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 06/20/2017

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 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews the facility neglected to perform wound care to 3 existing pressure ulcers for 1 of 3 residents reviewed for wound care (Resident #5). The findings included: Based on observation, record reviews, and staff interviews the facility failed to complete dressing changes as ordered to treat pressure ulcers for 1 of 3 sampled residents with wound care (Resident # 5). The findings included:	F 224	All wounds for Resident #5 were assessed by ADON and administrator on 6/20/2017 to assess for wound deterioration as a result of the missed treatment to sacrum and bilateral heels on 6/18/2017. No deterioration was observed as a result of the missed treatment. Observation and comparison of Vohra wound physician notes dated 6/13/17 and 6/20/17 showed no significant change in wounds with actual slight improvement noted to Right heel and sacrum. Nurse #4 received counseling and 1:1 education by regional corporate nurse	7/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/11/2017

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F 224	Continued From page 1 Resident #5 admitted to the facility on 03/17/17 with diagnoses that included pressure ulcer of the sacrum and non- Alzheimer's dementia. Review of a physician order dated 03/21/17 read in part, clean sacral wound with normal saline or wound cleanser, pat dry, apply anasept (medicated gel) gel, cover with sterile gauze, and dry dressing daily and as needed. Review of the most recent comprehensive minimum data set (MDS) dated 03/23/17 revealed that Resident #5 was severely cognitively impaired for daily decision making and required extensive assistance of 2 staff members with bed mobility. The MDS further revealed that Resident #5 had 1 Stage 4 pressure ulcer (PU) and 2 Unstageable PUs on admission. Review of a physician order dated 05/30/17 read in part, clean right and left heel ulcer with normal saline or wound cleanser, pat dry, apply wet sterile gauze with dakin (medicated wound cleanser) solution, cover with dry dressing and wrap with kerlix daily and as needed. Review of the June 01, 2017 through June 30, 2017 Treatment Administration Record (TAR) revealed that dressing changes for the sacrum, left heel, and right heel had been initialed, indicating they were completed on 06/17/17 by Nurse #3. None of the dressing changes (sacrum, left heel and right heel) had been initialed on 06/18/17, indicating that the dressing changes had not been completed. Observation of wound care with Resident #5 was made on 06/19/17 at 11:05 AM. The wound nurse was observed to don gloves and remove the	F 224	consultant on the importance of and facility expectation of completing treatments as ordered by the physician. All residents with pressure ulcers have the potential to be affected. All residents with pressure ulcers were assessed by clinical team on 6/25/17 to assure treatments were appropriate with interventions in place to promote wound healing and that treatments were being completed as ordered. Team consisted of Administrator, Tx nurse, Customer Relations nurse and dietary manager. Weekly QAPI wound meetings were initiated to review wound progress as well as treatment records and results of daily audits in place. Mandatory in-service was conducted on 7/5,7/6,7/7,7/8,7/9, and 7/10 by Regional Clinical consultant and administrative nurse designee. Emphasis was placed on importance and facilities expectation to complete treatments as ordered by MD. Audits Initiated: DON, Customer Relations nurse and weekend administrative nurse designee will audit treatment records daily to assure treatments were completed as ordered x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months.	

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F 224	Continued From page 2 dressing from Resident #5's sacral area and bilateral heels, all 3 dressings were dated 06/17/17 and contained moderate amount of drainage. The wound nurse was observed to clean all 3 PU's and apply new dressings as ordered. When the dressings were completed each was dated and initialed by the wound nurse. A review of the daily assignment sheet dated 06/18/17 revealed that Nurse #4 was responsible for Resident #5's unit on 06/18/17. An interview with Nurse # 4 was conducted on 06/20/17 at 11:24 AM. Nurse #4 confirmed that she was the nurse responsible for Resident #5's unit on 06/18/17. Nurse #4 stated that she did a couple of treatment changes on the 500 unit but did not recall performing Resident #5's wound care. Nurse #4 confirmed that the ordered wound care would be her responsibility but she could not recall performing the ordered dressing changes to Resident #5. An interview was conducted with the Director of Nursing (DON) on 06/20/17 at 1:30 PM. The DON stated that she expected the nurse who was responsible for the unit to complete the ordered wound care during his/her shift. She added that if the wound care was not completed she should have been notified so she could have corrected the situation. The DON confirmed she was unaware that the wound care had not been completed. An interview with the Clinical Care Coordinator for the 500 unit was conducted on 06/20/17 at 3:45 PM. The Clinical Care Coordinator stated that if there was not a wound nurse in the facility then it was the responsibility of the hall nurse to	F 224	QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.	

