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 08/27/2021

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

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E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 08/23/21 with additional informtion obtained through 08/27/21. Therefore the exit date was changed to 08/27/21. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 465V11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 08/23/21 with additional informtion obtained through 08/27/21. Therefore the exit date was changed to 08/27/21. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. There were 6 allegations investigated and 2 were substantiated. Event ID# 465V11.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the safety of a resident	F 689	The preparation and execution of the plan of correction does not constitute	9/23/21

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

Electronically Signed | 09/20/2021

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F 689	Continued From page 1 who was at high risk for falls and was observed by staff to be drowsy when the resident was left unsupervised in her wheelchair in her room resulting in a fall. This was for 1 of 3 residents reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on 07/06/21 with diagnoses that included a cerebral infarction and anxiety disorder. A nurse's note dated 07/06/21 at 11:06 pm revealed Resident #1 was observed kneeling on the floor next to her bed twice during the evening shift. A baseline care plan dated 07/08/21 revealed Resident #1 was a high risk for falls. A physician's progress note written on 07/14/21 by the Nurse Practitioner revealed Resident #1 to be confused with cognitive impairment due to encephalopathy from a recent stroke. A nurse's note dated 07/14/21 at 1:00 PM revealed Resident #1 was observed on the floor with her head against the raised flooring in the closet. An additional nurse's note dated 07/14/21 at 1:18 PM revealed a new order was obtained to send Resident #1 to the emergency room for evaluation and treatment. A therapy note revealed during her therapy session on 07/14/21, Resident #1 was falling asleep.	F 689	agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 discharged from the facility on 7/14/2021 and has not returned. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/16/2021, the Minimum Data Set (MDS) Coordinator Nurses #1 and MDS Coordinator Nurse #2 performed an audit to review all residents fall events within the past 14 days to ensure that no other residents were affected by the alleged noncompliance. The MDS Coordinators reviewed each fall event to determine whether the fall was caused by a resident that was noted to be drowsy not being placed to bed. No other residents were found during this audit to be affected by the alleged noncompliance Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 9/16/2021, the Director of Rehabilitation (DOR) educated the Occupational Therapist (OT) regarding to resident safety principles to include ensuring that residents are not left unattended when there is the potential for harm. On 9/16/2021, the DOR began educating	

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F 689	Continued From page 2 An interview with the Nursing Supervisor on 08/23/21 at 1:45 PM revealed she was speaking to Resident #1's family member when the Director of Nursing (DON) called them to Resident #1's room where they observed her on the floor with her head in the closet. The Nursing Supervisor stated the resident appeared to have fallen from her wheelchair as the brakes were in the locked position and the resident was lying to the side with her head in the closet. The Nursing Supervisor said she had just been transported to her room after a therapy session and Resident #1's family member had just stepped into her office to review her medications and discuss the resident experiencing increased drowsiness. An interview with the DON on 08/23/21 at 1:52 PM revealed he was the staff member who found Resident #1 on the floor in her room with her head on the closet floor. The DON explained Resident #1 was unable to identify what she was doing when she fell from the wheelchair. The DON stated Resident #1's wheelchair brakes had been locked and when Resident #1 fell her feeding tube had become disconnected. The DON was unsure if a change in her anti-anxiety medication contributed to Resident #1 having increased sleepiness recently, but stated if any resident is sleepy, they should be placed back to bed for safety. An interview with the Occupational Therapist (OT) on 08/24/21 at 9:50 AM revealed she had been the primary staff member for her OT treatments. The OT stated on 07/14/21, she had been training a new therapy employee while they were treating Resident #1 in the therapy gym. She stated she recalled Resident #1 to be drowsy during the session on 7/14/21 and had to be	F 689	all therapy staff regarding safety principles to include ensuring that residents are not left unattended when there is the potential for harm. This will be completed on 9/23/2021. The DOR will educate any therapy staff that were not educated on 9/16/2021 prior to the therapy staff member working their next scheduled shift. The DOR will be responsible for tracking who has completed and who remains to be educated. All newly hired therapy staff will be educated during facility orientation by the DOR. The DOR was notified of this responsibility on 9/16/2021. To ensure that this alleged noncompliance will not recur, should a resident be found to be drowsy during the therapy session, the therapy staff member will either assist the resident to bed or inform the nurse and/or nursing assistant that the resident has returned to the room and should be assisted to bed. Each morning during the clinical morning meeting, fall events will be reviewed to ensure that the cause of the fall was not due to a resident being left unattended after a therapy session. This clinical meeting is made up of the Director of Nursing (DON), DOR, MDS Coordinators, Administrator, Social Workers, SDC, and Nurse Supervisors. The clinical team was notified of this responsibility on 9/20/2021. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 9/20/2021 an audit tool was developed by the Quality Assurance and Process Improvement Committee consisting of the	

