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 03/21/2024

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 An unannounced recertification and complaint investigation survey was conducted on 03/17/24 through 03/21/24. The facility was found in compliance with the requirement CFR. 483.73, Emergency Preparedness. Event ID #8TCV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/17/24 through 03/21/24. Event ID# 8TCV11. The following intakes were investigated: NC00205075, NC00214328, NC00208839, NC00203770, NC00209462, NC00203704, NC00205052, NC00207273, NC00204937, NC00208910, and NC00204334. 12 of 23 allegations resulted in a deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. An extended survey was conducted. Immediate Jeopardy began on 6/9/23 and was removed on 6/14/23.	F 000		
F 550 SS=D	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.	F 550		4/19/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/11/2024

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.

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F 550	Continued From page 1 §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. §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 observations, record review and staff interviews, the facility failed to provide a dignified dining experience when Nurse Aide (NA) #1 stood at the beside while assisting a dependent resident during a meal for 1 of 7 resident	F 550	F550 Peak Resources Charlotte acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is	

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F 550 Continued From page 2

reviewed for dignity (Resident #59). The reasonable person concept was applied to this deficiency as individuals might feel a lack of dignity when staff stood over them and didn't attempt conversation while assisting them with a meal.

Findings included:

Resident #59 was admitted to the facility on 02/10/23 with diagnoses that included hemiplegia (paralysis on one side of the body) affecting the left non-dominant side.

The ,inimum Data Set (MDS) assessment dated 01/05/24 revealed Resident #59 had severe cognitive impairment and required partial/moderate staff assistance with eating.

A continuous observation of the breakfast meal was conducted on 03/19/24 from 8:45 AM to 8:56 AM. Resident #59 was lying in bed on her left side, with the bed low, head of the bed slightly elevated and the light above her bed turned off. Resident #59's breakfast tray was on the overbed table that was positioned next to the head of the bed in between the right side of the bed and wall. An empty chair was observed by the wall and closet at the foot of Resident #59's bed. NA #1 was observed on the right side of the bed standing in front of the overbed table with the height of Resident #59's bed positioned at NA #1's hip level and assisting Resident #59 with her meal. NA #1 remained standing over Resident #59 and did not bend down to Resident #59's eye level when giving her bites of food. NA #1 did not turn the light on or try to engage Resident #59 in conversation during the meal. When Resident #59 finished eating, NA #1 removed the meal tray

F 550

factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

Resident Affected
NA # 1 was immediately educated by the facility administrator on 3/19/24 that she should provide adequate lighting, sit at resident eye level, not stand over the resident and should engage the resident while feeding to promote dignity and respect. NA #1 was a contracted agency employee and was asked not to return to the facility. Resident #59 did not suffer any adverse effects related to the alleged deficient practice.

Other residents with potential to be affected.
All residents requiring assistance with feeding have the potential to be affected by the alleged deficient practice. On 3/19/24, the Director of Nursing was provided with a list of all residents who require feeding and observed staff assisting these residents with feeding to ensure they were sitting at eye level, the room was well-lit, and the staff was engaging with the resident during feeding. There were no additional observed concerns identified.

Systemic Changes
The Staff Development Coordinator (SDC) or designee will educate all nursing staff, including contracted agency staff on sitting eye level with resident, engaging in

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F 550	Continued From page 3 from the overbed table without talking to Resident #59, walked past the chair at the foot of the bed and out of the room to place Resident #59's meal tray into the meal cart. An observation and interview was conducted with NA #1 on 03/19/24 at 8:57 AM. NA #1 verified she was supposed to sit down next to residents when assisting them with a meal. NA #1 explained she stood up while assisting Resident #59 with her breakfast because there wasn't a chair in the room for her to sit. When NA #1 was shown the chair at the foot of Resident #59's bed, she stated she had not noticed the chair when she went into the room. During an interview on 03/19/24 at 10:03 AM, the Director of Nursing stated staff were expected to sit down next to residents when assisting them with their meal and she would be having a conversation with NA #1. During an interview on 03/20/24 at 8:30 AM, the Administrator stated staff were expected to sit down next to residents when assisting them a meal to ensure the resident's dignity was maintained.	F 550	conversation with the resident and feeding the resident in a well-lit room while assisting with meals. This will be completed by 4/19/2024. Any nursing staff out on leave or PRN status will be educated by the SDC/designee prior to returning to duty. All newly hired nursing staff are educated on resident rights, dignity, and respect during orientation by the SDC/designee. Monitoring An audit tool was developed to monitor for compliance with the plan of correction. The audit includes the following: " Are staff seated at eye level while feeding a resident? " Are staff engaging with the residents during feeding? " Is the room well-lit while staff are feeding the resident? The facility will monitor random meals on all shifts, including weekends. The Director of Nursing or designee will observe 5 residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee by the DON monthly x 3 months for review and further recommendations. Date of Completion: 04/19/2024	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp	F 554		4/19/24

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F 554	Continued From page 4 CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with the resident and staff the facility failed to assess if a cognitively impaired resident could self-administer inhalers kept at the beside for 1 of 1 resident reviewed for self-administration (Resident #43). The findings included: Resident #43 was admitted to the facility on 09/14/21 with diagnoses including chronic obstructive pulmonary disease, dementia, and Parkinson's disease. Review of the physician order dated 03/14/23 for mometasone-formoterol aerosol inhaler 200-5 micrograms (mcg) revealed Resident #43 was to inhale 2 puffs twice a day with special instructions the mouth should be rinsed out after use. There was no physician order Resident #43 could self-administer medications. Review of the medical records of Resident #43 revealed no assessment was completed to determine if the resident could self-administer medications. The care plan for Resident #43 last revised on 12/26/23 included the problem focus area for long term memory problems with fluctuating impaired daily decision making related to the diagnoses of	F 554	F554 Peak Resources Charlotte acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Affected Resident Nurse #1 removed the medication from the resident□s bedside on 3/17/2024. Resident #43 did not suffer any adverse effects related to alleged deficient practice. Nurse #1 was educated on medication administration on 3/17/24 by the Staff Development Coordinator (SDC). Education included the protocol to follow for medication administration and to ensure that medications are not left with a resident unless the resident has voiced the desire to self-administer medications, has been assessed as safe to self-administer medications and has a physician order to do so. Residents with potential to be affected All residents have the potential to be affected by the alleged deficient practice. All resident rooms were checked to see if	

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F 554

Continued From page 5

dementia. Interventions included administer medications as ordered. The care plan did not include a focus area for Resident #43 to self-administer medications.

Review of the quarterly Minimum Data Set dated 01/27/24 assessed Resident #43's cognition as severely impaired and indicated no shortness of breath occurred during the lookback period.

Review of the March 2024 Medication Administration Record revealed mometasone-formoterol aerosol inhaler 200-5 mcg inhale 2 puffs twice a day and rinse mouth after use for chronic obstructive pulmonary disease was initialed by the nurses to indicate it was administered from 03/01/24 through 03/18/24 at 8:00 AM and 8:00 PM per physician orders.

During an observation and interview on 03/17/24 at 1:20 PM Resident #43 revealed two medicated aerosol inhalers were placed in clear view and easy access. One placed on overbed table labeled mometasone-formoterol aerosol 200-5 mcg with the expiration date 11/29/24 and the second inhaler on the nightstand labeled mometasone-formoterol 200-5 mcg with the expiration date 07/08/24. Resident #43 stated she had used the inhalers prior to being admitted to the facility and kept using them twice a day because she had trouble breathing. Resident #43 did not recall when she last used one of the inhalers she kept in her room.

