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 02/07/2019

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
E 000	Initial Comments A recertification survey was conducted 2/4/19 - 2/7/19. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID: 8T7V11.	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the area of diagnoses for psychotic disorder and dementia on the Minimum Data Set (MDS) assessment for 2 out of 2 residents reviewed for MDS accuracy (Resident #28 and #71). The findings included: 1. Resident #28 was readmitted to the facility on 1/9/17 with medical diagnoses inclusive of seizure disorder and hypertension. Review of the medical record revealed Resident #28 did not have a diagnosis of psychotic disorder. Review of Resident #28's annual Minimum Data Set (MDS) dated 10/30/18 specified the resident had a diagnosis of psychotic disorder. An interview conducted with the MDS Coordinator on 2/6/19 at 2:50 PM revealed she had coded the diagnosis of psychotic disorder in error for Resident #28. The MDS Coordinator reported	F 641	F641 Accuracy of Assessments Residents #28 and #71 did not experience any adverse effect related to coding inaccuracy. For resident #28, the MDS dated 10/30/2018 was modified by the MDS nurse on 2/6/19 to reflect the appropriate diagnosis of psychotic disorder. For resident #71, the MDS dated 9/11/2018 was modified by the MDS nurse on 2/6/19 to reflect the appropriate diagnosis of dementia. The MDS coordinator audited all annual MDS assessments for the 4th quarter of 2018 on 3/2/19 to ensure coding accuracy of diagnoses. There were no additional modifications required on these MDS assessments. Education was provided to the MDS Coordinator on 2/6/19 by the MDS Director. Additional education was provided to MDS Coordinator and MDS Director by the Corporate Regional MDS	3/2/19

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

Electronically Signed | 03/01/2019

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F 641	Continued From page 1 she reviewed the psychiatrist note that indicated Resident #28 was ordered medication to treat psychotic symptoms. An interview conducted on 2/7/19 at 8:05 AM with the Director of Nursing revealed it was her expectation MDS assessments were coded accurately to reflect diagnosis. 2. Resident #71 was admitted to the facility on 9/9/17 with medical diagnoses inclusive of vascular dementia without behavioral disturbance and type 2 diabetes mellitus. Review of Resident #71's annual Minimum Data Set (MDS) dated 9/11/18, revealed Resident #71 was not coded for dementia. An interview conducted with the MDS Coordinator on 2/6/19 at 2:59 PM revealed it was an oversight for not coding Resident #71 with a diagnosis of dementia. An interview conducted on 2/7/19 at 8:05 AM with the Director of Nursing revealed it was her expectation MDS assessments were coded accurately to reflect diagnosis.	F 641	Consultant on 2/26/2019. Education included importance of coding MDS accurately, including all current active diagnoses. An MDS Audit tool was developed to include a review of assessments to determine accurate diagnosis coding. MDS coordinator or designee will utilize monitoring tool effective 2/6/19 and will audit 10% of MDS assessments for coding accuracy for diagnoses weekly x 4 weeks, then monthly x 3 months. The results of these audits will determine the need for further monitoring. MDS Director will report the findings of the audits to the Quality Assurance and Performance Improvement committee monthly for 4 months. The QAPI team will evaluate the need for additional monitoring and/or modification of the audits at that time.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(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, staff interviews, and record review, the facility failed to provide	F 677	F677 ADL Care Provided for Dependent Residents	3/2/19

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F 677	Continued From page 2 activities of daily living (ADL), in the area of grooming, for 1 of 3 residents (Resident #38) reviewed for ADL care. Findings included: Resident #38 was admitted to the facility on 9/16/2015. Diagnoses included dementia, hypertension and anxiety. Review of the Quarterly Minimum Data Set (MDS) dated 11/15/2018 revealed Resident #38 was cognitively impaired. Resident #38 required extensive assistance with personal hygiene by staff. Review of the revised care plan dated 1/4/2019 revealed that Resident #38 required ADL assistance and remained at risk for functional decline, impaired cognition and complaints of pain. The interventions included anticipate resident needs and dignity to be maintained. The goals included provide ADL assistance. An observation of Resident #38 was completed on 2/4/2019 at 11:09 AM. Resident #38's hair was not combed and appeared disheveled. An observation of Resident #38 was completed on 2/5/2019 at 10:52 AM. Resident #38 was observed in the common area with her hair not combed and sticking straight in the air. An observation of Resident #38 was completed on 2/6/2019 at 10:46 AM. Resident #38 was observed in the common area watching a movie. Her hair was not combed and sticking straight in the air.	F 677	Resident #38 was taken to the facility beauty parlor on 2/6/19 where her hair was washed, combed and set per her usual schedule. All dependent residents were assessed by Director of Nursing (DON) and Assistant Director of Nursing (ADON) to ensure that hair was clean, combed, and properly styled. All other residents' hair was clean, combed and properly styled. Assessment completed on 2/6/2019. Inservice training was started with all licensed nurses and Certified Nurses Aides on 2/6/2019, 2/26/19, and 2/27/19, by the DON, ADON, Staff Development Coordinator (SDC) and will be completed 3/2/19. Training included ensuring that dependent residents have clean hair and hair is combed properly daily. Licensed nursing staff and certified nurse aides on Leave of Absence, vacation, or PRN staff will be in serviced prior to returning to assignment. A grooming audit tool was developed to monitor that residents have been properly groomed (hair is clean and combed). The audit was started on Wednesday 2/6/19 by DON. Administrative nursing staff to include DON, ADON, and unit mangers will continue to audit 20 dependent residents weekly x 4 weeks, then 10 residents weekly x 4 weeks, then 5 residents weekly x 4 weeks. The results of these audits will determine the need for further monitoring.	

