STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345013	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 1/11/2023
NAME OF PROVIDER OR SUPPLIER **PEAK RESOURCES - CHARLOTTE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3223 CENTRAL AVENUE CHARLOTTE, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 583	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)

§483.10(h) Privacy and Confidentiality.
The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews, the facility failed to protect the private health information for 2 of 2 sampled residents (Resident #8 and #9) when their confidential medical information was left visible and unattended in a common area.

The findings included:

Resident #8 was admitted to the facility on 12/23/22.

Resident #9 was admitted to the facility on 1/6/23.

A continuous observation was made on 1/10/23 from 1:52PM to 1:59PM of an unattended medication cart computer located on the 300 hall. The Medication Aide (MA) #1 left the medication cart computer open with Resident #8 and Resident #9's patient information visible to the public when she went into the back room behind the nurses' station. During the observation, the controlled substance medication screen showed the names of Resident #8 and Resident #9 along with physician ordered medications on the computer screen which were exposed and accessible for anyone to view. During this time, two other staff members were present at the nurses' station within visibility of the medication cart computer screen. At 1:59 PM, MA #1 exited the back room of the nurses' station and proceeded to approach the medication cart. The medication cart computer timed out and displayed a black screen.

An interview was completed with MA #1 on 1/10/23 at 2:00 PM. MA #1 stated she knew she shouldn't have

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345013	MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	DATE SURVEY COMPLETE: 1/11/2023
NAME OF PROVIDER OR SUPPLIER **PEAK RESOURCES - CHARLOTTE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3223 CENTRAL AVENUE CHARLOTTE, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 583	Continued From Page 1

left the computer screen open but was trying to hurry up and do her 24-hour report (nursing report used for resident documentation and staff communication). MA #1 verbalized she had to maintain privacy and confidentiality of Resident #8 and Resident #9's medical information and should not leave it exposed for other people to read. MA #1 communicated she should have hit the "walk-away" button prior to leaving the medication cart computer.

An interview with the Director of Nursing (DON) on 1/10/23 at 2:32 PM revealed the medication aide should have locked the screen or covered it when she walked away. There was a button to click to lock the screen per the DON. The DON further explained staff were annually trained on Privacy and Confidentiality.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 01/11/2023

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 An onsite complaint investigation was conducted on 1/9/23 through 1/11/23. The following intakes were investigated: NC00194920, NC00195044, NC00194386. There were a total of 7 allegations; 3 were substantiated and cited (F677, F550). Event ID # CUNJ11.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		1/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/30/2023

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 correction is requisite to continued program participation.

(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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide care in a manner that maintained a resident's dignity who was dependent with incontinence care for 1 of 3 residents (Resident #3) reviewed for dignity. Resident #3 reported waiting for assistance with incontinence care made her feel sad and she felt as if she had done something wrong to be treated that way. The findings included: Resident #3 was admitted to the facility on 1/26/17. Resident #3 had diagnoses that included difficulty walking, generalized muscle weakness and hypotension. A review of the quarterly Minimum Data Set (MDS) assessment dated 11/8/22 revealed that Resident #3 was cognitively intact and able to verbalize her needs as well as communicate effectively with others. Resident #3 required extensive assistance with mobility and transfer. Resident #3 also required extensive assistance with activities of daily living. The MDS further indicated that Resident #3 was always incontinent	F 550	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 suffered no physical adverse effects related to the staffs alleged deficient practice. Resident #3 remains at the facility with no residual adverse effects. How the facility will identify other residents	