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F 224	Continued From page 3 complete the wound care. The Clinical Care Coordinator added that if Nurse #4 was responsible for the 500 unit then she should have completed the ordered wound care.	F 224		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to place a hand roll in a resident ' s contracted right hand as specified on the care plan for 1 of 3 sampled residents with a contracture (Resident #7). The findings included: Resident #7 was re-admitted to the facility on 03/21/13 with diagnoses that included traumatic brain injury, hemiplegia and others. The most recent Minimum Data Set (MDS) dated 03/16/17 specified the resident's cognition was severely impaired, he did not reject care and had no identified behaviors but required extensive assistance from staff for activities of daily living. The MDS also specified the resident had upper and lower extremity impairment on one side, was not receiving therapy services or restorative	F 282	Resident #7 was evaluated by PT and OT for positioning and contracture management. A new splint was initiated for residents right hand contracture. Resident is trialing new splint and remains on therapy caseload at this time. Residents Care plan was updated to reflect changes in his treatment plan. All Residents with contractures and splinting devices have the potential to be affected. All residents with contractures and splinting devices were screened by therapy to evaluate for any changes needed in their contracture management treatment plan. Residents were placed on therapy case load if needed and Comprehensive care plan was updated to reflect any changes in treatment plan.	7/13/17

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F 282	Continued From page 4 nursing services. A care plan updated on 06/19/17 to minimize Resident #7's risk for further decline specified a hand roll was to be placed in his right hand. On 06/19/17 at 3:55 PM observations were made of Resident #7 in bed and his right hand was clenched in a fist. There was no hand roll in place. The friend asked Resident #7 if he could open his right fist, he held up his right fist but was unable to open the clenched fist. On 06/20/17 at 10:55 AM observations were made of Resident #7 in bed and his right hand was clenched in a fist and no hand roll was in place. On 06/20/17 at 2:55 PM observations were made of Resident #7 in bed and his right hand was clenched in a fist and no hand roll was in place. On 06/20/17 at 2:58 PM nurse aide (NA) #5 was interviewed and stated she was Resident #7's nurse aide. She explained that she had only care for the resident a few times but relied on other nurses and nurse aides to report if a resident required specialized care such as splints or hand rolls. The NA stated she "never" placed anything in Resident #7's right hand and knew he was unable to use his right hand. The NA was unaware the resident was to have a hand roll in his right hand.	F 282	Audits Initiated: Customer Relations nurse,DON and weekend administrative nurse designee will audit splints and resident Comprehensive Care plans daily to assure splints are applied per treatment plan and as ordered x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months. QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.	

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F 282	Continued From page 5 On 06/20/17 at 3:30 PM the Director of Nursing (DON) was interviewed and reported that nurse aides were expected to follow the interventions on a care plan.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to render incontinence care on the day shift (Resident #6) and failed to trim a dependent resident's toenails (Resident #7) for 2 of 3 residents sampled for activities of daily living. The findings included: 1. Resident #6 was readmitted to the facility on 05/19/17 with diagnoses that included hypertension, pneumonia, wound infection, diabetes mellitus, anxiety, and others. Review of the most recent quarterly minimum data set (MDS) dated 05/23/17 revealed that Resident #6 was severely cognitively impaired for daily decision making and required total assistance of two staff members with toileting. The MDS further revealed that Resident #6 required an indwelling catheter and was always incontinent of bowel. An observation of Resident #6 was made on	F 312	Resident #6 received ADL/Incontinent care on 6/19/17 as soon as it was bought to the charge nurses attention. Residents catheter was also found to be leaking and changed. CNA #1 received counseling and 1:1 education on providing appropriate and timely ADL care per residents Tx plan and facilities expectation. Resident #7 had toenails trimmed by charge nurse on 6/20/2017. He was also placed on the list to be seen by podiatrist this month. Resident denied complaint of any pain due to nail care. All Residents have the potential to be affected. All residents had nails checked and nail care was given as needed and appropriate on 6/20/17 and 6/21/17. A mandatory in-service for Nursing staff	7/13/17

