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 01/25/2018

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 GUM711.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on an observation, interviews with 4 of 9 residents (Residents #73, #32, #16 and #38) during a Resident Council meeting and interviews with staff, the facility failed to post the results readily accessible from complaint surveys	F 577	Facility Administration failed to assure that the last two complaint survey results were placed in the Facility Survey History book. Results of the last 2 surveys and the	2/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2018

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F 577	Continued From page 1 conducted on 9/26/17 and 11/16/17. The findings included: An observation on 01/24/18 at 1:48 PM of the facility's book titled "Survey Inspection Results" located on a table in the facility's foyer revealed the results from complaint surveys conducted on 9/26/17 and 11/16/17 were not included. A Resident Council meeting conducted on 01/24/18 from 2:00 - 3:15 PM revealed 4 residents (Resident #73, #32, #16 and #38) were not aware that the State survey inspection results were available for their review. An interview on 01/24/18 at 4:09 PM with the administrator revealed she provided a copy of the 11/16/17 State survey inspection results to the receptionist to place in the "Survey Inspection Results" book and did not know why the results were not in the book. The administrator further stated that she placed a copy of the 9/26/17 State survey inspection results in the "Survey Inspection Results" book, but then removed it because she was waiting for a corrrection to that inspection. The administrator stated that she had not checked to see if the corrected copy of the 9/26/17 State surey inspection had been received. The administrator reviewed the "Survey Inspection Results" book and confirmed that the results from the 9/26/17 and 11/16/17 State survey inspections were not included. The administrator also confirmed that the correction to the 9/26/17 complaint survey had been received, but not yet placed in the book. An interview on 01/25/18 at 10:23 AM with the	F 577	location of Survey History book were Reviewed with Residents #73,#32,#16 and #38. All residents in the facility have the potential to have their resident rights affected by not having access to the most recent survey results. The survey history book was reviewed by the Administrator to assure that all survey results for the last 3 years were included in the Survey history book for review. Activity Director notified Residents in Resident council of the last two complaint survey results, the survey history book and its location. The Administrator will be responsible for printing any survey results and placing them in the survey history book. The Survey Book will be audited monthly x 6 months by the administrator to assure that any surveys complaint or annual results are posted. Audit will also be conducted to assure that book is intact with 3 years of surveys and that no items have been removed from the book. Administrator will report results of the audits to the Quality Assurance and Performance Improvement (QAPI) committee monthly x 6 months. QAPI team will evaluate need for any additional monitoring or modification of this requirement.	

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F 577	Continued From page 2 receptionist revealed she placed the results of one survey inspection that she received from the administrator in the facility's "Survey Inspection Results" book since her employment began in April 2017, but that she did not recall receiving anything else to add to the book.	F 577		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 636		2/9/18

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F 636	Continued From page 3 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to nutrition, tube feeding and hydration for 1 of 5 sampled residents with feeding tubes (Resident #107). The findings included:	F 636	Upon interview with the Contracted Registered Dietician it was discovered that she lacked a full understanding of the RAI CAA process and assumed that if all the information was covered in her progress note that she was covered in her analysis. Registered Dietician Received training on	

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F 636	Continued From page 4 Resident #107 was admitted to the facility on 12/29/17 with diagnoses which included dysphagia and diabetes mellitus. Admission orders included direction for continuous tube feeding 22 hours daily. Review of Resident #107's admission Minimum Data Set (MDS) dated 01/04/18 revealed short-term and long-term memory problems. The MDS indicated Resident #107 received over 51% or more proportion of total calories of nutrients and 501 cubic centimeters (cc.) or more average fluid intake through by parental or tube feeding. The MDS triggered the Nutrition, Feeding Tube and Dehydration/Fluid Maintenance Care Area Assessments (CAA). Review of Resident #107's Nutrition, Feeding Tube and Dehydration/Fluid Maintenance CAAs dated 01/08/18 revealed no documentation of findings with a description of the problem, contributing factors and risk factor related to nutrition, feeding tube or hydration. The CAAs listed Resident #107's medical record was reviewed, use of a feeding tube and decision to proceed to care plan There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Observations on 01/22/18 at 3:36 PM and 4:28 PM, on 01/23/18 at 9:23 AM, 10:09 AM, 1:55 PM and 2:48 PM and on 01/24/18 at 9:20 AM revealed Resident #107 used a feeding tube attached to a pump. Interview with Nurse #1 on 01/24/18 at 11:04 AM revealed Resident #107 received all fluids and	F 636	the CAA process in completing analysis of findings to support a decision to proceed or not proceed with a care plan. Training was conducted with the Registered Dietician on 1/25/18 by the Regional MDS consultant. The Nutrition, Feeding Tube, and dehydration/Fluid Maintenance CAA for Resident #107 was modified on 2/7/18 to include the analysis and decision to care plan. Resident #107 has since met short term goals and has discharged home as planned. All residents with Tube feeding have the potential to be affected by not having a complete Analysis of findings in the determination to proceed with care plan. The Triggered Nutrition,Feeding Tube and Dehydration/Fluid Maintenance CAA for all residents with tube feeding will be reviewed by Health Care Service Group Regional Dietician on 2/6/18 and 2/7/18 for detailed analysis and modified as needed. A CAA audit tool was developed. The Health Care Service Group Regional Registered Dietician will Audit all new comprehensive assessments with triggered Nutritional, Feeding Tube and Dehydration/Fluid Maintenance CAAs for detailed analysis of care plan determination. Audits will continue weekly x 3 months to assure compliance. Administrator will report findings of audits she receives from the Regional Dietician	