An interview was conducted on 03/17/24 at 2:18 PM with Nurse #1 assigned to administer medications to Resident #43. Nurse #1 revealed she administered mometasone-formoterol 200-5

F 554

there were any additional medications left at a resident□s bedside who was not properly assessed to self-administer medications. This was completed on 3/17/24 by the Director of Nursing (DON). There were no additional residents being adversely affected by the alleged deficient practice.

Systemic Changes
Education initiated on 3/17/24 by the SDC for all medication aides and licensed nurses including agency nurses on medication administration and protocol for self-administration of medications. This education includes the following:
" Medications are not left with a resident unless the resident has voiced the desire to self-administer medications, has been assessed as safe to self-administer medications and has a physician order to do so.
This will be completed by The Staff Development Coordinator by 4/19/2024. Any licensed nurse or medication aide out on leave or PRN status will be educated prior to returning to duty by the SDC/designee. Education on medication administration procedures is included as part of orientation for all licensed nurses and medication aides by the SDC/designee. This education is also provided to the nursing agency for any agency nurses working in the facility in their orientation packet of material.

Monitoring
An audit tool was developed to monitor and ensure that licensed nurses and

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F 554	Continued From page 6 mcg to Resident #43 for the 8:00 AM scheduled dose and used the inhaler stored on the medication cart. Nurse #1 stated she was unsure if Resident #43 was cognitively intact to administer mometasone-formoterol and she would check the physician orders and the medical records for a self-administer assessment to see if those were in place. Nurse #1 revealed she did not know Resident #43 had two inhalers of mometasone-formoterol in the room and removed them both. During an interview on 03/18/24 at 2:06 PM the Director of Nursing (DON) stated the ability of Resident #43 to self-administer would need to be assessed before medications could be kept in the room. She stated due to the cognitive status of Resident #43 she did not consider the resident was able to self-administer mometasone-formoterol. She explained for a resident to be able to self-administer they would need to be assessed for their ability to safely administer the medication and must store it in a locked box and have the ability to lock the box, remove the medication, and return the medication to the box and relock it. The DON revealed she would expect the nurse staff to remove the inhalers from the room of Resident #43 and out of reach of anyone.	F 554	medication aides are following facility policy for medication administration and medications are not left at a resident bedside unless they have been properly assessed to self-administer medications and have a physician order to do so. The SDC, DON or designee will monitor 5 nurses and/or medication aides weekly x 4 weeks on random shifts, including weekends, then biweekly x 4 weeks, then monthly x 1 month. Results will be reported to the Quality Assurance and Performance Improvement (QAPI) team by the DON monthly x 3 months for review and further recommendations. Date of Completion: 04/19/2024	
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:	F 677		4/19/24

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F 677 Continued From page 7

Based on observations, record review, and interviews with residents and staff the facility failed to assist dependent residents with removing unwanted chin hairs (Resident #29) and cleaning and trimming dirty fingernails (Resident #60) for 2 of 3 residents reviewed for activities of daily living.

The findings included:

1. Resident #29 was admitted to the facility on 09/17/29 with diagnoses including dementia and cerebral ischemic attack (insufficient blood flow to an area of the brain).

Review of the quarterly Minimum Data Set (MDS) dated 2/7/24 assessed Resident #29 was cognitively intact and required substantial/maximal assistance with personal hygiene including shaving. The MDS indicated Resident #29 did not exhibit rejection of care behaviors during the lookback period.

During an observation and interview on 3/17/24 at 12:45 PM Resident #29 had several areas on her chin with patches of white and gray colored hairs. Resident #29 revealed nursing staff had not offered to trim or shave her chin hairs and she would like them shaven off.

During an observation and interview on 03/18/24 at 2:04 PM there was no change and Resident #29 continued to have several patches of white and gray hairs on her chin. Resident #29 revealed when she asked for the chin hairs to be shaven off, she was told there were no razors.

An interview was conducted on 03/19/24 at 3:05 PM with Med Aide #1 assigned to provide care for

F 677

F677
Peak Resources Charlotte acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

Affected Resident
Resident # 29 chin hairs were shaved on 3/18/24 by the Medication Aide and resident # 60 nails were cleaned and trimmed on 3/18/24 by the Certified Nurses Assistant. Resident #29 and Resident #60 remain at the facility and did not suffer any adverse effects related to the alleged deficient practice.

Other residents with potential to be affected.
All residents were reviewed for grooming of facial hair and nail care by the Nursing Supervisor on 3/18/24. There were no other residents adversely affected by the alleged deficient practice.

Systemic changes
All nursing staff (Licensed Nurses, Certified Nursing Assistants, Medication Aides) will be educated by the Staff Development Coordinator/designee on assisting with activities of daily living including shaving of unwanted facial hair and nailcare to keep nails clean and trimmed. This will be completed by 4/19/24. Any nursing staff out on leave or

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Resident #29. Med Aide #1 revealed on 3/18/24 (Monday) and was assigned to provide care for Resident #29. Med Aide #1 stated she assisted residents with activities of daily living care as needed including shaving chin hairs. She explained Resident #29's acceptance of care fluctuated and sometimes she allowed nurse staff to assist her with activities of daily living and personal hygiene and other times she might not feel like it and refuse care. She stated chin hairs should be shaven as needed and on bath days and did not recall if she noticed the chin hairs and had not offered to shave them during her shifts.

During an observation and interview on 03/18/24 at 2:04 PM the Director of Nursing (DON) observed Resident #29's chin hairs. The DON revealed the expectation was for nursing staff to offer to shave chin hairs when visible as needed.

2. Resident #60 was admitted to the facility on 12/19/17 with diagnoses including type 2 diabetes mellitus and vascular dementia.

Review of the quarterly MDS dated 1/29/24 assessed Resident #60 was cognitively intact and dependent on staff for activities of daily living. The MDS indicated Resident #60 did not exhibit rejection of care behaviors during the lookback period.

Review of the physician order dated 2/20/24 revealed Resident #60 shower days were scheduled during the evening shift (3:00 PM - 11:00 PM) on Monday and Thursday.

During an observation and interview on 3/17/24 at 11:16 AM Resident #60 revealed her fingernails on both hands extended approximately 1

PRN status will be educated by the SDC/designee prior to returning to duty.
All newly hired nursing staff are educated on ADL care, including grooming and nail care during orientation by the SDC/designee.

Monitoring
An audit tool was developed to monitor for unwanted facial hair and proper nail care.
The Director of Nursing (DON) or designee will complete these audits on 5 residents weekly for 4 weeks, the biweekly x 4 weeks, then monthly x 1 month.
The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the DON for review and further recommendations.