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F 312	Continued From page 6 06/19/17 at 11:24 AM. Resident #6 was lying in bed with her family at bedside. Upon entering Resident #6's room there was odor of feces. Resident #6's gown was soiled with fecal matter, and there was a pillow between Resident #6's legs that contained a large yellow ring on the pillowcase. The yellow ring extended over approximately half of the pillow case and was half dried but remained slightly wet. Resident #6's family member indicated that she had come to visit her loved one at approximately 10:32 AM and found her family member in this condition. The family member stated that the pillowcase was solid and was wet through to the pillow and she was just going to throw the pillow away. An observation of incontinence care was made on 06/19/17 at 11:37 AM with Nursing Assistant (NA) #1. NA #1 was observed to enter Resident #6's room and turn Resident #6 to her right side and proceed to clean the soft formed fecal matter off of the resident's bottom. When all the fecal matter had been removed from Resident #6, the soiled pad and gown were removed from Resident #6 and replaced with clean ones. An interview with NA #1 was conducted on 06/19/17 at 11:48 AM. NA #1 confirmed that she was responsible for Resident #6 on first shift. She stated that she had not changed or rendered any care to Resident #6 since arriving at the facility for her shift at 7:00 AM. NA #1 explained that she reported for duty at 7:00 AM and started bathing another resident and by the time she had completed the other resident's bath the breakfast trays were on the hall and she did not have time to render any care to any other residents before she had to serve the breakfast meal. NA #1 explained that Resident #6 did not wear a brief	F 312	was given on ADL care on 7/5,7/6,7/7,7/8,7/9 and 7/10/17 by Regional Clinical Consultant and or Administrative nurse designee. Emphasis was placed on nail care incontinent care and facilities expectation of timely and appropriate care in accordance to Residents plan of care. Nurses were educated on their role to assure their assigned residents are receiving timely ADL care by CNA's and that they also assist when needed with ADL care. Audits Initiated: Customer Relations nurse ,DON and weekend administrative nurse designee will complete audits of ADL care to assure appropriate and timely incontinent care and nail care is received daily x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months. QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.	

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F 312	Continued From page 7	F 312		

due the wound on her bottom.

An interview with NA #2 was conducted on 06/19/17 at 4:09 PM. NA #2 confirmed that she worked third shift and was responsible for Resident #6. NA #2 stated that she last rendered care to Resident #6 at approximately 5:45 AM. She added that she checked Resident #6 approximately every two hours through the night and each time that she had checked Resident #6 she had a small amount of soft formed stool on her. She added that each time she discovered Resident #6 had the stool on her she would clean her up and place a new pad under her.

An interview was conducted with Nurse #1 on 06/20/17 at 10:47 AM. Nurse #1 confirmed that she was the nurse responsible for Resident #6 on first shift on 06/19/17 and 06/20/17. She stated that she had been in Resident #6's room on 06/19/17 at approximately 9:30 AM to administer Resident #6's medications. Nurse #1 stated she did not smell any fecal matter but she did not check to see if Resident #6 had been incontinent. Nurse #1 stated she did not know that Resident #6 needed to be cleaned up until her family came in and found her soiled. Nurse #1 stated that she expected each resident including Resident #6 to be checked for incontinence before each meal and if found soiled then to be cleaned up.

An interview with the Director of Nursing (DON) was conducted on 06/20/17 at 1:30 PM. The DON stated that Resident #6 was checked for incontinence at least every two hours but usually "much more frequently." The DON was not aware that care had not been rendered to Resident #6 until 11:37 AM on 06/19/17, and that "was unacceptable to her." The DON stated that NA #1

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should have rendered care to Resident #6 sometime earlier in the morning and if soiled then she should have cleaned her up.
2. Resident #7 was re-admitted to the facility on 03/21/13 with diagnoses that included traumatic brain injury, hemiplegia and others. The most recent quarterly Minimum Data Set (MDS) dated 03/16/17 specified the resident's cognition was severely impaired, he did not reject care and had no identified behaviors, but required extensive assistance from staff for activities of daily living. The MDS also specified the resident had upper and lower extremity impairment on one side, was not receiving therapy services or restorative nursing services.

A care plan updated on 06/19/17 specified Resident #7 needed total care from staff for personal hygiene and grooming.

Further review of the medical record revealed Resident #7 had not been seen by a Podiatrist.

On 06/19/17 at 3:35 PM Resident #7's friend was interviewed and explained the resident had been in the facility for almost 9 years following an accident and was dependent on staff for care. She explained that she had observed Resident #7's feet and noted his toenails to be long.

On 06/19/17 at 3:55 PM observations were made of Resident #7 in bed with bare feet. Observations of the Resident's feet revealed his toenail length extended a ¼ inch beyond the tips of the toes. Some of the nails were jagged.