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F 689	Continued From page 3 redirected multiple times that morning. The OT further explained she and the orientee had transported Resident #1 back to her room, placed her facing the television, and locked her brakes before leaving her alone in her room. When asked why Resident #1 was not placed back to bed, the OT stated Resident #1 required a mechanical lift and 2 staff for transfer assistance and she needed to stay up longer to build up her endurance with sitting in the chair unassisted. The OT explained she had not thought about putting Resident #1 back to bed despite her drowsiness on 07/14/21. An interview with the Physical Therapist (PT) on 08/24/21 at 11:06 AM revealed Resident #1 had been treated by the PT on the morning of 07/14/21 and had required maximum assistance to stand, required increased cues, required physical assistance to sit on the edge of the bed and unable to sit independently once in the sitting position, and experienced drowsiness during the treatment. PT stated Resident #1 had a therapy goal of staying up in the chair; however, she should have been placed back to bed when she was drowsy for safety. An interview with the Nurse Practitioner (NP) on 08/26/21 at 11:00 AM revealed she was new to the facility; however, she was able to review the routine NP's notes and indicated the NP had been aware of Resident #1's fall history. The NP stated Resident #1 should not have been left unattended in her room after being drowsy during her therapy session on 07/14/21. The NP stated Resident #1 should have been placed back in her bed for safety. An interview with the Medical Director on	F 689	Administrator, DON, SDC and Regional Nurse. The Administrator will use the audit tool to monitor whether any fall was caused by a resident that was left unattended and not put to bed. Monitoring will occur each business day for 4 weeks; then two times a week for 4 weeks; then one time a week for 4 weeks. The Administrator will report the results of the audit to the Quality Assurance and Performance Improvement Committee for tracking and trending. The date when the corrective action will be completed is September 23, 2021.	

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F 689	Continued From page 4 08/26/21 at 12:00 PM revealed he was aware of Resident #1's fall history and although no known injury occurred as a result of Resident #1's fall on 07/14/21, the treating therapist should not have left her in her wheelchair unattended after being sleepy during her therapy session and the therapist should have known to place Resident #1 back in bed to prevent her from falling.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		9/23/21

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F 842	Continued From page 5 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 842	The preparation and execution of the	

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F 842	Continued From page 6 facility failed to ensure a resident's change of condition was documented in the medical record when a cognitively impaired resident's gastrostomy (feeding) tube became dislodged, and she had to be sent to the emergency room to have the feeding tube replaced for 1 of 1 resident reviewed for safety (Resident #1). Findings included: Resident #1 was admitted to the facility on 07/06/21 with diagnoses that included a cerebral infarction, after care for a gastrostomy tube, and anxiety disorder. A review of medical record revealed no documentation of a change in condition on 07/07/21 for Resident #1 who was sent to the emergency room for evaluation and treatment after her feeding tube became dislodged. A review of the emergency room report dated 07/07/21 revealed Resident #1 was seen in the emergency room for a dislodged gastrostomy tube. The report further revealed the gastrostomy tube was unable to be replaced by emergency room staff and a trauma surgeon was consulted for replacement of the tube. The report indicated after dilation of the gastrostomy site, a new gastrostomy tube was able to be placed in the emergency room. A physician's progress note written on 07/14/21 by the Nurse Practitioner revealed Resident #1 to be confused with cognitive impairment due to encephalopathy from a recent stroke. An interview with the Nursing Supervisor on 08/23/21 at 1:45 PM revealed she recalled	F 842	plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 discharged from the facility on 7/14/2021 and has not returned. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/16/2021, the Minimum Data Set (MDS) Coordinator conducted an audit to review all residents with a change in condition requiring transfer to the hospital within the past 14 days to ensure that the change of status was documented in the medical record. No other hospital transfer events were found to be missing change of status documentation in the medical record. No additional resident was identified as having been adversely affected by the alleged deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Nurse #1 is no longer employed at Peak Resources Charlotte. On 9/16/2021, the Regional Nurse, Director of Nursing (DON) and Staff Development Coordinator (SDC) began educating all licensed nursing staff on documenting a change of resident condition in the medical record. The SDC	