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Date of Correction 4/19/24

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F 677	Continued From page 9 centimeter pass the tip of the finger and appeared dirty with a build-up of a brown colored debris underneath several of the fingernails. Resident #60 revealed nail care was provided by staff, when necessary, but she was unable to recall how often. Resident #60 stated it was time her nail care was done. An interview was conducted on 03/19/24 at 3:04 PM with Med Aide #1 assigned to provide care for Resident #60. Med Aide #1 revealed she worked 12 hours shifts from 7:00 AM to 7:00 PM and worked on 3/14/24 (Thursday) and 3/18/24 (Monday) and assigned to provide care for Resident #60. Med Aide #1 stated she assisted residents with activities of daily living care including nail care, but she could not cut a diabetic resident's fingernails the nurse would have to do it. Med Aide #1 revealed she did not notice Resident #43's fingernails were dirty underneath the nail or appeared long and she did not offer to clean the nails and had not informed a nurse the resident's fingernails needed to be trimmed. Med Aide #1 revealed fingernails should be trimmed and cleaned as needed and on bath days. An interview and observation on 03/18/24 at 1:54 PM with the DON revealed Resident #60 had not refused nail care and wanted her fingernails trimmed and cleaned. The DON observed Resident #60 fingernails extended approximately 1 cm past the tip of finger with a build-up of brown colored debris underneath several of the nails. The DON revealed Resident #60 was diabetic and it was the nurse's responsibility to cut a diabetic resident's fingernails as needed. The DON revealed dirty fingernails should be cleaned by nursing staff when visibly dirty. The DON	F 677		

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F 677	Continued From page 10 revealed assessments were done by the nurses and they were expected to check the resident's fingernails and if nails need to be cleaned or trimmed and ensure it was done.	F 677		
F 689 SS=J	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 observations, record review and staff interviews, the facility failed to prevent a resident with severe cognitive impairment, who wore an elopement alarm device due to known wandering and exit-seeking behaviors, from exiting the facility unsupervised and without staff knowledge by leaving an unalarmed exit door propped open for 1 of 4 residents reviewed for accidents (Resident #212). On 06/09/23, Resident #212 was noticed by staff at approximately 5:30 PM wandering the halls with her purse and was last seen in the facility at 6:35 PM sitting in the activity room by herself. At approximately 7:30 PM, Resident #212 was observed outside the building in the back parking area by a visitor and staff. While outside for approximately an hour, Resident #212 walked from the back parking lot around the side of the building toward the front entrance of the facility which was approximately 50 to 75 feet from the main road before turning around and walking back to the parking area	F 689	Past noncompliance: no plan of correction required.	

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located in back of the facility.

Findings included:

Resident #212 was admitted to the facility on 09/30/21 with diagnoses that included non-Alzheimer's dementia.

A physician's order for Resident #212 dated 12/21/22 read, Apply elopement alarm device related to dementia, risk for elopement.

A quarterly Minimum Data Set (MDS) assessment dated 05/26/23 revealed Resident #212 had severe impairment in cognition. She was independent with walking and wandered daily during the MDS assessment period.

A wandering/elopement care plan, initiated on 10/04/21 and last revised on 06/09/23, revealed Resident #212 was at risk for wandering and elopement due to ambulatory status and dementia. Interventions included for staff to check Resident #212's elopement alarm device for function and placement every shift.

Review of Resident #212's June 2023 Medication Administration Record (MAR) revealed the following physician orders:
Check function of elopement alarm device to the right leg daily, 11:00 PM to 7:00 AM.
Check placement of elopement alarm device to right leg daily. On 06/09/23, Resident #212's wanderguard alarm was noted intact on the right lower extremity, each shift.
Both orders were initialed daily as completed per physician orders.

A staff progress note dated 06/09/23 at 8:00 PM

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F 689	Continued From page 12 written by the former Director of Nursing (DON) read in part, "Resident #212 was observed outside of the building by staff. Resident #212 was collected by staff and brought back into the facility. No signs or symptoms of distress noted. Skin assessment performed and no injuries noted. Resident #212 in no distress. Resident #212 stated she didn't know why she went outside." The facility's investigation revealed an unsigned and undated investigation summary that read in part, at approximately 7:30 PM a visitor notified the front desk that there may be a resident outside the facility. Nurse #1 immediately responded; however, Nurse Aide (NA) #2 had seen Resident #212 outside in the back parking lot and was escorting her back into the facility. At 7:35 PM, Nurse #1 initiated a comprehensive head count to ensure all residents were accounted for with no discrepancies noted. Resident #212 was assessed with no injuries identified. Resident #212 was previously identified as a wanderer and had an elopement alarm device in place on her right leg that was checked for functionality and was working properly. At 8:30 PM, the DON and Maintenance Director arrived at the facility and reviewed the camera footage which revealed Resident #212 exited through the service door located at the back of the building that was left propped open by Dietary Staff who were taking out trash at the end of their shift. Resident #212 was observed on the video footage with her purse over her arm, trying to get into parked cars and walked around the exterior of the building but never left the facility property. Interviews with staff working on 06/09/23 at the time of Resident #212's elopement revealed Resident #212 had been	F 689		

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pacing the halls since approximately 5:30 PM after supper and was last observed sitting alone in the activity room at approximately 6:35 PM.

A witness statement dated 06/09/23 that was obtained from NA #2 read, "I was changing a resident on the 600 Hall when I looked up and saw Resident #212 outside. I immediately kept the resident I was working with safe and proceeded out the service hall door, retrieved Resident #212 and brought her back inside to her room." There was nothing documented that noted the time this had occurred.

A telephone attempt for an interview with NA #2 on 03/20/24 at 2:54 PM was unsuccessful. The only phone number the facility had on file for NA #2 was incorrect.

A witness statement dated 06/09/23 that was obtained from Med Aide #2 read, "I saw Resident #212 pacing the halls at 5:30 PM. That was while I was finishing my medication pass." There was nothing else documented.

A telephone attempt for an interview with Med Aide #2 on 03/21/24 at 2:30 PM was unsuccessful.

A witness statement dated 06/09/23 with Nurse #5 on 06/09/23, read, "I last saw Resident #212 at 6:35 PM in the activity room sitting by herself." There was nothing else documented.

A telephone attempt for an interview with Nurse #5 on 03/21/24 at 2:35 PM was unsuccessful.

During an interview on 03/21/24 at 2:46 PM, Nurse #1 confirmed she was at the facility the

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evening of 06/09/23 when Resident #212 exited the facility unsupervised. Nurse #1 stated from what she could recall, prior to the visitor informing the front desk, she seemed to think it was NA #2 who had told her that Resident #212 was observed outside the building and as he was informing her of the incident, another staff member (she could not recall who) had gone outside to escort Resident #212 back inside the building. She was unable to recall the exact time but stated it was not that dark outside yet when NA #2 told her he was in another resident's room providing care, looked out the window and saw Resident #212 in the back parking lot. Nurse #1 explained Resident #1 was ambulatory and always walked around the facility carrying her purse. She could not remember how Resident #212 was able to exit the building or where exactly she was located outside but thought Resident #212 was found standing out back by the dumpster area. Nurse #1 stated immediately after Resident #212 was brought back into the facility, she completed a head-to-toe assessment of Resident #212 with no injuries identified. She added Resident #212 was at her baseline and displayed no signs or symptoms of distress.

During an interview on 03/21/24 at 10:05 AM, the Social Worker (SW) Assistant revealed she was not present at the facility on 06/09/23 when Resident #212 exited the building unsupervised. The SW Assistant recalled being informed that the service hall exit door was accidentally left propped open and that was how Resident #212 was able to exit the building. She explained Resident #212 had dementia, was known to wander and always carried her purse as she walked up and down the hallways. The SW Assistant stated she had not known Resident

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F 689	Continued From page 15 #212 to go up to exit doors and try to open them, she just looked out the windows. During interviews on 03/20/24 4:35 PM and 03/21/24 at 2:15 PM, the Maintenance Director recalled he was already at home the evening of 06/09/23 when he was notified that Resident #212 was observed outside the facility and he immediately came back to the facility. When he reviewed the video footage, Resident #212 was observed exiting through the back service hall exit door that dietary staff had left propped open while taking trash out to the dumpster. He stated Resident #212 exited through the door, walked down the sidewalk toward the dumpsters and then turned toward the right of the building and continued walking on the sidewalk past the dumpsters all the way around to the front of the building almost to the front entrance which he estimated to be approximately 100 yards. Once Resident #212 reached the front of the building, she stopped and then turned around and walked back the same way until she reached the dumpsters where she remained until staff came to escort her back into the facility. He added she never left the facility property. The Maintenance Director stated he also saw on the video footage 2 Dietary Staff, one male and one female (he could not recall their names but stated they were no longer employed), who were standing by the dumpsters as Resident #212 walked past them. He was not sure how they did not notice Resident #212 and stated they may have been looking in the dumpster at that time or thought she was a staff member since she was carrying her purse but he could not recall for sure. The Maintenance Director explained the video footage was only kept for a period of 10 days before it automatically started recording over previous	F 689		

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footage and stated he did not write down the times from the video footage when Resident #212 exited the building or when staff had gone out to the dumpster area to escort her back into the facility. When asked about the time frame mentioned in the facility's investigation summary which noted Resident #212 was last observed in the facility at approximately 6:30 PM and a visitor reported a resident was outside the facility at approximately 7:30 PM, the Maintenance Director stated it was getting dark around the time he arrived back at the facility on 06/09/23 and Resident #212 being outside unsupervised for an hour sounded pretty accurate the best he could recall. The Maintenance Director explained at the time, the back service hall door was not wanderguard protected and after reviewing the video footage, he immediately put an alarm on the top of the exit door that automatically alarmed anytime the door was opened. He also ordered a wanderguard alarm system that was installed on the back service door following the incident on 06/09/23.