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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 550	Continued From page 2 of urine and frequently incontinent of bowel. On 1/10/23 at 12:58 PM an observation was done on the hall where Resident #3 resided. Upon entering Resident #3's room a distinct smell consistent with a bowel movement was noted. Resident #3 was observed to be turned on her left side facing the door with her bottom raised off the bed all while gripping the side rail. Resident #3 stated that she needed assistance with being cleaned up as she had soiled herself. The resident stated that she had previously used her call light to ask for assistance and that a staff member came to her room and turned off the call light and stated that they would have someone come to help her. Resident #3 further stated that she had been watching the clock across from her bed and noticed that an hour had passed after the staff member left and never returned. Resident #3 was encouraged to activate her call light again at 1:00 PM. During a continuous observation on the hall on 1/10/23 from 1:00 PM to 1:40 PM, Housekeeper #1 was observed in the hallway, but no other staff member was present, and no one answered Resident #3's call light. A call bell was heard ringing and the light outside the room that indicated the call light had been activated was on. Housekeeper #1 stated that she noticed that Resident #3's call light had been alarming for some time. Housekeeper #1 went from room to room to seek staff to help Resident #3 but was unsuccessful. She noted that there were staff members sitting at the nurses' station. The surveyor approached the nurses' station and observed Nurse Aide (NA) #1 sitting beside the call light system monitor.	F 550	having the potential to be affected by the same deficient practice: All other incontinent residents in the facility have the potential to be affected. An audit was conducted on January 27, 2023; by the Assistant Administrator and Nursing Management team by interviewing and/or direct observation to determine if any additional residents did not receive incontinent care timely. It was determined that no other residents were 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: The facility policies related to incontinence care were reviewed by facility administration on January 27, 2023. and no updates were necessary. NA #1 was educated by the Director of Nursing on January 27, 2023, on the importance of answering call lights in a timely matter and if unable to fulfill resident□s request, that the Certified Nursing Assistant and/or nurse is notified of the resident needs/requests. Education also included responding to audible alerts from the call light system by looking down each hall to see which room light might be illuminated in the instance that the monitor is malfunctioning. In the instance that the monitor is malfunctioning to enter a repair request into the electronic system (TELS).	

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F 550	Continued From page 3 NA #1 was observed walking down the hall to ask Resident #3 what she needed on 1/10/23 at 1:50 PM. NA #1 stated that she had not been assigned to Resident #3 and her nurse aide was providing care to another resident on another hall. As NA #1 entered the room, Resident #3 told NA #1 that she needed assistance with being changed because she had a bowel movement. On 1/10/23 at 1:55 PM, an interview was conducted with NA #1. She stated she didn't hear Resident #3's call light going off while she was sitting at the nurses' station and that the call light system monitor wasn't working properly. The call light monitor at the nurses' station normally displayed which room number had an activated call light and Resident #3's room number did not show up on the monitor. On 1/10/23 at 2:06 PM, an interview was conducted with NA #2 who was assigned to care for Resident #3. NA #2 stated that she had been on another hall assisting another resident and was unaware that Resident #3 needed assistance. She further stated that she had last checked on Resident #3 at around 12:45PM when she picked up her meal tray and Resident #3 had voiced no concerns to her. She also stated that if a nurse aide was in another room or busy, another team member sometimes answered call lights but that was not always the case. On 1/10/23 at 2:15 PM, an interview was conducted with Nurse #1 who was assigned to Resident #3. Nurse #1 stated that she was unaware that Resident #3 had her call light on and had been waiting for assistance with incontinence care as she had been busy assisting	F 550	All staff will be educated regarding the importance of answering call lights in a timely matter and if unable to fulfill resident□s request, that the Certified Nursing Assistant and/or nurse is notified of the resident needs/requests. This will be completed by the Director of Nursing and/or designee by January 31, 2023. This education will include the following: " The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. " A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. " The facility must protect and promote the rights of the resident. " The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. " The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. " Problems associated with incontinence and moisture, including skin breakdown " Preventing skin breakdown by providing timely incontinence care " Incontinent residents will be checked for incontinence every 2 hours at a	

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F 550 Continued From page 4

another resident on another hall. She also stated resident needs should be addressed promptly. Nurse #1 stated she last checked on Resident #3 prior to 1:00 PM because the resident activated her call light for assistance, and she had voiced no complaints or concerns to her when she turned off the call light. Nurse #1 stated that Resident #3 told her that she didn't need anything, so she left.

On 1/11/23 from 9:15 AM until 9:20 AM an observation and interview were conducted with Resident #3. Upon entering the room there was a noticeable odor of feces. Resident #3 was observed laying on her left side and stated she needed to be cleaned up. The resident stated that someone came into the room at 9:00 AM and turned off her call light and stated they would return but never did and that she had been waiting since. Resident #3 was encouraged to activate her call light for assistance. Resident #3 stated that it made her sad when she wasn't provided incontinence care and whenever she waited for an extended period of time to be changed. Resident #3 further stated that it made her feel as if she had done something wrong when she was treated that way. The resident stated that sometimes she waited a very long time before she was assisted with incontinence care.