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F 312	Continued From page 9 On 06/20/17 at 11:30 AM the Director of Nursing (DON) observed Resident #7's toenails and stated she would get a nurse to trim them due to the length. The DON explained that nurse aides were responsible for trimming nails (fingers and toes) on shower days and as needed unless the resident was a Diabetic and then the nurse would trim them. The DON stated she didn ' t know if Resident #7 was a Diabetic or not, but due to the length of the nails she wanted a nurse to trim them. On 06/20/17 at 1:35 PM nurse aide (NA) #5 was interviewed and stated nurse aides were supposed to trim nails unless the resident was a Diabetic. She reported she was assigned to Resident #7 but was unaware when he had last had his toenails trimmed and did not know they needed to be trimmed. She explained that when giving showers to residents she checked nail length and trimmed them as needed.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		7/13/17

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F 314	Continued From page 10 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews the facility failed to complete dressing changes as ordered to treat pressure ulcers for 1 of 3 sampled residents with wound care (Resident # 5). The findings included: Resident #5 admitted to the facility on 03/17/17 with diagnoses that included pressure ulcer of the sacrum and non- Alzheimer's dementia. Review of a physician order dated 03/21/17 read in part, clean sacral wound with normal saline or wound cleanser, pat dry, apply anasept (medicated gel) gel, cover with sterile gauze, and dry dressing daily and as needed. Review of the most recent comprehensive minimum data set (MDS) dated 03/23/17 revealed that Resident #5 was severely cognitively impaired for daily decision making and required extensive assistance of 2 staff members with bed mobility. The MDS further revealed that Resident #5 had 1 Stage 4 pressure ulcer (PU) and 2 Unstageable PUs on admission. Review of a physician order dated 05/30/17 read in part, clean right and left heel ulcer with normal saline or wound cleanser, pat dry, apply wet sterile gauze with dakin (medicated wound cleanser) solution, cover with dry dressing and	F 314	All wounds for Resident #5 were assessed by ADON and administrator on 6/20/2017 to assess for wound deterioration as a result of the missed treatment to sacrum and bilateral heels on 6/18/2017. No deterioration was observed as a result of the missed treatment. Observation and comparison of Vohra wound physician notes dated 6/13/17 and 6/20/17 showed no significant change in wounds with actual slight improvement noted to Right heel and sacrum. Nurse #4 received counseling and 1:1 education by regional corporate nurse consultant on the importance of and facility expectation of completing treatments as ordered by the physician. All residents with pressure ulcers have the potential to be affected. All residents with pressure ulcers were assessed by clinical team on 6/25/17 to assure treatments were appropriate with interventions in place to promote wound healing and that treatments were being completed as ordered. Team consisted of Administrator, Tx nurse, Customer Relations nurse and dietary manager. Weekly QAPI wound meetings were	

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F 314	Continued From page 11 wrap with kerlix daily and as needed. Review of the June 01, 2017 through June 30, 2017 Treatment Administration Record (TAR) revealed that dressing changes for the sacrum, left heel, and right heel had been initialed, indicating they were completed on 06/17/17 by Nurse #3. None of the dressing changes (sacrum, left heel and right heel) had been initialed on 06/18/17, indicating that the dressing changes had not been completed. Observation of wound care with Resident #5 was made on 06/19/17 at 11:05 AM. The wound nurse was observed to don gloves and remove the dressing from Resident #5's sacral area and bilateral heels, all 3 dressings were dated 06/17/17 and contained moderate amount of drainage. The wound nurse was observed to clean all 3 PU's and apply new dressings as ordered. When the dressings were completed each was dated and initialed by the wound nurse. An interview with the wound nurse was conducted on 06/19/17 at 11:30 AM. The wound nurse indicated that he worked Monday through Friday and Nurse #3 was the wound nurse on the weekends. He added that if there was not a wound nurse present in the facility then the hall nurses were responsible for completing the ordered wound care. An interview with Nurse #3 was conducted on 06/19/17 at 2:43 PM. Nurse #3 confirmed that she was the weekend treatment nurse and she worked on 06/17/17 but did not work on 06/18/17. She added that the nurse responsible for the hall would be responsible for completing the ordered wound care in her absence. Nurse #3 confirmed	F 314	initiated to review wound progress as well as treatment records and results of daily audits in place. Mandatory in-service was conducted on 7/5,7/6,7/7,7/8,7/9, and 7/10 by Regional Clinical consultant and administrative nurse designee. Emphasis was placed on importance and facilities expectation to complete treatments as ordered by MD. Audits Initiated: Customer Relations nurse ,DON and weekend administrative nurse designee will audit treatment records daily to assure treatments were completed as ordered x4 weeks, then 3x a week x 4 weeks, then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months. QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.	

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F 314	Continued From page 12	F 314		

that she had completed Resident #5's dressing changes to her sacrum, left, and right heels on 06/17/17 and she had initialed and dated each that she performed that day.

A review of the daily assignment sheet dated 06/18/17 revealed that Nurse #4 was responsible for Resident #5's unit on 06/18/17.