An observation of the back service hall door and parking area behind the back of the building was conducted on 03/20/24 at 4:30 PM. Inside the facility at the end of a resident hallway were double fire doors that opened to the service hall. Posted on the double fire doors were signs that read, "keep doors closed and do not prop open door for any reason." When entering the service hall through the double fire doors, to the left was the exit door where Resident #212 had exited the facility on 06/09/23 that was locked and had an elopement alarm system. Just outside the exit door was a sidewalk that led out to the parking lot and dumpsters where Resident #212 was found. The dumpsters were located at the end of the

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sidewalk a short distance from the exit door. The sidewalk continued around the right side of the building exterior to the front of the building. Along the left side and back perimeter of the parking lot were trees that separated the facility from wooded areas. Along the right side of the parking lot was a side road with trees and wooded areas along the outer perimeter of the side road. In the front of the building was another parking area that led to the main road that was approximately 50 to 75 feet from the front entrance of the facility.

Telephone attempts on 03/20/24 at 2:15 PM and 03/21/24 at 12:45 PM for an interview with the former DON were unsuccessful.

During an interview on 03/21/24 at 2:53 PM, the Regional Director of Operations for Dietary Services revealed they were unable to determine who propped the exit door open on 06/09/23 when Resident #212 exited the building unsupervised. She stated education was reinforced with all dietary staff not to prop exit doors open and doing so would be grounds for termination.

Telephone attempts on 03/20/24 at 2:19 PM and 03/21/24 at 1:22 PM for an interview with the former Administrator were unsuccessful.

An online website named Weather Underground was used to obtain the outside weather in the Charlotte area on 06/09/23 which noted at 5:52 PM the temperature was 79 degrees Fahrenheit (F), at 6:52 PM the temperature was 78 degrees F, and at 7:52 PM the temperature was 76 degrees F.

The Administrator was notified of Immediate

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F 689	Continued From page 18 Jeopardy on 03/21/24 at 1:13 PM. The facility provided the following Corrective Action Plan with a completion date of 06/16/23: Address how corrective action will be accomplished for the residents found to have been affected by the deficient practice: On 06/09/23 Resident #212 exited through the service hall door located at the back of the building and walked approximately 100 yards around the exterior of the building to the front entrance. Staff had not realized Resident #212 was missing until approximately 7:30 PM when a visitor alerted the receptionist at the front desk that a resident was outside. Staff immediately located Resident #212 near the dumpster area at the back of the building and assisted her back inside. Skin assessment with no injuries noted on 06/09/23. Resident #212 placed on q (every) 15 minute checks with a one-on-one Certified Nursing Assistant (CNA) for 24 hours. Resident #212 had no further attempts to leave the facility through 06/23/23. A planned discharge to a locked memory care unit occurred on 06/23/23. On 6/9/23 the Director of Nursing arrived at the facility with the Maintenance Director and completed a root cause analysis. This analysis included a review of the exterior camera footage. Resident #212 was noted to exit the facility via the service hall door at the rear of the facility. Resident was visible via the camera footage the entire period in which she was outside of the facility and never left the property. It was determined that dietary staff propped the exit door open to take the trash out.	F 689		

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F 689	Continued From page 19 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing and MDS Nurses completed a 100% audit for residents to ensure that an elopement assessment has been completed in order to determine their elopement risk on 6/12/23. All residents identified with elopement risk will have Wander Guard placed, updated elopement risk assessment and care plan updated. No further residents were identified. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not reoccur: On 06/09/23 the rear exit door, which the resident exited from, was closed immediately by facility staff. On 06/09/23 all staff present in the facility, including contract agency staff, were educated by the Staff Development Coordinator that all doors that lead outside of the facility may not be propped open, keeping service hall doors closed. The Maintenance Director checked the system to assure functionality on 6/9/23. A screecher alarm (high pitched) was added to the rear exit door (back service hall) on 6/9/23. The Wanderguard system was functioning properly. This education of all exit doors leading out of facility not to be propped open has been included in orientation to be completed with the facility tour. On 06/12/23 A QAPI meeting was held to discuss and develop a plan of correction, audits and inclusion in QAPI process and meetings. The Maintenance Director ordered signage on	F 689		

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6/12/23 to be placed as a reminder to keep doors closed for resident safety. The Maintenance Director conducted elopement drills for team education. This was completed on 6/12/23 and 6/13/23. The Maintenance Director also educated all staff, including contract agency staff, on which doors are allowed to be used when exiting the facility. This was completed on 6/12/23-6/13/23. Any staff out on leave or PRN (as needed) status were educated by the Maintenance Director or designee prior to returning to duty. This education is part of the orientation process for newly hired employees and is conducted during orientation by the Maintenance Director.

The Maintenance Director updated the anti-wandering door bar system which alarms and locks the door when a resident approaches with a wander guard transmitter and the updated anti-wandering door bar system required replacement of all resident transmitters (bracelets) for the Wander Guard system on 6/16/23. This included adding an additional anti-wandering door bar system to the rear exit door (back service hall) through which Resident #212 exited the facility on 06/09/23.

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

A Quality Assurance Performance Improvement (QAPI) Audit Tool was initiated on 6/12/23 to monitor exit doors to ensure that no doors have been propped open. The Maintenance Director will complete random audits designee 5x per week for 4 weeks, then 3x per week for 4 weeks, then weekly for 4 weeks using the Quality

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Assurance Performance Improvement (QAPI) Audit Tool of exit doors to ensure that no doors have been propped open. The monitoring tool was initiated on 6/12/23. This Quality Assurance Performance Improvement (QAPI) tool will be monitored by the Administrator or designee 5x per week for 4 weeks, then 3x per week for 4 weeks, then weekly for 4 weeks. 100% of exit doors will be monitored. On 6/12/23 the decision was made that the results will be reported to the Quality Assurance Performance Improvement (QAPI) team by the Administrator. The need for further monitoring will be determined by the QAPI team.

IJ removal date: 6/14/23.

Date of completion: 06/17/23.

The monitoring audits of the facility exit doors for June 2023, July 2023 and August 2023 were reviewed with no concerns identified. Observations of the facility exit doors revealed they were kept closed and locked and the fire doors leading to the service hall had signage posted not to prop the doors open. The alarm on the back service hall exit door was confirmed during an observation. Elopement books were observed at each nurses' station and reception desk. The elopement books contained information and pictures for each resident identified as high risk. Interviews conducted with staff on various shifts and departments revealed they received re-education related to elopement and residents with exit-seeking behaviors, not leaving exit doors propped open, and they had participated in facility elopement drills. The completion date of 6/17/23 was validated.