On 1/11/23 at 11:59 AM, an interview with the Director of Nursing (DON) revealed that all staff should answer call lights promptly and assess resident needs between 15-20 minutes. The DON stated all staff were responsible for answering call lights in a timely manner regardless of if it was their assigned resident or not. The DON stated that even if the call light system had not been

F 550

minimum to determine the need for incontinence care.

" The staff is to ensure someone is always present on the floor to meet resident□s requests. If non-clinical staff should respond to call lights and are not able to meet the resident□s needs or requests, they are to inform the nurse and /or certified nursing assistant immediately.

" The staff must respond to audible alerts from the call system by looking down each hall to see which room light might be illuminated in the instance that the monitor is malfunctioning. In the instance that the monitor is malfunctioning to enter a repair request for maintenance into the electronic system (TELS).

Any staff out on leave or prn status will be educated prior to returning to their assignment by the Director of Nursing/designee. Newly hired staff and contracted staff will be educated during orientation by the Director of Nursing/designee.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

An audit tool was developed to monitor incontinent residents to ensure that timely incontinence care has been provided as necessary to maintain resident□s cleanliness and comfort and to determine if resident□s right regarding incontinence care were being followed.

The Director of Nursing, Assistant

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F 550	Continued From page 5 working call lights were still audible and visible from the nurses' station.	F 550	Administrator and /or designee will audit 5 incontinent residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x1 month. These audits will occur on random days, shifts, and weekends. The audit will include observations and interviews to ensure compliance. The need for further monitoring will be determined by the prior month of auditing. An audit tool was developed to monitor for call light answering times. Call light audit tool will be completed by Nursing Management team 2 x weekly x 4 weeks, then 1x weekly x 4 weeks then biweekly x 4 weeks. The results of these audits will determine the need for further monitoring. Results of these audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee Meeting by the Director of Nursing monthly x 3 months for review and further recommendations. Completion date: January 31, 2023	
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 record review, observations, resident, staff, and family member interviews, the facility failed to provide incontinence care to 1 of 3 dependent residents (Resident #3) reviewed for	F 677	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is	1/31/23

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F 677	Continued From page 6 activities of daily living (ADL). The findings included: Resident #3 was admitted on 1/26/17. Resident #3 had diagnoses that included difficulty walking, generalized muscle weakness and hypotension. A review of the quarterly Minimum Data Set (MDS) assessment dated 11/8/22 revealed that Resident #3 was cognitively intact and able to verbalize her needs as well as communicate effectively with others. Resident #3 required extensive assistance with mobility and transfer. Resident #3 also required extensive assistance with activities of daily living. The MDS further indicated that Resident #3 was always incontinent of urine and frequently incontinent of bowel. Resident #3's care plan last updated on 11/11/22 showed the following: Resident #3 required various levels of activities of daily living assistance and remained at risk for functional decline. Interventions included: provide ADL assistance, monitor for incontinent episodes and change promptly. On 1/10/23 at 12:58 PM an observation was done on the hall where Resident #3 resided. Upon entering Resident #3's room a distinct smell consistent with a bowel movement was noted. Resident #3 was observed to be turned on her left side facing the door with her bottom raised off the bed all while gripping the side rail. Resident #3 stated that she needed assistance with being cleaned up as she had soiled herself. The resident stated that she had previously used her call light to ask for assistance and that a staff member came to her room and turned off the call	F 677	completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On January 10, 2023, NA #1 provided incontinence care to Resident #3. Resident #3 remains at the facility with no residual adverse effects. How the facility will identify other residents having the potential to be affected by the same deficient practice: All other incontinent residents in the facility have the potential to be affected. An audit was conducted on January 27, 2023, by the Assistant Administrator and Nursing Management team by interviewing and/or direct observation to determine if any additional residents did not receive incontinent care timely. It was determined that no other residents were 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	

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F 677

Continued From page 7

light and stated that they would have someone come to help her. Resident #3 further stated that she had been watching the clock across from her bed and noticed that an hour had passed after the staff member left and never returned. Resident #3 was encouraged to activate her call light again at 1:00 PM.