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F 636	Continued From page 5 nutrition through a feeding tube. Interview with the Registered Dietician (RD) on 01/24/18 at 11:28 AM revealed she wrote the Nutrition, Feeding Tube and Dehydration/Fluid Maintenance CAAs. The RD explained she did not know documentation of contributing factors, risk factors and an analysis of findings were required. Interview with the MDS Coordinator on 01/24/18 at 11:37 AM revealed she signed the CAAs when completed but did not review the CAAs for content. The MDS Coordinator reported Resident #107's Nutrition, Feeding Tube and Dehydration/Fluid Maintenance CAAs did not contain documentation of an analysis of findings. Interview with the Administrator on 01/24/18 at 11:45 AM revealed she expected staff to document a comprehensive assessment with an analysis of findings.	F 636	to the Quality Assurance and Performance Improvement (QAPI) committee monthly x 3 months. QAPI team will evaluate need for any additional monitoring or modification of this requirement.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		2/7/18

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F 693	Continued From page 6 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interviews, and record review, the facility failed to provide a tube feeding at the physician ordered flow rate for 1 of 5 sampled residents who received tube feedings (Resident #107). The findings included: Resident #107 was admitted to the facility on 12/29/17 with diagnoses which included dysphagia and diabetes mellitus. Admission orders included tube feeding at 55 cubic centimeters (cc.) per hour for 22 hours with 100 cc of water every 2 hours. Review of Resident #107's admission Minimum Data Set (MDS) dated 01/04/18 revealed short-term and long-term memory problems. The MDS indicated Resident #107 received over 51% of total calories of nutrients and 501 cubic centimeters (cc.) or more average fluid intake through by parental or tube feeding. Review of Resident #107's care plan dated 01/08/18 revealed nutritional interventions included administration of tube feeding and hydration per physician's orders.	F 693	Nurse #1 while hanging tube feeding on 1/22/18,1/23/18 and 1/24/18 did not check physician order to assure that the set rate was correct resulting in resident receiving tube feeding at a rate of 45ml/hr rather than 55ml/hr and water flushes at 120ml every 2 hrs instead of the 100 ml every 2hrs as ordered. Order for Resident #107 was clarified on 1/24/18 and MD made aware of the discrepancies. Resident was weighed on 1/24/18 with no noted weight loss. Resident was placed on weekly weights. Residents pump settings were changed on 1/24/18 by Nurse #1 to deliver 55ml/hr of tube feeding and water flushes at 100 ml every 2 hrs. All residents receiving tube feeding have the potential to be affected by tube feeding rate and or flushes being set inaccurately. All tube feeding rates and flushes were checked on 1/24/18 by Administrator and DON. All other tube feeding and flushes were running at the correct rate.	

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F 693	Continued From page 7 Review of a Registered Dietician's (RD) note dated 01/19/18 revealed Resident #107 weighed 111.4 pounds and received nutrition through a gastrostomy tube. The RD documented a rate of formula at 55 milliliters (ml.)/hour (hr.) for 22 hours with 100 ml. of water flushes every 2 hours. This provided Resident #107 with 1815 calories, 82 grams of protein and 2124 ml. of water. The RD documented the current tube feeding regimen met Resident #107's needs. Observation on 01/22/18 at 3:36 PM and at 4:28 PM revealed Resident #107's tube feeding connected to a pump. The tube feeding rate was 45 ml/hr. with a water flush setting of 120 ml. every 2 hours. Observation on 01/23/18 at 9:23 AM, 10:09 AM and at 2:48 PM revealed Resident #107's tube feeding connected to pump. The tube feeding rate was 45 ml/hr. with a water flush setting of 120 ml. every 2 hours. Observation on 01/24/18 at 9:20 AM and 11:04 AM revealed Resident #107's tube feeding connected to pump. The tube feeding rate was 45 ml/hr. with a water flush setting of 120 ml. every 2 hours. Interview on 01/24/18 at 11:05 AM with Nurse #1 revealed she hung and set Resident #107's tube feeding rate at 9:00 AM. Nurse #1 checked Resident #107's physician's orders and reported the rate should be 55 ml/hr. with a water flush of 100 ml. every 2 hours. Upon observation of Resident #107's tube feeding on 01/24/18 at 11:06 AM, Nurse #1 announced the rate was incorrect and she would	F 693	Inservice training was conducted on 1/25/18, 2/5/18 2/6/18 and 2/7/18 with all licensed nurses to include checking tube feeding rate and flush is set correctly before signing tube feeding order on MAR Q shift. A daily tube feeding and flush rate audit was started on 1/24/18. Administrative nursing staff to include DON,ADON,SDC and unit managers will continue to audit Tube feeding rate and water flush compliance. Audits will include checking tube feeding rate and water flushes against physician orders to assure compliance Audits will continue daily x 4 weeks, then 3x a week x 4 weeks, then weekly x 4 weeks. DON will report results of audits to the Quality assurance and performance Improvement (QAPI) committee monthly x 3 months. QAPI team will evaluate need for any additional monitoring or modification of this requirement	