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F 695	Continued From page 22	F 695		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post cautionary and safety signs that indicated the use of oxygen for 5 of 5 residents reviewed for respiratory care (Residents #17, #34, #58, #60, and #311). Findings included: a. Resident #34 was admitted to the facility on 10/12/10 with diagnoses that included respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and dependence on supplemental oxygen. A physician's order for Resident #34 dated 01/25/24 read, oxygen at 3 liters per minute (LPM) every shift. The annual Minimum Data Set (MDS) assessment dated 03/12/24 revealed Resident #34 was nonverbal and received oxygen therapy during the MDS assessment period. An observation conducted on 03/18/24 at 2:28 PM revealed Resident #34 lying in bed receiving	F 695	F695 Peak Resources Charlotte acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Resident Affected The facility has been a Tobacco free facility since 2016. Signs indicating the facility is a Tobacco Free Property were posted at the entrances of the building and across the property per Life Safety Regulations and facility policy. An oxygen in use sign is posted wherever oxygen is stored in the facility. An oxygen in use sign was posted at the entrances to the facility on 3/20/24 by the Maintenance Department. No resident was adversely affected by the alleged deficient practice.	4/19/24

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supplemental oxygen at 3 LPM. There was no sign posted on the door or doorframe of Resident #34's room to indicate oxygen was in use.

Subsequent observations conducted on 03/19/24 at 11:00 AM and 4:46 PM and 03/20/24 at 9:40 AM revealed Resident #34 lying in bed receiving supplemental oxygen at 3 LPM. There was no sign posted on the door or doorframe of Resident #34's room to indicate oxygen was in use.

b. Resident #60 was admitted to the facility on 12/19/17 with diagnoses that included congestive heart failure and respiratory failure.

A physician's order for Resident #60 dated 08/04/23 read, oxygen at 2 liters per minute (LPM) continuously.

The quarterly Minimum Data Set (MDS) assessment dated 03/12/24 revealed Resident #60 had intact cognition and received oxygen therapy during the MDS assessment period.

An observation conducted on 03/19/24 at 8:43 AM revealed Resident #60 lying in bed receiving supplemental oxygen at 2 LPM. There was no sign posted on the door or doorframe of Resident #60's room to indicate oxygen was in use.

Subsequent observations conducted on 03/19/24 at 4:47 PM and 03/20/24 at 9:45 AM revealed Resident #60 lying in bed receiving supplemental oxygen at 2 LPM. There was no sign posted on the door or doorframe of Resident #60's room to indicate oxygen was in use.

During interviews on 03/20/24 at 11:58 AM and 1:34 PM, the Unit Manager revealed either she or

F 695

Systemic Changes
The Administrator educated the Maintenance Department on 3/20/2024 regarding the requirements that a sign be posted at the entrance to the facility that the facility is Tobacco free and the requirement that a sign be posted at the entrance to the facility that there is oxygen in use.
An audit tool was developed to monitor for compliance with the plan of correction.
The audit includes the following:
- Is there a sign posted at the entrances to the facility that there is oxygen in use?
- Are there signs posted where oxygen is stored?

The Administrator will conduct these audits monthly x 3 months to ensure compliance with the plan of correction.
The Maintenance Director will ensure these signs are posted at all times while completing the preventative maintenance rounds.

The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee by the Administrator monthly x 3 months for review and further recommendations.

Date of Completion: 04/19/2024

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the Family Nurse Practitioner entered oxygen orders into the resident's Electronic Health Record (EHR). The Unit Manager stated she did not know anything about oxygen cautionary signage that should be posted outside the rooms of residents receiving supplemental oxygen. She explained there was a sign posted as you entered the front entrance of the facility that read 'no smoking, oxygen in use' and staff could determine who was on oxygen by the physician order in their EHR.

During an interview on 03/20/24 at 4:23 PM, the Director of Nursing revealed she was unaware that oxygen cautionary signage should be posted outside the rooms of residents receiving supplemental oxygen.

During an interview on 03/20/24 at 5:15 PM, the Administrator explained the facility was a non-smoking facility and their protocol was to post a cautionary sign on the front entrance of the facility informing visitors oxygen was in use instead of posting signage outside or in resident rooms.

An observation and interview was conducted with the Administrator on 03/20/24 at 5:30 PM. At the front entrance of the facility, there were various informational signage posted on the door or to the left and right sides of the facility entrance but none that indicated oxygen was in use. The Administrator stated she was not sure why there was no sign posted outside the front of the facility indicating oxygen was in use and there should have been.

c. Resident #17 was admitted to the facility on 08/22/23 with diagnoses that included acute

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respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and chronic obstructive pulmonary disease (long-term lung disease that makes it hard to breathe).

A physician's order for Resident #17 dated 11/27/23 read, oxygen at 2 liters per minute (LPM) continuously.

The quarterly Minimum Data Set (MDS) assessment dated 02/20/24 revealed Resident #17 had moderate impairment in cognition and received oxygen therapy during the MDS assessment period.

An observation conducted on 03/18/24 at 10:30 AM revealed Resident #17 was receiving supplemental oxygen at 2 LPM. There was no sign posted on the door or doorframe of Resident #17's room to indicate oxygen was in use.

Subsequent observations conducted on 03/19/24 at 8:40 AM and 03/20/24 at 10:00 AM revealed Resident #17 was receiving supplemental oxygen at 2 LPM. There was no sign posted on the door or doorframe of Resident #17's room to indicate oxygen was in use.

d. Resident #58 was admitted to the facility on 08/31/23 with diagnoses that included shortness of breath and dependence on supplemental oxygen.

A physician's order for Resident #58 dated 03/04/24 read, oxygen at 3 liters per minute (LPM) continuously.

The quarterly Minimum Data Set (MDS)

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assessment dated 03/06/24 revealed Resident #58 had severe cognitive impairment and received oxygen therapy during the MDS assessment period.

An observation conducted on 03/19/24 at 8:43 AM revealed Resident #58 was receiving supplemental oxygen at 3 LPM. There was no sign posted on the door or doorframe of Resident #58's room to indicate oxygen was in use.

A second observation conducted on 03/20/24 at 10:02 AM revealed Resident #58 was receiving supplemental oxygen at 3 LPM. There was no sign posted on the door or doorframe of Resident #58's room to indicate oxygen was in use.

e. Resident #311 was admitted to the facility on 03/12/24 with diagnoses that included acute and chronic respiratory failure with hypoxia.

A physician's order for Resident #311 dated 03/12/24 read, oxygen at 4 liters per minute (LPM) via nasal cannula continuously.

The admission Minimum Data Set (MDS) assessment dated 03/17/24 revealed Resident #311 had intact cognition and received oxygen therapy during the MDS assessment period.

An observation conducted on 03/19/24 at 8:44 AM revealed Resident #311 was receiving supplemental oxygen at 4 LPM. There was no sign posted on the door or doorframe of Resident #311's room to indicate oxygen was in use.

A second observation on 03/20/24 at 4:47 PM and 03/20/24 at 10:03 AM revealed Resident #311 was receiving supplemental oxygen at 4

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F 695	Continued From page 27	F 695		

LPM. There was no sign posted on the door or doorframe of Resident #311's room to indicate oxygen was in use.

During interviews on 03/20/24 at 11:58 AM and 1:34 PM, the Unit Manager revealed either she or the Family Nurse Practitioner entered oxygen orders into the resident's Electronic Health Record (EHR). The Unit Manager stated she did not know anything about oxygen cautionary signage that should be posted outside the rooms of residents receiving supplemental oxygen. She explained there was a sign posted as you entered the front entrance of the facility that read 'no smoking, oxygen in use' and staff could determine who was on oxygen by the physician order in their EHR.

