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 02/20/2018

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 The Division of Health Service Regulation requested additional information to complete the survey. The exit date was extended to 2/20/18.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff, nurse practitioner (NP), and physician interviews, and record review, the facility failed to follow up and communicate STAT (without delay) lab results to the ordering nurse practitioner or on-call provider for 1 of 3 residents (Resident #1). The failed practice resulted in a delay of greater than 18 hours to treat Resident #1 who had a new onset of acute renal failure per the lab results. The findings included: Resident #1 was admitted on 10/10/17 and readmitted on 1/30/18 with diagnoses that included infection and inflammation reaction due to internal left knee prosthesis with subsequent encounters and diabetes. The record was initially reviewed on 2/19/18 as a closed record. A review of the Prospective Payment System 5	F 684	Resident #1 discharged from facility to hospital and did not return to facility upon discharge from the hospital. Upon investigation of the delay in receiving the stat lab results and calling them promptly to MD it was revealed that the lab never called the abnormal lab results to the facility as they are supposed to as part of our vendor agreement. Second shift and third shift nurse also failed to follow up on the Stat lab results. All residents in the facility have the potential to be affected by stat labs not being received and acted on timely. The Administrator and DON met with the owner of Carolina Lab to discuss reporting of critical labs values and that the lab had	3/12/18

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

Electronically Signed | 03/07/2018

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F 684	Continued From page 1 day assessment dated 2/6/18 revealed the resident was cognitively intact, required extensive to total assistance for activities of daily living (ADL), and received an antibiotic 7 out of 7 days. A review of the care plan dated 10/18/17 revealed Resident #1 required extensive levels of ADL assistance and remained at risk for a functional decline. Interventions included staff to report any further deterioration in status to the physician. A review of the NP progress note dated 2/7/18 at 2:04pm revealed Resident #1 was seen at the request of nursing for complaints of decreased level of consciousness and weaknesses. The NP indicated the resident was febrile during her visit at 100.9 Fahrenheit, had not eaten on 2/7/18, and had appeared very weak and confused. The noted included an action plan for a STAT Complete Blood Count (CBC), Basic Metabolic Panel (BMP), and Urinary Analysis (UA) related to resident being febrile and to follow up on STAT labs related to the altered mental status. A review of an order dated 2/7/18 at 2:30pm read, Complete Blood Count with Differential (CBC w/Diff); Comprehensive Metabolic Panel (CMP); UA; Urine Culture: (ALL LABS STAT). A review of the NP progress note dated 2/8/18 at 11:05am revealed Resident #1 had no improvements in mental status noted during the visit and was not answering questions or following commands on this day. The NP indicated STAT labs collected on 2/7/18 revealed Resident #1 was in acute renal failure with a Blood Urea Nitrogen (BUN) result of 38 and Creatinine result of 4.05.	F 684	failed to call results or fax the results timely. Oz Idlibi the Vice President at Carolina lab has set up new systems to have critical labs called timely. After looking at the lab systems it was decided to change lab vendors. Change in lab will not occur until April 16th. Per contract a 30 day notice has to be given to Carolina Medical Lab to end contract. Under the new lab system with CLS Lab Facility administrative nurses including DON will receive a text that they need to check the system for a critical lab value. Critical labs will also be called and faxed. To safe guard systems through transition of labs a Stat lab log form was created and imitiated to assure that all stat lab results are obtained timely. The log will be reported on every shift change between supervisors to alert the oncoming shifts of labs that are still awaiting results. The log will show the time lab was ordered, drawn and time lab results were received and time MD was notified. All Licensed Nursing staff, Physicians and physician extenders will be in-serviced on the requirement of the stat orders log by 3/12/18. In-services and training will be done by the SDC and DON. The stat lab log will be audited Daily by the DON, ADON or Weekend Supervisor. Lab log audits will continue daily x 4 weeks then 3x a week x 4 weeks then weekly x 4 weeks to assure compliance. DON will report findings of audits to the	

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F 684	Continued From page 2 A review of Resident #1's emergency room(ER) admission physical examination dated 2/8/18 at 2:18pm revealed the physician assistant (PA) documented Resident #1 was presented to the ER with encephalopathy, low-grade temperature and tachycardia from her rehab facility. The PA documented the CMP revealed acute kidney injury (AKI) with a creatinine of 4.98 compared to 1.2 on 1/30/18. BUN was 49 compared to 12 one week prior to ER assessment. Resident #1 was admitted to the hospital. An interview with Nurse #1 on 2/19/18 at 1:09pm revealed she had made the decision on 2/7/18 to not send Resident #1 to a scheduled medical appointment due to the change in mental status. She stated the Nurse Supervisor, NP, and Appointment Coordinator were notified of the decision. Nurse #1 indicated the NP assessed Resident #1 on 2/7/18 due to her concerns. Nurse # 1 stated on 2/8/18 the NP gave her orders to send the resident out and she called the sister who agreed with the decision. An interview on 2/19/18 at 1:25pm with the NP revealed she had ordered STAT labs on 2/7/18 at 2:30pm. She stated Resident #1's abnormal labs should have been called to her on 2/7/18 and was not. She explained the abnormal labs revealed Resident #1 was in acute renal failure (ARF) and if there was not a delay in getting the STAT lab results the resident would have gotten IV fluids sooner. The NP revealed the delay of receiving lab results in her professional opinion did make a big difference and Resident #1 would have most likely been sent to the hospital on 2/7/18 if the on-call provider had been called. An interview with the Lab Manager on 2/19/18 at	F 684	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 684	Continued From page 3	F 684		

2:50pm revealed Resident #1's labs dated 2/7/18 were received from the facility at 3:44pm on 2/7/18 and results were made available at 4:41pm on 2/7/18 via the electronic lab site. A faxed copy was sent to the facility at 12:39pm on 2/8/18.

An interview with Nurse #1 on 2/19/18 at 3:20pm revealed she had worked both 1st and 2nd shift on 2/7/18 and had been responsible for the care of Resident #1. She indicated it was standard for normal lab results to be put in the physician notebook once received and all abnormal lab results were reported via telephone to the NP or physician during normal business hours and to on-call after hours. Nurse #1 stated she did not receive a faxed report with lab results for Resident #1 on 2/7/18 and remembered the 3rd shift nurse asking about the results.

An interview on 2/19/18 at 3:40pm with the Administrator and DON indicated there had been ongoing problems receiving timely STAT and Critical lab results. The Administrator indicated her expectation was for STAT labs to be followed up within the 4 hour window with the lab and reported immediately to the ordering provider.

An interview with the physician responsible for Resident #1 on 2/20/18 at 3:11pm revealed he gets nervous when a Creatinine gets higher above 3.0. He stated at that point residents can go downhill quickly. He explained when he sees a Creatinine much more than 3.0 he only sits on it for a short period because there could be a blockage, sepsis, or a reaction to the kidneys from a prescribed medication. He indicated a Creatinine of 4.0 to 6.0 can mean dialysis for the patient. The Physician stated the whole interface

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F 684	Continued From page 4 with the lab needed to be fixed and had been an ongoing issue.	F 684		