An interview with Nurse # 4 was conducted on 06/20/17 at 11:24 AM. Nurse #4 confirmed that she was the nurse responsible for Resident #5's unit on 06/18/17. Nurse #4 stated that she did a couple of treatment changes on the 500 unit but did not recall performing Resident #5's wound care. Nurse #4 confirmed that the ordered wound care would be her responsibility but she could not recall performing the ordered dressing changes to Resident #5.

An interview was conducted with the Director of Nursing (DON) on 06/20/17 at 1:30 PM. The DON stated that she expected the nurse who was responsible for the unit to complete the ordered wound care during his/her shift. She added that if the wound care was not completed she should have been notified so she could have corrected the situation. The DON confirmed she was unaware that the wound care had not been completed.

An interview with the Clinical Care Coordinator for the 500 unit was conducted on 06/20/17 at 3:45 PM. The Clinical Care Coordinator stated that if there was not a wound nurse in the facility then it was the responsibility of the hall nurse to complete the wound care. The Clinical Care Coordinator added that if Nurse #4 was responsible for the 500 unit then she should have

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F 314	Continued From page 13 completed the ordered wound care.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal	F 315		7/13/17

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F 315	Continued From page 14 bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to anchor a urinary catheter tubing to a resident's thigh to prevent trauma or dislodgment of the catheter for 1 of 1 resident sampled (Resident # 5). The findings included: Review of a facility policy titled "Catheter Care, Urinary" dated August 2015 read in part, "ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (NOTE: Catheter tubing should be strapped to the resident's inner thigh)." Resident # 5 was admitted to the facility on 03/17/17 with diagnoses that included: hypertension, non-Alzheimer's dementia, pressure ulcer of the sacrum, and others. Review of the most recent comprehensive minimum data set (MDS) dated 03/23/17 revealed that Resident #5 was severely cognitively impaired for daily decision making and required extensive assistance of two staff members with activities of daily living. An observation of Resident #5 was made on 06/19/17 at 10:37 AM. Resident #5 was resting in bed with eyes open. There was an indwelling catheter hanging from the side of the bed in a privacy bag. Further inspection of the catheter revealed that the catheter tubing was under Resident #5's right leg and was not secured to either leg to prevent trauma or dislodgement. Resident #5's right leg was resting on top of the	F 315	A catheter leg strap was put into place for resident #5 on 6/19/17 to anchor catheter tubing and prevent pulling on catheter. All residents with catheters have the potential to be affected All residents with catheters were assessed on 6/19/17 by DON and ADON to assure catheter leg straps were in place to anchor and secure catheter tubing. In-service training was conducted 7/5/17-7/10/17 on facilities policy and procedure for securing Foley catheter tubing and facilities expectation that all residents with catheter tubing have catheters secured by leg straps at all times unless other directive is noted for securing catheter tubing in their treatment plan. Audits Initiated: Customer Relations nurse, DON and weekend administrative nurse designee will audit catheters for placement of tubing and to assure tubing is anchored properly by leg strap daily x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months. QAPI team will review findings and	

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F 315	Continued From page 15 catheter tubing and was noted to be pulling on the catheter from the insertion site. An interview was conducted with NA #3 on 06/19/17 at 10:40 AM. NA #3 stated she had bathed Resident #5 and changed her gown but she did not want to get up. She added she would offer again later to get Resident #5 up. NA #3 stated that Resident #5's catheter tubing should always be on top her leg to prevent pulling and she must have missed that when she was providing care to the resident. NA #3 observed Resident #5 during the interview and confirmed that the catheter tubing was pulling against the insertion site. She moved the catheter to lay on top of Resident #5's right leg instead of under her leg. She added that some residents had a leg strap that secured the catheter tubing to the resident's leg but it just depended on the resident. An interview was conducted with Nurse #1 on 06/19/17 at 10:50 AM. Nurse #1 stated that the NAs provided the catheter care and she followed up to make sure it was done properly and to ensure the catheter was not leaking. Nurse #1 stated that when the resident was up in a wheelchair the catheter was placed in a privacy bag but if the resident remained in bed the catheter tubing was anchored to the resident's leg. She added that if she was aware that the catheter was not anchored she would have applied the anchor. An observation of Nurse #1 was made on 06/19/17 at 11:02 AM. Nurse #1 was observed to apply a leg band to Resident #5's right leg, securing the catheter tubing. An interview was conducted with the Director of	F 315	evaluate need for any additional monitoring or modification of this requirement.	