During an interview on 03/20/24 at 4:23 PM, the Director of Nursing revealed she was unaware that oxygen cautionary signage should be posted outside the rooms of residents receiving supplemental oxygen.

During an interview on 03/20/24 at 5:15 PM, the Administrator explained the facility was a non-smoking facility and their protocol was to post a cautionary sign on the front entrance of the facility informing visitors oxygen was in use instead of posting signage outside or in resident rooms.

An observation and interview was conducted with the Administrator on 03/20/24 at 5:30 PM. At the front entrance of the facility, there were various informational signage posted on the door or to the left and right sides of the facility entrance but none that indicated oxygen was in use. The Administrator stated she was not sure why there

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F 695	Continued From page 28 was no sign posted outside the front of the facility indicating oxygen was in use and there should have been.	F 695		
F 761 SS=D	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 record review, observations, and interviews with the Director of Clinical Services Pharmacist and staff the facility failed to store an unopened bottle of medicated eye drops and a multi-use insulin pen per manufacturer's	F 761	F761 Peak Resources Charlotte acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is	4/19/24

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recommendations and failed to discard a multi-use insulin pen by the date on the label and failed to ensure medications left in a resident's room were under direct observation by the administering nurse for 1 of 1 resident (Resident #51) and 2 of 8 medication carts reviewed for medication storage (200-hall med cart and 500-hall med cart #1).

The findings included:

1. Review of manufacturer's package insert for Latanoprost eye drops (medicated drops used to treat glaucoma) read in part, "store unopened bottle(s) under refrigeration at 36°F to 46°F. Once a bottle was opened for use, it may be stored at room temperature up to 77°F for 6 weeks."

An observation of the 200-hall medication cart with Nurse #3 on 03/19/24 at 11:46 AM revealed an unopened bottle of latanoprost eye drops with no open date to indicate how long it had been stored at room temperature. Nurse #3 revealed the latanoprost eye drops were administered at bedtime and should be stored in the refrigerator designated for medications until ready for use. Nurse #3 revealed when latanoprost eye drops arrived from pharmacy the bottle and the plastic bag they were put in were labeled with instructions to refrigerate.

During an interview on 03/19/24 at 11:57 AM the Unit Manager stated the process for storing latanoprost eye drops was to place them in the refrigerator designated for medications until needed for use. She stated when latanoprost eye drops were removed from the refrigerator the open date was written on the bottle then the eye drops could be placed on the medication cart.

F 761

factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

Affected Resident
The medications on the floor of Resident #51 room were immediately disposed of by Nurse #2 on 3/17/2024. The opened, exposed, undated and expired medications from the 200 and 500 hall medication carts were immediately removed and discarded by the Director of Nursing on 3/19/2024. No resident was affected by the alleged deficient practice.

Residents with potential to be affected
All residents in the facility have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON), Registered Nurse (RN) Supervisor and Staff Development Coordinator (SDC) checked all medication carts in the facility to ensure that there were no opened and undated, exposed and/or expired medications in the medication cart on 3/19/24. No additional opened, undated, exposed or expired medications were observed in any cart in the facility. There were no additional loose medications observed in any other resident room. No resident was affected by the alleged deficient practice.

Systemic Changes
All licensed nurses will be educated on policy regarding proper labeling and storage of drugs and biologicals by the

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F 761	Continued From page 30 An interview was conducted on 03/19/24 at 12:24 PM with the Director of Clinical Services Pharmacist. The Pharmacist stated latanoprost eye drops should be kept in the refrigerator until needed for use and the bottle dated when it was placed on medication cart. Review of the manufacturer's package insert for lispro insulin (fast-acting medication used to lower blood glucose) pen read in part, "Storage and Handling: not in-use (unopened) refrigerate at 36° to 46°F and in-use (opened) store for 28 days at room temperature only (Do not refrigerate). When stored at room temperature, insulin lispro can only be used for a total of 28 days, including both not in-use (unopened) and in-use (opened) storage time." Review of the manufacturer's package insert for lantus insulin (long-acting medication used to lower blood glucose) pen storage read in part, "in use (opened) discard after 28 days. An observation of the 500-hall medication cart #1 with Med Aide #1 and the Director of Nursing (DON) on 03/19/24 at 12:07 PM revealed a multi-use lispro insulin pen with no in use (opened) or discard date to indicate when it was initially stored at room temperature and when to discard per manufacturer's recommendations. A multi-use lantus insulin pen with the open date 01/21/24 and discard date 02/17/24. During an interview on 03/19/24 at 12:07 PM Medication Aide #1 stated she was responsible for checking the medication cart for expired meds, but she did not administer insulin and did not check to ensure the pens were labeled with	F 761	SDC, DON and/or their designee. In addition, a list of medications with shortened expiration dates is also located on all medication carts for reference. This education will be completed by 4/19/2024. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to duty by the Staff Development Coordinator. Newly hired licensed nursing staff are educated on this process during orientation by the Staff Development Coordinator. Monitoring An audit tool was developed to ensure compliance with the plan of correction. The audit tool contains the following: 1. Are there any expired medications on the medication carts? 2. Are there any opened, undated medications on the medication carts? The Director of Nursing or RN Supervisor will audit 50% of all medication carts and medication storage rooms weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of the audits will determine the need for further monitoring. QAPI All audit information will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) meeting monthly by Director of Nursing to be analyzed and reviewed for further recommendations. Completion date: 4/19/2024	

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F 761	Continued From page 31 an open or discard date. During an interview on 03/19/24 at 12:15 PM the DON revealed night shift nurses and Med Aides checked the carts for expired medications and the labels for open and discard dates. She stated nurses and Med Aides were also expected to check their carts for expired meds and for in use (opened) insulin pens with no dates during medication administration. An interview was conducted on 03/19/24 at 12:24 PM with the Director of Clinical Services Pharmacist. The Pharmacist revealed multi-use insulin pens should be stored in the refrigerator and when removed for in use (opened) labeled with the date then placed on the med cart. He stated lispro and lantus insulins should be discarded when stored at room temperature for 28 days and if not, it lost its efficacy to lower the body's blood glucose levels. 2. An observation of the floor around Resident #51's bed on 03/17/24 at 3:16 PM revealed one round white pill at the foot of the bed and one round white pill and one orange pill to the left of the bed. The pills were out of Resident #51's reach. An interview with Nurse #2 on 03/17/24 at 3:24 PM revealed she was caring for Resident #51 on 03/17/24 on the 7:00 AM to 7:00 PM shift and gave all his pills crushed in applesauce. She stated she watched Resident #51 swallow his pills each time he received medication on 03/17/24 and she had no idea what the 2 white pills and 1 orange pill were or how long they had been there. Nurse #2 stated she had not noticed the pills in Resident #51's floor and she had been in his	F 761		

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F 761	Continued From page 32 room several times throughout her shift. An observation of the floor around Resident #51's bed on 03/18/24 at 2:21 PM revealed a partially crushed orange pill under his bed. The pill was out of Resident #51's reach. An interview with Nurse #4 on 03/18/24 at 2:24 PM revealed she was caring for Resident #51 on 03/18/24 on the 7:00 AM to 3:00 PM shift and gave all his pills whole one at a time. She stated she watched him swallow each pill when she gave him medication on 03/18/24 and she did not notice the orange pill on the floor. Nurse #4 stated she had given Resident #51 hydralazine (a diuretic) the morning of 03/18/24 and that was the only orange pill he received. She stated she had not noticed the orange pill on the floor, and she had been in and out of Resident #51's room several times throughout the day. An interview with the Director of Nursing (DON) on 03/18/24 at 2:50 PM revealed she would not expect to find medications on the floor. She stated she expected nurses to remain with residents while they took each medication at the time they were administered.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		4/19/24