During a continuous observation on the hall on 1/10/23 from 1:00 PM to 1:40 PM, Housekeeper #1 was observed in the hallway, but no other staff member was present, and no one answered Resident #3's call light. A call bell was heard ringing and the light outside the room that indicated the call light had been activated was on. Housekeeper #1 stated that she noticed that Resident #3's call light had been alarming for some time. Housekeeper #1 went from room to room to seek staff to help Resident #3 but was unsuccessful. She noted that there were staff members sitting at the nurses' station. The surveyor approached the nurses' station and observed Nurse Aide (NA) #1 sitting beside the call light system monitor.

NA #1 was observed walking down the hall to ask Resident #3 what she needed on 1/10/23 at 1:50 PM. NA #1 stated that she had not been assigned to Resident #3 and her nurse aide was providing care to another resident on another hall. As NA #1 entered the room, Resident #3 told NA #1 that she needed assistance with being changed because she had a bowel movement.

On 1/10/23 at 1:55 PM, an interview was conducted with NA #1. She stated she didn't hear Resident #3's call light going off while she was sitting at the nurses' station and that the call light system monitor wasn't working properly. The call

F 677

recur:

The facility policies related to incontinence care were reviewed by facility administration on January 27, 2023. and no updates were necessary.
NA #1 was educated by the Director of Nursing on January 27, 2023, on the importance of answering call lights in a timely matter and if unable to fulfill resident□s request, that the Certified Nursing Assistant and/or nurse is notified of the resident needs/requests. Education also included responding to audible alerts from the call light system by looking down each hall to see which room light might be illuminated in the instance that the monitor is malfunctioning. In the instance that the monitor is malfunctioning to enter a repair request into the electronic system (TELS).
All staff will be educated regarding the importance of answering call lights in a timely matter and if unable to fulfill resident□s request, that the Certified Nursing Assistant and/or nurse is notified of the resident needs/requests. This will be completed by the Director of Nursing and/or designee by January 31, 2023.
This education will include the following:

" Problems associated with incontinence and moisture, including skin breakdown
" Preventing skin breakdown by providing timely incontinence care
" Incontinent residents will be checked for incontinence every 2 hours at a minimum to determine the need for incontinence care.

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light monitor at the nurses' station normally displayed which room number had an activated call light and Resident #3's room number did not show up on the monitor. NA #1 further stated that when she changed Resident #3, she had a medium-sized bowel movement and she only had to change her brief. Her drawsheet and bedsheet were both dry.

On 1/10/23 at 2:06 PM, an interview was conducted with NA #2 who was assigned to care for Resident #3. NA #2 stated that she had been on another hall assisting another resident and was unaware that Resident #3 needed assistance. She further stated that she had last checked on Resident #3 at around 12:45PM when she picked up her meal tray and Resident #3 had voiced no concerns to her. She also stated that if a nurse aide was in another room or busy, another team member sometimes answered call lights but that was not always the case.

On 1/10/23 at 2:15 PM, an interview was conducted with Nurse #1 who was assigned to Resident #3. Nurse #1 stated that she was unaware that Resident #3 had her call light on and had been waiting for assistance with incontinence care as she had been busy assisting another resident on another hall. She further stated a medication aide was assigned to administer medications to Resident #3's hall and she was assigned to oversee the medication aide. She also stated resident needs should be addressed promptly. Nurse #1 stated she last checked on Resident #3 prior to 1:00 PM because the resident activated her call light for assistance, and she had voiced no complaints or concerns to her when she turned off the call light.

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" The staff is to ensure someone is always present on the floor to meet resident□s requests. If non-clinical staff should respond to call lights and are not able to meet the resident□s needs or requests, they are to inform the nurse and /or certified nursing assistant immediately.
" The staff must respond to audible alerts from the call system by looking down each hall to see which room light might be illuminated in the instance that the monitor is malfunctioning. In the instance that the monitor is malfunctioning to enter a repair request for maintenance into the electronic system (TELS).
Any staff out on leave or prn status will be educated prior to returning to their assignment by the Director of Nursing/designee. Newly hired staff and contracted staff will be educated during orientation by the Director of Nursing/designee.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

An audit tool was developed to monitor incontinent residents to ensure that timely incontinence care has been provided as necessary to maintain resident□s cleanliness and comfort and to determine if resident□s right regarding incontinence care were being followed.
The Director of Nursing, Assistant Administrator and /or designee will audit 5 incontinent residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x1 month. These audits will occur on

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Nurse #1 stated that Resident #3 told her that she didn't need anything, so she left.