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F 315	Continued From page 16 Nursing (DON) on 06/20/17 at 1:30 PM. The DON stated the facility used leg straps to secure the catheter tubing to the resident's leg. She added that if Resident #5's catheter tubing was pulling or tugging then the tubing should have been anchored to Resident #5's leg.	F 315		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, visitor interview, staff interviews and record review the facility failed to place a hand roll in a resident's contracted right hand to prevent further decline in range of motion for 1 of 3 sampled residents with a contracture (Resident #7). The findings included: Resident #7 was re-admitted to the facility on 03/21/13 with diagnoses that included traumatic brain injury, hemiplegia and others. The most recent Minimum Data Set (MDS) dated 03/16/17	F 318	Resident #7 was evaluated by PT and OT for positioning and contracture management. A new splint was initiated for residents right hand contracture. Resident is trialing new splint and remains on therapy caseload at this time. Residents Care plan was updated to reflect changes in his treatment plan. All Residents with contractures and splinting devices have the potential to be affected. All residents with contractures and splinting devices were screened by	7/13/17

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F 318	Continued From page 17 specified the resident's cognition was severely impaired, he did not reject care and had no identified behaviors but required extensive assistance from staff for activities of daily living. The MDS also specified the resident had upper and lower extremity impairment on one side, was not receiving therapy services or restorative nursing services. A care plan updated on 06/19/17 to minimize Resident #7's risk for further decline specified a hand roll was to be placed in his right hand. On 06/19/17 at 3:35 PM Resident #7's friend was interviewed and explained the resident had been in the facility for almost 9 years following an accident. She explained the resident suffered right sided weakness and was supposed to have a hand roll in his right hand to prevent the hand from becoming stiff. She added that when she visited the hand roll was never in place. She added that nurse aides caring for the resident didn't know to place a hand roll in Resident #7's hand. She stated she last visited the resident on 06/18/17 and stayed throughout the day with Resident #7 and during the day, no hand roll was in place. During the visit she tried to open the resident's hand and had difficulty because the resident's hand was stiff. On 06/19/17 at 3:55 PM observations were made of Resident #7 in bed and his right hand was clenched in a fist. There was no hand roll in place. The friend asked Resident #7 if he could open his right fist, he held up his right fist but was unable to open the clenched fist.	F 318	therapy to evaluate for any changes needed in their contracture management treatment plan. Residents were placed on therapy case load if needed and Comprehensive care plan was updated to reflect any changes in treatment plan. Audits Initiated: Customer Relations nurse , DON and weekend administrative nurse designee will audit splints and resident Comprehensive Care plans daily to assure splints are applied per treatment plan and as ordered x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months. QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.	

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On 06/20/17 at 10:50 AM a restorative aide was interviewed and reported Resident #7 was not on restorative caseload.

On 06/20/17 at 10:55 AM observations were made of Resident #7 in bed and his right hand was clenched in a fist and no hand roll was in place.

On 06/20/17 at 2:46 PM Occupational Therapist (OT) #1 was interviewed and explained she was 1 of 3 occupational therapists employed at the facility. The OT stated she was not familiar with Resident #7 and was unaware of he was ever on an OT caseload. The OT reviewed Resident #7's medical record and noted a physician's order dated 04/01/13 for nursing to apply hand roll to right hand daily as tolerated. The OT stated that Resident #7 had not been on therapy caseload for over a year and therapy would rely on nursing to notify them of a change in Resident #7's condition

On 06/20/17 at 2:55 PM observations were made of Resident #7 in bed and his right hand was clenched in a fist and no hand roll was in place.

On 06/20/17 at 2:58 PM nurse aide (NA) #5 was interviewed and stated she was Resident #7's nurse aide. She explained that she had only care for the resident a few times but relied on other nurses and nurse aides to report if a resident required specialized care such as splints or hand

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F 318	Continued From page 19 rolls. The NA stated she "never" placed anything in Resident #7's right hand and knew he was unable to use his right hand. The NA was unaware the resident was to have a hand roll in his right hand. On 06/20/17 at 3:30 PM the Director of Nursing (DON) was interviewed and reported that nurse aides were expected to follow the interventions on a care plan.	F 318		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is	F 431		7/13/17

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F 431	Continued From page 20 maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure insulin products in a cart which contained diabetic medication and supplies when the cart was left unattended for 1 of 9 "diabetic carts." The findings included: On 06/19/17 at 4:02 PM an unlocked medication	F 431	700 hall nurse received counseling and 1;1 education on drug storage. Emphasis was placed on locking med carts and Diabetic carts when not in view and secure storage of all medications in locked carts when not in view. No Residents were affected by deficient practice. Mandatory in-service training was	