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F 812	Continued From page 33 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean floor in 1 of 1 walk-in cooler and 1 of 1 walk-in freezer; label and date open food items and discard expired food in 1 of 1 walk-in cooler; store food off the floor for 1 of 1 walk-in freezer; and store food off the floor in 1 of 1 dry storage room. These practices had the potential to affect food served to residents. Findings included: 1. An initial observation of the walk-in cooler on 03/17/24 at 10:42 AM revealed the following: (a). multiple dried brown stains on the floor and surveyor's shoes stuck to the floor. (b). a gallon of balsamic vinaigrette dressing with an open date of 04/13/23 (c). half of a deli-style turkey breast with an open date of 02/14/24 (d). an opened and undated gallon of barbecue sauce An interview with the Dietary Manager on 03/17/24 at 10:46 AM revealed the floor of the	F 812	F812 Peak Resources Charlotte acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Resident Affected The Dietary Manager cleaned the floor in the walk-in cooler and the walk-in freezer on 3/17/2024. The Dietary Manager discarded the unlabeled, undated and expired food in the walk-in cooler on 3/17/2024. The Dietary Manager removed the food in the walk-in freezer and dry storage room that was not stored off of the floor on 3/17/2024. No residents suffered any adverse effects related to the alleged deficient practice. Other residents with potential to be affected	

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walk-in cooler had been cleaned approximately two weeks ago and she was working with housekeeping to try to find a product to remove the stains and not leave the floor sticky. She stated she was not sure how long the balsamic dressing was good for after being opened and she could not locate an expiration date on the dressing. The Dietary Manager stated the deli-style turkey breast was good for one month after being opened and the barbecue sauce should have been dated when it was opened by the staff member who opened the sauce.

A follow-up interview with the Dietary Manager on 03/19/24 at 2:46 PM revealed she was responsible for ensuring all opened food items were dated and used or discarded by their expiration date. She stated the dressing and deli-style turkey should have been discarded and were not due to her oversight.

An interview with the Administrator on 03/20/24 at 5:02 PM revealed she expected all food items to be labeled and dated and used or discarded on or before the expiration date. She confirmed dietary staff had been working to find a solution to remove stains from the floor.

2. An initial observation of the walk-in freezer on 03/17/24 at 10:48 AM revealed the following:

(a). scattered food debris to freezer floor
(b). two boxes of hamburger buns sitting directly on the freezer floor

An interview with the Dietary Manager on 03/17/24 at 10:50 AM revealed the floor of the freezer should be clean and free of debris and it was deep cleaned two weeks ago.

F 812

On 3/17/2024, The Dietary Manager/designee checked all other food in the walk-in freezer, walk-in cooler and dry storage room to ensure that all food was labeled, dated, within expiration date and stored off of the floor. There were no other food items improperly stored in these areas. No residents suffered any adverse effects related to the deficient practice.

Systemic Changes
The Dietary Manager will educate all dietary staff regarding cleaning of floors in the kitchen, proper storage procedures for food items in the kitchen. This education included labeling, dating, discarding of expired food and that food must be kept off of the floor. This will be completed by 4/19/2024. Any dietary staff out on leave or PRN status will be educated prior to returning to duty. This education is provided to all dietary staff by the Dietary Manager/designee during the orientation process.
An audit tool was developed to monitor for compliance with the plan of correction.
The audit includes the following:
" Is food labeled and/or dated properly?
" Have expired food items been discarded prior to the expiration date?
" Are food items stored on the floor?
" Are the kitchen floors clean?

The Dietary Manager will complete these audits weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month.

The results of these audits will be brought

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F 812	Continued From page 35 In an interview with the Dietary Manager on 03/19/24 at 2:46 PM she confirmed stock should not be stored on the floor of the walk-in freezer. She stated she was working as a cook on 03/14/24 and trying to rearrange stock in the freezer and that was why the boxes of hamburger buns were sitting on the floor of the walk-in freezer. An interview with the Administrator on 03/20/24 at 5:02 PM revealed stock should not be stored on the floor and the freezer floor should be clean. 3. An observation of the dry storage room on 03/17/24 at 10:55 AM revealed a box of soybean oil sitting directly on the floor. In an interview with the Dietary Manager on 03/19/24 at 2:46 PM she confirmed stock should not be stored on the floor of the dry storage room. She stated she was working as a cook on 03/14/24 and trying to rearrange stock in the dry storage room and that was why the box of oil was sitting on the floor. An interview with the Administrator on 03/20/24 at 5:02 PM revealed stock should not be stored on the floor.	F 812	to the Quality Assurance and Performance Improvement Committee by the Dietary Manager monthly x 3 months for review and further recommendations. Date of Completion: 04/19/2024	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure the area surrounding	F 814	F 814 Peak Resources Charlotte acknowledges	4/19/24

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F 814

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dumpsters remained free of garbage and debris and failed to close the doors to the dumpsters that contained waste for 2 of 2 dumpsters reviewed. These failures had the potential to attract pests and rodents.

Findings included:

An observation of the dumpster area with the Dietary Manager on 03/17/24 at 10:56 AM revealed scattered gloves on the ground around the dumpsters, six wooden pallets lying on the ground around the dumpsters, and both dumpster doors were open.

An interview with the Dietary Manager on 03/17/24 at 10:56 AM revealed it was the responsibility of the housekeeping and maintenance departments to keep the dumpster area clean and the trash can lids closed.

An interview with the Director of Housekeeping on 03/20/24 at 4:27 PM revealed the housekeeping, dietary, and maintenance departments were all responsible for ensuring the dumpster area was clean and the dumpster lids were closed.

An interview with the Maintenance Director on 03/20/24 at 4:48 PM revealed it was the responsibility of the maintenance and housekeeping departments to ensure the area around the dumpsters were clean and free of debris. He stated he had been employed at the facility for a year and a half and the wooden pallets had been in the dumpster area since he began working at the facility.

An interview with the Administrator on 03/20/24 at

F 814

receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

Resident Affected
The garbage and debris surrounding the dumpsters was immediately removed by the Dietary and Housekeeping Manager on 3/17/2024. The doors to the dumpsters were immediately closed by the Dietary Manager on 3/17/2024. No resident suffered any adverse effects related to the alleged deficient practice.

Other residents with potential to be affected
The Housekeeping Manager observed the facility grounds for any garbage and/or debris on 3/17/2024. Any loose garbage was taken to the dumpster and was properly disposed into the dumpster. The Housekeeping Manager observed any dumpster on the facility grounds to ensure that the doors were closed. This was completed on 3/17/2024. There were no other issues identified. No residents suffered any adverse effects related to the alleged deficient practice.

