandering behaviors. The Interim DON identified Residents #90, #234, #155 and #200 as confused residents with wandering behaviors who required supervision and redirection.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356		2/26/16

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F 356	Continued From page 11 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interview, the facility failed to update the nurse staffing data on a daily basis in the front lobby for 2 of 4 days of the survey conducted from 1/25/16 - 1/28/16. Findings included: On 1/27/16 at 9:00 AM, observation revealed the posted staffing in the front lobby was still dated	F 356	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory	

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 01/28/2016

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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 356	Continued From page 12 for 1/26/16. At 2:30 PM on 1/27/16, observation revealed the posted staffing in the front lobby was still dated for 1/26/16. On 1/28/16 at 8:20 AM, observation revealed the posted staffing in the front lobby was still dated for 1/26/16. At 12:30 PM on 1/28/16, observation revealed the posted staffing in the front lobby was still dated for 1/26/16. During an interview on 01/28/16 at 12:45 PM, the staffing coordinator said she was responsible for updating and posting the staffing daily. She stated there was a master copy of staffing posted by the time clock. Staffing changes are done daily and posted in the staffing books at each nursing station. She stated she was also responsible for updating the staffing data posted in the front lobby on a daily basis as well. Observation on 01/28/16 at 2:30 PM revealed the posted staffing in the front lobby had been changed to reflect staffing on 01/28/16.	F 356	requirements. F356 No resident was affected by the nurses staffing data information not being posted daily. Those with potential: Education was conducted by Staff Development Coordinator regarding the regulation F356 i.e.: nurses staffing information must be posted daily. The education was provided to All Facility Departments. 2/15/2016. Continued compliance: An audit tool was developed to observe the nurse staffing information. The audit will be done daily for 2 weeks, then 3x week for 4 weeks, then weekly for 6 weeks. Ongoing audits will be determined by the prior 12 weeks of audits. QA: results of the audits will be reviewed at the QAPI meeting over the next 3 months.	