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F 431	Continued From page 21 cart was observed in the 700 hallway. The cart was unattended. During the observation there were housekeeping staff and residents in the hallway close to the unlocked medication cart. Additional observations of the cart revealed a plastic tray on top of the cart with 8 insulin pens and 3 insulin vials. On 06/19/17 at 4:07 PM nurse #2 approached the unlocked medication cart. The nurse was interviewed and stated she forgot to lock it. The nurse went on to explain that she was in orientation and working with another nurse who had the key to the cart, so she decided to leave it unlocked while she was away from the cart. The nurse confirmed that insulin pens and insulin vials were left unsecured while she was away from the cart. On 06/20/17 at 3:30 PM the Director of Nursing (DON) was interviewed and stated she would expect a nurse to lock a medication cart when left unattended and ensure all medications were secured.	F 431	provided daily from 7/5-7/10 on Medication storage. Emphasis was placed on securing all meds appropriately in locked cart before leaving med cart or diabetic cart. Medications are never to be left unattended on top of carts. Audits Initiated: Customer Relations nurse,DON and weekend administrative nurse designee will complete rounds with audits daily x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months. QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F 520		7/13/17

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F 520	Continued From page 22 (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in December 2016 and March 2017. This was for 4 recited deficiencies originally cited in December	F 520	All QAPI committee members received in-service training on QAPI process and expectations on 7/11/17. New process of reviewing QAPI plans was implemented and in-serviced. A new position was created and	

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F 520	Continued From page 23 2016 on an annual recertification survey and in March 2017 on a complaint survey. The deficiencies were in the areas of provide assistance with activities of daily living, services to maintain range of motion, provide care in accordance with the care plan and drug storage. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Committee (Resident #7 and #6). The findings are included. This tag is cross referred to: 1. F 282 Based on observations, staff interviews and record review the facility failed to place a hand roll in a resident's contracted right hand as specified on the care plan for 1 of 3 sampled residents with a contracture (Resident #7). The facility was cited in March 2017 for F 282 when they failed to provide restorative nursing services as identified on the care plan. 2. F 312 Based on observations, staff interviews and record review the facility failed to render incontinence care on the day shift (Resident #6) and failed to trim a dependent resident ' s toenails (Resident #7) for 2 of 3 sampled residents reviewed for activities of daily living. The facility was cited in March 2018 for F 312 for failing to provide nail care. 3. F 318 Based on observations, visitor interview,	F 520	implemented for a Customer Relations nurse to assist with quality improvement and customer service. F282 Resident #7 was evaluated by PT and OT for positioning and contracture management. A new splint was initiated for residents right hand contracture. Resident is trialing new splint and remains on therapy caseload at this time. Residents Care plan was updated to reflect changes in his treatment plan. All Residents with contractures and splinting devices have the potential to be affected. All residents with contractures and splinting devices were screened by therapy to evaluate for any changes needed in their contracture management treatment plan. Residents were placed on therapy case load if needed and Comprehensive care plan was updated to reflect any changes in treatment plan. Audits Initiated: Customer Relations nurse , DON and weekend administrative nurse designee will audit splints and resident Comprehensive Care plans daily to assure splints are applied per treatment plan and as ordered x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse, will report findings of audits to the Facility Quality Assurance /Performance Improvement	

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	345013	A. BUILDING _____ B. WING _____	C 06/20/2017

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F 520	Continued From page 24 staff interviews and record review the facility failed to place a hand roll in a resident's contracted right hand to prevent further decline in range of motion for 1 of 3 sampled residents with a contracture (Resident #7). The facility was cited in March 2017 for F 318 for failing to provide restorative nursing services. 4. F 431 Based on observations and staff interviews the facility failed to secure insulin products in a cart which contained diabetic medications and supplies when the cart was left unattended for 1 of 9 "diabetic carts." The facility was cited for F 431 in December 2016 for failing to remove expired medications. On 06/20/17 at 3:42 PM the Administrator was interviewed and explained she had been the facility's Administrator for less than 3 months but was aware of the previous annual recertification and complaint investigation citations. The Administrator explained that the areas cited had been incorporated into the facility's Quality Assurance program that met monthly. The Administrator stated the facility had developed effective auditing tools to prevent repeat deficient practice but felt the facility still had areas for improvement.	F 520	Committee monthly x 3 months. QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement. F312 Resident #6 received ADL/Incontinent care on 6/19/17 as soon as it was bought to the charge nurses attention. Residents catheter was also found to be leaking and changed. CNA #1 received counseling and 1:1 education on providing appropriate and timely ADL care per residents Tx plan and facilities expectation. Resident #7 had toenails trimmed by charge nurse on 6/20/2017. He was also placed on the list to be seen by podiatrist this month. Resident denied complaint of any pain due to nail care. All Residents have the potential to be affected. All residents had nails checked and nail care was given as needed and appropriate on 6/20/17 and 6/21/17. A mandatory in-service for Nursing staff was given on ADL care on 7/5,7/6,7/7,7/8,7/9 and 7/10/17 by Regional Clinical Consultant and or Administrative nurse designee. Emphasis was placed on nail care incontinent care and facilities expectation of timely and appropriate care in	