Systemic Changes
The Administrator educated the Dietary, Housekeeping and Maintenance Director on the proper disposal of garbage and debris and the requirement to keep the

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F 814	Continued From page 37 5:02 PM revealed she expected the dumpster area to be clean and free of debris and the lids of the dumpsters should be closed.	F 814	dumpster doors closed after disposal of garbage into the dumpster. This was completed on 3/17/2024. The Dietary, Housekeeping and Maintenance Director will educate their staff on these practices. This will be completed by 4/19/2024. Any staff out on leave or PRN status will be educated by the Department Manager prior to returning to duty. All newly hired Dietary, Housekeeping and Maintenance staff are educated on these practices during orientation by the Department Manager/designee. An audit tool was developed to monitor for compliance with the plan of correction. The audit includes the following: • Are dumpster areas free from garbage and/or debris? • Are the dumpster doors closed? The Administrator will conduct these audits 1x/week x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee by the Administrator monthly x 3 months for review and further recommendations. Date of Completion: 04/19/2024	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written	F 867		4/19/24

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F 867

policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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F 867	Continued From page 39 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct	F 867		

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F 867	Continued From page 40 distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the focused infection control and complaint investigation survey on 08/27/21, the complaint investigation survey on 12/09/21, the recertification and complaint investigation survey	F 867	F867 To correct this deficiency the following items were completed. o The Administrator was educated by the Corporate Compliance Manager regarding the purpose of the Quality Assurance and Performance Improvement (QAPI) Program. The	

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on 09/29/22, complaint investigation survey on 11/03/22, and the complaint investigation survey on 01/11/23. This was for six repeat deficiencies: one in the area of free of accident hazards/supervision/devices originally cited on 08/27/21 during the focused infection control and complaint investigation survey and again on 12/09/21 during the complaint investigation survey, one in the area of food procurement: store/prepare/serve and one in the area of dispose garbage and refuse properly originally cited on 09/29/22 during a recertification and complaint investigation survey, one in the area of residents right to self-administer medications originally cited on 11/03/22 during a complaint investigation survey, and one in the area of resident rights/exercise of rights and activities of daily living provided for dependent residents originally cited on 01/11/23 during a complaint investigation survey. All six deficiencies were subsequently recited on 03/21/24 during the recertification and complaint investigation survey. The continued failure of the facility during six federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.

The findings included:

This tag is cross referenced to:

F550: Based on observations, record review and staff interviews, the facility failed to provide a dignified dining experience when Nurse Aide (NA) #1 stood at the beside while assisting a dependent resident during a meal for 1 of 7 resident reviewed for dignity (Resident #59). The reasonable person concept was applied to this deficiency as individuals might feel a lack of

F 867

education included the objectives of the QAPI program including to identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan as needed, the purpose of the QAPI program to provide a means for resident care and safety issues to be resolved, and how the committee monitors issues and follows up with unresolved issues that have been identified. This was completed on 04/15/2024.

o Facility QAPI committee members will then be in-serviced by the Administrator on the following:

o The purpose of the QAPI Program

o QAPI Committee is responsible for identifying and reviewing issues from past surveys and evaluating the current plan for its effectiveness and changing the plan, as necessary.

o How the QAPI Committee monitors issues and follows up with unresolved issues that have been identified.

o QAPI committee members include the Medical Director, Pharmacy Consultant, Administrator, Director of Nursing, Minimum Data Set (MDS) nurses, Admission Coordinator, Social Worker, Business Office Manager, Staff Development Coordinator, Nursing Supervisor, Medical Records Manager, Maintenance Director, Housekeeping Supervisor, Dietary Manager, Treatment

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F 867	Continued From page 42 dignity when staff toward over them and didn't attempt conversation while assisting them with a meal. During the complaint investigation survey of 01/11/23, the facility to provide care in a manner that maintained a resident's dignity who was dependent with incontinence care. This made the Resident feel sad and as if she had done something wrong to be treated that way. F554: Based on observations, record review, interviews with the resident and staff the facility failed to assess if a cognitively impaired resident could self-administer inhalers kept at the beside for 1 of 1 resident reviewed for self-administration (Resident #43). During the complaint investigation survey of 11/03/22, the facility failed to assess a resident for self-administrating medications. F677: Based on observations, record review, and interviews with residents and staff the facility failed to assist dependent residents with removing unwanted chin hairs (Resident #29) and cleaning and trimming dirty fingernails (Resident #60) for 2 of 3 residents reviewed for activities of daily living. During the complaint investigation survey of 01/11/23, the facility failed to provide incontinence care to a dependent resident. F689: Based on observations, record review and staff interviews, the facility failed to prevent a resident with severe cognitive impairment, who wore an elopement alarm device due to known wandering and exit-seeking behaviors, from	F 867	Nurse and Activities Director. o A tool will be utilized to assist the QAPI committee. The tool, titled, "QAPI Self-Evaluation", includes the following: o Does the QAPI committee have a current plan in place? o Does the committee identify who is responsible for overseeing the plan/project? o Is the plan working? o If the plan is not working have changes been put in place to improve? o Is the outcome measurable? o Has the project been successful? o Can the plan be considered resolved? o This tool was developed for a QAPI sub-committee to establish the success of the QAPI projects and make recommendations as necessary. The sub-committee is made up of 3 members of the QAPI general Committee which will include the Director of Nursing, Staff Development Coordinator and the Administrator. Monitoring: o The Self-Evaluation tool will be completed by the sub-committee at scheduled meetings monthly prior to the next scheduled QAPI monthly meeting o Findings of the sub-committee will be addressed at the monthly QAPI meeting when all participants attend. o The Self-Evaluation tool will be utilized for 3 months; ongoing use of the tool will be determined by the recommendations of the QAPI Committee based on results of this tool.	

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F 867	Continued From page 43 exiting the facility unsupervised and without staff knowledge by leaving an unalarmed exit door propped open for 1 of 4 residents reviewed for accidents (Resident #212). On 06/09/23, Resident #212 was noticed by staff at approximately 5:30 PM wandering the halls with her purse and was last seen in the facility at 6:35 PM sitting in the activity room by herself. At approximately 7:30 PM, Resident #212 was observed outside the building in the back parking area by a visitor and staff. While outside for approximately an hour, Resident #212 walked from the back parking lot around the side of the building toward the front entrance of the facility which was approximately 50 to 75 feet from the main road before turning around and walking back to the parking area located in back of the facility. During the focused infection control and complaint investigation survey of 08/27/21, the facility failed to ensure the safety of a resident 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. During the complaint investigation survey of 12/09/21, the facility failed to transfer a resident to bed without injury. The Resident was transferred to bed and after complaints of pain, the Resident was assessed with an acute fracture of the distal fibula (ankle). F812: Based on observations and staff interviews the facility failed to maintain a clean floor in 1 of 1 walk-in cooler and 1 of 1 walk-in freezer; label and date open food items and discard expired food in 1 of 1 walk-in cooler; store food off the floor for 1 of 1 walk-in freezer; and store food off	F 867	QAPI The results of the self-evaluation tool will be brought to the QAPI meeting monthly by the Administrator and reviewed by the QAPI team. The QAPI Team will make recommendations and changes if necessary. Completion date: 4/19/24.	

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F 867	Continued From page 44	F 867		

the floor in 1 of 1 dry storage room. These practices had the potential to affect food served to residents.

During the recertification and complaint investigation survey of 09/29/22, the facility failed to label and date refrigerated items and to maintain a temperature of 41 degrees or below in a nourishment refrigerator.

F814: Based on observations and staff interviews the facility failed to ensure the area surrounding dumpsters remained free of garbage and debris and failed to close the doors to the dumpsters that contained waste for 2 of 2 dumpsters reviewed. These failures had the potential to attract pests and rodents.

During the recertification and complaint investigation survey of 09/29/22, the facility failed to ensure garbage was contained in a closed dumpster and maintain a clean grease trap free of buildup.

During an interview on 03/21/24 at 4:40 PM, the Administrator revealed when she started employment in December 2023, she reviewed the previous Quality Assurance (QA) minutes and the facility's 2567's for the past three years. The Administrator stated the breakdown regarding the repeat deficiencies was likely due to difficulty with past leadership. The Administrator explained the QA committee met monthly to discuss various topics/peer audits and if needed, established goals and action plans for improvement. The Administrator stated her goal going forward was to ensure consistency with monitoring so that compliance was achieved and maintained.