On 1/10/23 at 2:55PM, an interview was conducted with Medication Aide (MA) #2 who was assigned to care for Resident #3. He stated he could not recall what time he had been on the hall but remembered that he had assisted another resident on the hall and did not notice Resident #3's call light being on. MA #2 also stated that Resident #3 didn't voice any concerns the last time he was on the hall.

On 1/11/23 from 9:15 AM until 9:20 AM an observation and interview were conducted with Resident #3. Upon entering the room there was a noticeable odor of feces. Resident #3 was observed laying on her left side and stated she needed to be cleaned up. The resident stated that someone came into the room at 9:00 AM and turned off her call light and stated they would return but never did and that she had been waiting since. Resident #3 was encouraged to activate her call light for assistance. The resident stated that sometimes she waited a very long time before she was assisted with incontinence care.

On 1/11/23 at 9:18 AM, MA#1 came into Resident #3's room to assist the resident with incontinence care. Resident #3's brief was noted to be soiled with both urine and stool. Resident #3 had a medium-sized bowel movement but her draw sheet was also wet with urine. No skin issues were noted.

On 1/11/23 at 9:20 AM, an interview was conducted with Resident #3's family member who voiced concerns regarding ADL for his mother.

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random days, shifts, and weekends. The audit will include observations and interviews to ensure compliance. The need for further monitoring will be determined by the prior month of auditing. An audit tool was developed to monitor for call light answering times. Call light audit tool will be completed by Nursing Management team 2 x weekly x 4 weeks, then 1x weekly x 4 weeks then biweekly x 4 weeks. The results of these audits will determine the need for further monitoring. Results of these audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee Meeting by the Director of Nursing monthly x 3 months for review and further recommendations.

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F 677	Continued From page 10 The family member stated that Resident #3 sometimes waited hours before she was provided incontinence care. The family member also stated that he had observed MA #1 on several occasions walk by the resident's room and disregarded the call light which was alarming. On 1/11/23 at 9:25 AM an interview was conducted with MA #1. MA #1 stated she did her best to answer all call lights promptly even if she wasn't assigned to the resident. She stated that Resident #3 was able to voice her needs and would use her call light when she needed assistance. MA #1 stated she was unaware that Resident #3's call light had been alarming previously and that at 9:20 AM was the first time she had noticed the call light was going off. On 1/11/23 at 9:36 AM an interview was conducted with NA #3 who stated that she had been assigned to care for Resident #3 for the day. NA #3 revealed that at around 9:00 AM she had been on another hall providing care for another resident. NA #3 stated that before going to the other hall she had gone into Resident #3's room to answer her call light but she did not recall what time it was. NA#3 revealed that she was aware that Resident #3 needed assistance with incontinence care and informed the resident that she would return and turned off the resident's call light. NA#3 stated that she had to get another resident up out of the bed because the resident was going to an activity. On 1/11/23 at 11:59 AM, an interview with the Director of Nursing (DON) revealed that all staff should answer call lights promptly and assess resident needs between 15-20 minutes. The DON stated all staff were responsible for answering call	F 677		

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F 677	Continued From page 11 lights in a timely manner regardless of if it was their assigned resident or not.	F 677		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with resident, staff and the Medical Director, the facility failed to respond to a resident's complaint of pain for 1 of 1 resident reviewed for pain management (Resident #2). Resident #2 was observed sweating, grimacing, and stated her pain level was at a 10. The findings included: Resident #2 was admitted to the facility on 8/24/10 with diagnoses of unspecified pain, stage four pressure ulcer of left hip, muscle spasms, unspecified muscle contractures, and anxiety disorder. Resident #2's care plan last updated on 12/26/22 showed a problem area for pain. The care plan showed Resident #2 was at risk for alterations in comfort related to chronic pain and that the resident was able to verbalize needs with staff. Interventions included to administer medication for pain, encourage Resident #2 to request pain medication before pain became unbearable, and to monitor and record complaints of pain, as well	F 697	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On January 10, 2023, NA #1 repositioned Resident #2 to relieve her pain using non-pharmacological methods. Resident #2 remains at the facility with no residual adverse effects. How the facility will identify other residents having the potential to be affected by the same deficient practice:	1/31/23

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as positioning for comfort with physical support as necessary.