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F 693	Continued From page 8 immediately adjust the tube feeding the correct rate of 55 ml./hr. with a water flush of 100 ml. every 2 hours. Nurse #1 explained she did not notice the rate when she hung the feeding. Interview with the Registered Dietician (RD) on 01/24/18 at 11:12 AM revealed Resident #107 should receive the tube feeding formula at a rate of 55 ml/hr. with a water flush of 100 ml. every 2 hours. The RD reported the slower rate of 45 ml./hr. did not make an appreciable difference in Resident #107's nutrition. Interview with the Director of Nursing (DON) on 01/24/18 at 11:22 AM revealed staff should follow the physician's orders and set Resident #107's tube feeding rate at 55 ml./hr and 100 ml water flushes every 2 hours. Telephone interview with Resident #107's physician on 01/25/18 at 11:06 AM revealed he expected staff to set the tube feeding and water flush rate as ordered.	F 693		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; 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	F 867	The Facility Administrator conducted a Quality Assurance and Improvement Committee Training meeting on 2/7/18. In the training the recitation of tag	2/7/18

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F 867	Continued From page 9 interventions the committee put into place in August, 2017. This was for a deficiency cited during the facility's complaint investigation and follow-up survey conducted on 08/04/17. The deficiency was in the area of comprehensive assessments. The continued failure of the facility to sustain compliance during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 483.20 (b) Comprehensive Assessments & Timing: Based on observations, staff interviews, and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to nutrition, tube feeding and hydration for 1 of 5 sampled residents with feeding tubes (Resident #107). The facility was recited for 483.20 (b) for failure to conduct a comprehensive assessment regarding nutrition, tube feeding and dehydration/fluid maintenance. The 483.20 (b) was originally cited during a complaint investigation and follow-up survey on 08/04/17 for failure to conduct a comprehensive assessment regarding cognition. Interview with the Administrator on 01/25/18 at 4:51 PM revealed the facility monitored and audited comprehensive assessments with a focus on cognitive assessments.	F 867	483.20,(F636) was discussed as the example with a group discussion to identify and discuss areas needing further improvement with our QA process and what could be done going forward to prevent reoccurrence. All residents residing at the facility have the potential to be affected by failure to sustain compliance with QAPI plans. • Facility QAPI committee members were in-serviced by the Administrator and the Director of Nursing about the Quality Assurance Performance Improvement Committee, program and procedures by 2 -6-18. The in-service objective is: • Identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan, as necessary. • The Facility committee members will understand the purpose of the QA program i.e.: to provide a means for a resident(s) care and safety issues to be resolved. • Committee members will understand how the QAPI Committee monitors issues and follows up with unresolved issues that have been identified. Systemic changes: • The QAPI policy was reviewed by the Administrator on 2-5-18, the policy states the facility shall develop, implement and	

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F 867	Continued From page 10	F 867		

maintain an ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care and to resolve identified problems. No changes to the policy were necessary.

- A tool was developed, titled Self Evaluation. The tool included the following:
  - o Does the QAPI committee have a current plan in place?
  - o Does the committee identify who is responsible to oversee the plan/project?
  - o Is the plan working?
  - o If the plan is not working have changes been put in place to improve?
  - o Is the outcome measurable?
  - o Has the project been successful?
  - o Can the plan be considered resolved?
- This tool was developed for a QAPI committee to establish the successfulness of the QAPI projects and make recommendations as necessary.

Monitoring:

- The Self-Evaluation tool will be completed by the QAPI-committee at scheduled meetings monthly.
- The Self-Evaluation tool will be utilized for 6 months; ongoing use of the tool will be determined by the prior 6 months of self-Evaluating the QAPI process.

QAPI

The results of the self-evaluation tool will be brought to the QAPI meeting monthly by the Administrator and reviewed by the QAPI team. The QAPI Team will make changes if necessary.

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