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F 842	Continued From page 7	F 842		

Resident #1 to frequently fidget with her feeding tube and the feeding tube had come detached from the insertion site on 07/07/21 and had to be sent to the hospital to have the feeding tube replaced.

An interview with the DON on 08/23/21 at 1:52 PM revealed he recalled he was familiar with Resident #1's frequent pulling of her feeding tube but was unable to locate the documentation of details surrounding the tube becoming dislodged on 07/07/21 and Resident #1 being sent to the emergency room to have the feeding tube replaced. The DON indicated all changes of condition should be documented in the medical record at the time of the occurrence.

An interview with Nurse #1 on 08/25/21 at 3:23 PM revealed she worked on 07/06/21 on the night shift. Nurse #1 indicated she had been in Resident #1's room last around 5 AM when she recalled Resident #1's feeding tube intact and delivering her ordered nutrition feedings. Nurse #1 recalled she had been picking at the tube multiple times during the night.

An interview with Nurse #2 on 08/25/21 at 3:38 PM revealed she worked on 07/07/21 on day shift. Nurse #2 recalled she entered Resident #1's room and found Resident #1's feeding tube dislodged and no longer delivering her ordered nutrition feedings. Nurse #2 indicated she notified the Nurse Practitioner and received orders to send Resident #1 to the hospital for evaluation and feeding tube replacement. Nurse #2 further revealed she notified EMS of needed transport for Resident #1; however, transport to the hospital was delayed until approximately 10:30 AM secondary to non-emergency transport. Nurse #2 will educate any licensed nursing staff that were not educated on 9/16/2021 prior to the licensed nurse working their next scheduled shift. The SDC will be responsible for tracking who has completed and who remains to be educated. All newly hired licensed nurses will be educated during facility orientation by the SDC. The SDC was notified of this responsibility on 9/16/2021.
To ensure that this alleged noncompliance will not recur, each business day during the clinical morning meeting, 100 % of hospital transfer events will be reviewed to ensure that the change of status is clearly documented in the medical record. This clinical meeting is made up of the Director of Nursing (DON), MDS Coordinators, Administrator, Social Workers, SDC, and Nurse Supervisors. The clinical team was notified of this responsibility on 9/16/2021. The Nurse Supervisors are responsible for reviewing and reporting the results during the morning clinical meeting. The Administrator informed the Nurse Supervisors and educated the clinical team on 9/17/2021.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.
On 9/16/2021 an audit tool was developed by the Quality Assurance and Performance Improvement Committee consisting of the Administrator, DON, SDC and Regional Nurse. The DON will use the audit tool to monitor for clear documentation of status changes requiring a hospital transfer. Monitoring will occur each business day for 4 weeks;

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F 842	Continued From page 8 stated she had been trained to document any changes in condition in the resident's medical record and stated she thinks she must have forgotten before she completed her shift. An interview with the Medical Director (MD) on 08/26/21 at 12:00 PM revealed he was aware Resident #1 had dislodged her feeding tube and had to be sent to the emergency room to have it replaced. The MD stated he would expect a change in a resident's medical condition such as a dislodged gastrostomy tube to be documented in the medical record.	F 842	then two times a week for 4 weeks; then one time a week for 4 weeks. The DON will report the results of the audit to the Quality Assurance and Performance Committee for tracking and trending. Include dates when corrective action will be completed. The date when the corrective action will be completed is, September 23, 2021.	