A review of the quarterly Minimum Data Set (MDS) assessment dated 12/29/22 revealed Resident #2 was cognitively intact and was able to verbalize her needs and communicate effectively with others. Resident #2 was totally dependent on staff assistance with all activities of daily living including bed mobility and transfer. She had impaired range of motion to both the upper and lower extremities. The MDS also showed that the resident received as needed pain medication for pain but her pain frequency and pain level were not assessed during this assessment period.

A review of Resident #2's physician orders showed the following orders for pain: a start date of 4/29/22 for Acetaminophen tablet 500 milligrams (mg) administer 1,000 mg orally once a day as needed for pain, Acetaminophen tablet 1,000 mg orally at bedtime for pain.

A review of Resident #2's Medication Administration Record (MAR) for January 2023 revealed that the resident had not received any as needed Acetaminophen for 1/10/23 on day shift. The last doses of Acetaminophen had been administered at 10:00 PM on 1/09/23 and at 2:50 AM on 1/10/23. The MAR also showed her pain level was assessed by Nurse #1 on the day shift on 1/10/23 at level 0.

On 1/10/23 at 12:58 PM, an observation was made on the hall where Resident #2 resided and heard Resident #2 scream out for assistance. Upon entering Resident #2's room the resident stated that she was in pain and needed

F 697

All other residents in the facility have the potential to be affected. An audit was conducted on January 31, 2023, by the Director of Nursing and Nursing Management team by interviewing and/or direct observation to determine if any additional residents had pain that had not been assessed or addressed timely. It was determined that no other residents were 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:
MA#2 was educated by the Director of Nursing on January 31, 2023, on observing residents for signs of pain when administering scheduled medications and providing pain medications as needed to relieve pain per prescriber's orders. If there is no order for pain medications, to notify the nurse as soon as possible.
All medication aides will be educated on observing residents for signs of pain when administering scheduled medications and providing pain medications as needed to relieve pain per prescriber's orders. If there is no order for pain medications, to notify the nurse as soon as possible by the Director of Nursing and/or designee by January 31, 2023.
Any staff out on leave or prn status will be educated prior to returning to their assignment by the Director of Nursing/designee. Newly hired staff and contracted staff will be educated during orientation by the Director of

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assistance. Resident 2 rated her pain at that time to be a 10 out of 10 (based on a numerical pain scale with 0 meaning no pain, 1-3 meaning mild pain, 4-7 meaning moderate pain, and 8 and above meaning severe pain) and stated that the pain had felt higher but 10 was the highest number on the pain scale. Resident #2 had been observed to be sweaty/diaphoretic (sweating heavily) and had facial grimacing. The resident stated that her pain was near her bottom. Resident #2 was encouraged to activate her call light at 1:00 PM.

During a continuous observation on the hall on 1/10/23 from 1:00 PM to 1:40 PM, Housekeeper #1 was observed in the hallway, but no other staff member was present and no one answered Resident #2's call light. A call bell was heard ringing and the light outside the room that indicated the call light had been activated was on. Housekeeper #1 stated that she noticed that Resident #2's call light had been alarming for some time. Housekeeper #1 went from room to room to seek staff to help Resident #2 but was unsuccessful. She noted that there were staff members sitting at the nurses' station. The surveyor approached the nurses' station and observed Nurse Aide (NA) #1 sitting beside the call light system monitor. NA #1 stated that the call light system had not been functioning properly for some time and that she was unsure if anyone had been made aware. NA #1 stated that incorrect room numbers were showing up on the call light system monitor and the rooms that had activated call lights did not show up on the monitor.

NA #1 was observed walking down the hall to ask Resident #2 what she needed on 1/10/23 at 1:45

F 697

Nursing/designee.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
An audit tool was developed to monitor residents to ensure that Medication Aides observed for signs of pain and administered ordered pain medication as needed or reported to the nurse timely. The Director of Nursing, Assistant Administrator and /or designee will audit 5 residents 2 times weekly x 4 weeks, then weekly x 4 weeks, then biweekly x 4 weeks. These audits will occur on random days, shifts, and weekends. The audit will include observations and interviews to ensure compliance. The need for further monitoring will be determined by the prior month of auditing. Results of these audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee Meeting by the Director of Nursing monthly x 3 months for review and further recommendations.