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F 520	Continued From page 25	F 520	accordance to Residents plan of care. Nurses were educated on their role to assure their assigned residents are receiving timely ADL care by CNA's and that they also assist when needed with ADL care. Audits Initiated: Customer Relations nurse,DON and weekend administrative nurse designee will complete audits of ADL care to assure appropriate and timely incontinent care and nail care is received daily x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months. QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement. F318 Resident #7 was evaluated by PT and OT for positioning and contracture management. A new splint was initiated for residents right hand contracture. Resident is trialing new splint and remains on therapy caseload at this time. Residents Care plan was updated to reflect changes in his treatment plan. All Residents with contractures and splinting devices have the potential to be affected.	

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F 520	Continued From page 26	F 520	All residents with contractures and splinting devices were screened by therapy to evaluate for any changes needed in their contracture management treatment plan. Residents were placed on therapy case load if needed and Comprehensive care plan was updated to reflect any changes in treatment plan. Audits Initiated: Customer Relations nurse, DON and weekend administrative nurse designee will audit splints and resident Comprehensive Care plans daily to assure splints are applied per treatment plan and as ordered x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months. QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement. F431 700 hall nurse received counseling and 1;1 education on drug storage. Emphasis was placed on locking med carts and Diabetic carts when not in view and secure storage of all medications in locked carts when not in view. No Residents were affected by deficient practice.	

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F 520	Continued From page 27	F 520	Mandatory in-service training was provided daily from 7/5-7/10 on Medication storage. Emphasis was placed on securing all meds appropriately in locked cart before leaving med cart or diabetic cart. Medications are never to be left unattended on top of carts. Audits Initiated: Customer Relations nurse, DON and weekend administrative nurse designee will complete rounds with audits daily x4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks. Customer Relations nurse will report findings of audits to the Facility Quality Assurance /Performance Improvement Committee monthly x 3 months. QAPI team will review findings and evaluate need for any additional monitoring or modification of this requirement.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345013	A. BUILDING: _____ B. WING _____	6/20/2017

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PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 153	483.10(g)(2)(3) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS

(g)(2) The resident has the right to access personal and medical records pertaining to him or herself.

(i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and

(ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:

(A) Labor for copying the records requested by the individual, whether in paper or electronic form;

(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and

(C)Postage, when the individual has requested the copy be mailed.

(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff and family interviews the facility failed to provide a copy of a medical record upon written request to the family member for 1 of 1 resident reviewed for request of medical records (Resident #3).

The findings included:

Interview on 06/19/17 at 2:05 PM with the responsible party of Resident #3 revealed she submitted a written request for Resident #3's medical records on 05/24/17 to be mailed to her and that she had not yet received the records, nor had anyone at the facility given her an explanation as to why she had not received them.

On 06/20/17 at 11:05 AM the Medical Records Director (MRD) provided a form titled "Request for Access to Protected Health Information" which had been completed by the family member of Resident #3. The form included the following notations:

Medical records for the time period of 05/01/17 through 05/24/17 for Resident #3.
Family member request for the medical records for Resident #3 to be mailed to them.
Request form signed and dated by family member on 05/24/17.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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F 153	Continued From Page 1

Interview with the MRD on 06/20/17 at 11:25 AM revealed the MRD stated she had assisted Resident #3's family member with filling out the request for Resident #3's medical records in the early morning of 05/24/17. The MRD explained that the Administrator intervened in the conversation between the MRD and the family member and the MRD left the family member with the Administrator. The MRD stated she later asked the Administrator what she needed to do about the request for Resident #3's medical records and the Administrator told her she was still working with the family member and would let her know if she still wanted the medical records or not.

Interview with the Administrator on 06/20/17 at 12:05 PM revealed she intervened on the conversation between the MRD and Resident #3's family member the morning of 05/24/17 because she felt the family member was upset about whether or not Resident #3 would be able to come back to the facility and requested the medical records because of that. The Administrator stated she explained to the family member that Resident #3 could come back to the facility on the rehabilitation unit and could be moved over to the long term care unit when a bed became available, then the family member understood and thanked her for the explanation. The Administrator further stated that the family member then told her that she no longer wanted Resident #3's medical records. The administrator could not provide documentation of the family member's rescinded request.

Interview with the family member on 06/20/17 at 12:15 PM revealed she remembered the conversation with the Administrator the morning of 05/24/17 but did not rescind her request for Resident #3's medical records.