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F 677	Continued From page 3 An interview was completed with Resident #38's nurse aide (NA) #1 on 2/6/2019 at 10:49 AM. NA #1 stated Resident #38 required total care assistance with set up for meals. NA #1 continued to explain that Resident #38 was unable to comb her hair. NA #1 further stated it was difficult to comb Resident #38's hair and she normally went to the beauty shop to have her hair done weekly. NA #1 verbalized Resident #38 had not been to the beauty shop in two weeks. NA #1 stated that she should have attempted to comb Resident #38's hair with hair care products in her room. An interview was completed with the Unit Manager (UM) on 2/6/2019 at 11:01 AM. The UM stated she cared for Resident #38 approximately two weeks ago and she was able to comb Resident #38's hair with her personal hair products in her room. The UM further stated she was able to style Resident #38's hair in a ponytail. The UM explained Resident #38 normally went to the beauty shop but had not gone for the past two weeks due to the stylist being ill, and Resident #38 being in a geri chair. The UM continued to explain Resident #38's family provided hair products in her room that were available to staff when she was not able to go to the beauty shop. The UM stated she expected the NAs to utilize the hair products provided by the family and comb Resident #38's hair as part of her daily ADL care. An interview was completed with the Director of Nursing on 2/6/2019 at 11:10 AM. The DON stated her expectation of staff would be to comb the Resident #38's hair daily as part of her ADL care.	F 677	DON will report the data from the audit to the Quality Assurance and Performance Improvement committee monthly x 3 months. The QAPI team will evaluate the data and need for any additional monitoring or modification of this requirement if needed.	

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 _____	2/7/2019

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 761	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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 observation and staff interviews, the facility failed to discard an insulin pen available for use in 1 of 9 medication carts. The insulin had been opened and available for use for Resident #10. The findings included: Resident #10 was readmitted to the facility on 11/20/18 with medical diagnoses that included diabetes mellitus and hypertension. A review of the physician orders dated 12/26/18 for Resident #10 revealed an order for Novolog Flex pen (fast acting insulin) per sliding scale once a day on Mondays. On 02/05/19 at 10:19 AM, an observation of the 400 Hall medication cart revealed a Novolog pen had been opened on 01/01/19 for Resident #10. Review of Resident #10's January and February 2019 Medication Administration Record revealed the Novolog Flex pen had not been administered. During an interview with Nurse#1 on 02/05/19 at 10:20 AM, Nurse #1 reported nurses had been instructed to indicate the date insulin was opened and the date when the insulin expired by writing the date opened and date of expiration on the label. Nurse #1 stated insulin expired twenty-eight days after opened and Resident #10's Novolog pen should have been discarded by nursing staff. She reported nurses were expected to check the expiration date of all medications before administration. Nurse #1 also reported medication carts were checked by a nurse during the 11:00 PM - 7:00 AM shift, two to three times weekly for expired medications,

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The above isolated deficiencies pose no actual harm to the residents

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F 761	Continued From Page 1

discontinued medications and discharged residents. Nurse #1 indicated the assistant director of nursing (ADON) checked the medication carts monthly for expired medications. She further stated a technician from the pharmacy checked medication carts monthly for expired medications.

During an interview with the ADON on 2/5/19 at 10:50 AM, she reported the pharmacy technician checked monthly and she did a weekly visual spot check for expired medications. She stated insulin pens expired twenty-eight days after they were opened and should then be discarded. The ADON further stated insulin should have the date it was opened and a expiration date written on the label.

During an interview on with the Director of Nursing (DON) on 2/7/19 at 8:03 AM, she stated it was her expectation for nurses, managers, and the pharmacy technician to check for expired medications in the medication carts. She stated managers and nurses should check for expired medications on a weekly basis and each time a medication was administered to the residents. The DON stated the nurse who opened the insulin should indicate date insulin was opened and date insulin expired. She further stated an insulin pen would expire twenty-eight days after opened and should not be available for use after the expiration date.