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PM. Resident #2 replied to NA #1 that she was in pain. NA #1 stated to Resident #2 that she would need to inform the nurse and to keep her call light on. NA #1 then proceeded to answer another call light on the hall. After answering the other call light, NA #1 went back to Resident #2's room and turned off her call light. NA #1 stated that she had not been assigned to Resident #2 and her nurse aide was providing care to another resident on another hall.

On 1/10/23 at 1:50 PM, a follow up interview with Resident #2 revealed her pain level was currently 4 out of 10 and that she did not usually ask for a pain medication and wanted to do non-pharmacological interventions first. Resident #2 stated all she needed was to be turned and repositioned by a staff member to relieve her bottom pain. Resident #2 had been repositioned off her bottom with the use of a pillow.

On 1/10/23 at 1:55 PM, an interview was conducted with NA #1. She stated she didn't hear Resident #2's call light going off while she was sitting at the nurses' station and that the call light system monitor wasn't working properly. The call light monitor at the nurses' station normally displayed which room number had an activated call light and Resident #2's room number did not show up on the monitor. NA #1 stated when she went back to check on Resident #2 and turned off her call light, Resident #2 requested her to reposition her off her bottom so she did what Resident #2 had asked her to do. Resident #2 did not request for any pain medication.

On 1/10/23 at 2:06 PM, an interview was conducted with NA #2 who was assigned to care for Resident #2. NA #2 stated that she had been

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in another hall assisting another resident and was unaware of Resident #2 needing assistance. She further stated that she had last checked on Resident #2 at around 12:45PM when she picked up her meal tray and Resident #2 had voiced no concerns to her. She also stated that if a nurse aide was in another room or busy, another team member sometimes answered call lights but that was not always the case.

On 1/10/23 at 2:15 PM, an interview was conducted with Nurse #1 who was assigned to Resident #2. Nurse #1 stated that she was unaware that Resident #2 had her call light on and had been waiting for assistance for pain relief because she had been busy assisting another resident on another hall. Nurse #1 stated that no one had informed her that Resident #2 had complained of pain. She further stated a medication aide was assigned to administer medications to Resident #2's hall and she was assigned to oversee the medication aide. She also stated resident needs should be addressed promptly. Nurse #1 stated she last checked on Resident #2 prior to 1:00 PM and she had voiced no complaints or concerns to her.

On 1/10/23 at 2:55PM, an interview was conducted with Medication Aide (MA) #2 who was assigned to care for Resident #2. He stated he could not recall what time he had been on the hall but remembered that he had assisted another resident on the hall and did not notice Resident #2's call light being on. MA #2 also stated that Resident #2 did not complain to him about being in pain and did not request any pain medication on 1/10/23.

On 1/11/2023 at 11:59 AM, an interview with the

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F 697	Continued From page 16 Director of Nursing (DON) revealed that all staff should answer call lights promptly and assess resident needs between 15-20 minutes. The DON stated all staff was responsible for answering call lights in a timely manner regardless of if it was their assigned resident or not. The DON stated that even if the call light system had not been working call lights were still audible and visible from the nurses' station. On 1/11/2023 at 12:10 PM, an interview with the Medical Director (MD) revealed Resident #2 did have complaints of pain and had an as needed pain medication that was available to her if she needed it. The MD stated that staff should respond promptly to resident needs as well as complaints of pain.	F 697		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain a fully functioning call system when the call light monitor did not work at 1 of 2 nurses' stations (Long-term side) to alert staff of a call light being activated for 2 of 4 residents reviewed for call light functioning (Resident #2 and Resident #3).	F 919	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state	1/31/23

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The findings included:

Resident #2 was admitted to the facility on 8/24/10.

Resident #3 was admitted to the facility on 1/26/17.

On 1/10/23 at 12:58 PM, an interview with Resident #3 in her room revealed she had been waiting for incontinence care. A staff member went into the room to turn off her call light and said to her that she would send another staff member to assist her. Resident #3 was encouraged to turn her call light back on. At 1:00 PM, while waiting in Resident #3's room, Resident #2 was heard screaming across the hallway. Resident #2 stated that she was in pain and needed assistance. Resident #2 was also encouraged to activate her call light.

During a continuous observation on the hall on 1/10/23 from 1:00 PM to 1:40 PM, Housekeeper #1 was observed in the hallway, but no other staff member was present and no one answered Resident #2 and Resident #3's call lights. A call bell was heard ringing both inside the rooms and in the hallway and the light outside the rooms that indicated the call lights had been activated were on. Housekeeper #1 stated that she noticed that Resident #2 and Resident #3's call lights had been alarming for some time. Housekeeper #1 noted that there were staff members sitting at the nurses' station. The surveyor approached the nurses' station and observed Nurse Aide (NA) #1 sitting beside the call light system monitor. NA #1 stated that the call light system had not been functioning properly for some time that day and

F 919

regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been.

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On January 10, 2023, NA #1 repositioned Resident #2 to relieve her pain using non-pharmacological methods. Resident #2 remains at the facility with no residual adverse effects.
On January 10, 2023, NA #1 provided incontinence care to Resident #3. Resident #3 remains at the facility with no residual adverse effects.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

All other residents in the facility have the potential to be affected. An audit was conducted on January 10, 2023, the Maintenance Director reprogrammed the monitor for the call system and audited the rooms for that monitor to ensure that it was functioning properly. It was determined that no other residents were adversely affected by the alleged deficient practice.

Address what measures will be put into place or systemic changes made to

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F 919	Continued From page 18 that she was unsure if anyone had been made aware. NA #1 stated that incorrect room numbers were showing up on the call light system monitor and the rooms that had activated call lights did not show up on the monitor. NA #1 stated the room number that showed up on the monitor was neither Resident #2 or Resident #3's and she had checked on that room number but the call light had not been activated in that room. NA #1 stated she had assumed the call bell was for the room number that showed up on the monitor and she did not notice that Resident #2 and Resident #3's call lights had been on outside their rooms. An interview with the Director of Nursing (DON) on 1/11/23 at 12:10 PM revealed she was aware that the call light system monitor at one of the nurses' station was not working so staff who were sitting at the nurses' station did not know which rooms had activated their call lights. The DON stated they should have notified the Maintenance Director when they noticed issues with the call light system. An interview with the Maintenance Director on 1/10/23 at 2:30 PM revealed that the call light system monitor at the nurses' station was not working properly. He explained that the call light system, once activated in the resident rooms, would activate the light above the door frame outside the resident room and make an audible sound to alert staff. The call light system should also display on the monitor at the nurses' station which resident room had activated their call light. He communicated that at times the system had to be reset to register the resident room numbers to show on the display monitor at the nurses' station and he was in the process of completing the reset. He stated that he had completed halls 900,	F 919	ensure that the deficient practice will not recur: NA #1 was educated by the Director of Nursing on January 27, 2023, on the importance of reporting malfunctions to the call light system by entering a repair request into the electronic system (TELS). On January 27, 2023, the Director of Nursing, Assistant Administrator and Department Directors began educating all staff regarding the importance of reporting malfunctions to the call light system by entering a repair request into the electronic system (TELS). Education will be completed by January 31, 2023. Any staff out on leave or prn status will be educated prior to returning to their assignment by their supervisor. Newly hired staff and contracted staff will be educated during orientation by the Director of Nursing, supervisor, or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit tool was developed to monitor the facility call light systems to ensure they are operating properly. The audit tool was initiated on January 31, 2023, the Maintenance Director/or designee will audit 5 resident call lights 2 times weekly x 4 weeks, then weekly x 4 weeks, then biweekly x 4 weeks. The need for further monitoring will be determined by the prior month of auditing. Results of these audits will be brought to	

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 01/11/2023

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 919	Continued From page 19 800, and was working on 700. He stated that there were still glitches with the resident room numbers showing on the display monitor at the nurses' station and he was working through those glitches. An interview with the Administrator on 1/11/23 at 3:20 PM revealed that call lights were audible and visible even if the call light system monitor wasn't working, and that staff should respond promptly.	F 919	the Quality Assurance and Performance Improvement (QAPI) Committee Meeting by the Maintenance Director monthly x 3 months for review and further recommendations. Completion date: January 31, 2023	