

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

PRINTED: 06/01/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/12/2011
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - PINELAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 801 PINEHURST AVENUE CARTHAGE, NC 28327	
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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to provide adequate supervision to prevent the fall of 1 of 3 sampled residents who was at risk for falls. Resident #3.</p> <p>Findings included:</p> <p>Resident #3 was admitted to the facility on 12/26/05 with diagnoses which included: dementia; congestive heart failure; osteoporosis; muscle weakness; abnormality of gait; and, anxiety.</p> <p>The review of the quarterly MDS (Minimum Data Set) dated 12/6/10 indicated Resident #3 had severely impaired memory and cognition problems, and required the extensive assistance of two staff for transfers, bed mobility, and toileting to the bathroom.</p> <p>A review of the Nurse's Notes revealed that on 2/19/11 at 2:30pm, Resident #3 was found by staff sitting on the bathroom floor in front of the toilet. The resident informed staff that she was</p>	F 323	<p>Filing the plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.</p> <p>F323</p> <p>Corrective action for resident #3: The MDS for resident #3 was found to have been coded incorrectly in that resident #3 actually should have been coded as one person assist instead of 2 person assist. Subsequently, the MDS was corrected to indicate one person assist for resident #3. The resident information sheet (source of communication for staff) was updated as well. Staff was in serviced about revision made regarding care requirements for resident #3.</p> <p>For those residents with the potential to be affected, the following was completed:</p>	6/9/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Delista Benfield*

TITLE

*Administrator*

(X6) DATE

*6/20/11*

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 323	<p>Continued From page 1</p> <p>attempting to transfer from the toilet to the wheelchair, unassisted; but slid to the floor. The facility's intervention documented on the Resident/Accident report on 2/20/11 indicated the staff were to offer to toilet the resident every two hours during the day.</p> <p>Review of Resident #3's Care Plan (updated 2/2011) revealed the resident was a fall risk related to impaired mobility, unsteady gait, and impaired vision. Interventions included: assist resident while in bathroom; offer to toilet every two hours; ensure staff aware that resident is at high risk for falls; and, maintain record of falls, and evaluate for patterns.</p> <p>The Physical Therapy Plan of Care (2/23/11) revealed Resident #3 received treatment five times each week for four weeks for gait abnormality. The resident was discharged from physical therapy on 3/7/11 and referred to restorative nursing for continuation of ambulation exercises. The resident was to have use of a rolling walker for short distances and a wheelchair for long distances.</p> <p>Review of the Quarterly Screens/Fall Risk Screen dated 3/7/11 indicated Resident #3 was a high risk for falls.</p> <p>The review of the annual MDS (Minimum Data Set) dated 3/7/11 indicated Resident #3 had severely impaired memory and cognition problems, and required the extensive assistance of two staff for transfers, bed mobility, and toileting to the bathroom.</p> <p>A review of the Nurse's Note dated 5/2/11</p>	F 323	<ol style="list-style-type: none"> <li>The care plan and MDS for each current resident have been reviewed by the DON and MDS Coordinator for accuracy.</li> <li>The information contained in each assessment and care plan have been measured for accuracy by re-assessing each resident face to face and ensuring that both forms of assessment match.</li> <li>Staff was in serviced regarding any changes related to the requirement of care for any resident.</li> </ol> <p>Measures taken/put in place are as follows:</p> <ol style="list-style-type: none"> <li>Each MDS nurse will continue to complete a through face to face assessment of each resident and will conduct staff interviews prior to the completion of any care plan.</li> </ol>	

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F 323	<p>Continued From page 2</p> <p>revealed that at 7:30pm a nursing assistant was ambulating Resident #3 to the bathroom using the rolling walker; as the nursing assistant stepped from behind the resident to open the bathroom door, the resident's legs weakened causing the resident to fall. The resident's right elbow hit the door causing a small skin tear. The facility's intervention documented on the Resident/Accident report on 5/3/11 indicated the staff were to ensure the door was open and not to leave the resident; the resident required standby assistance.</p> <p>The Care Plan for Falls was updated on 5/2011 and the interventions were: toilet resident per schedule and request; make sure that all staff members are aware that resident is at high risk for falls; remind resident to not toilet self; keep call light and most frequently used personal items within reach; provide verbal reminders to resident to call when needing assistance; and, change incontinent pad whenever necessary.</p> <p>During an observation on 5/9/11 at 3:30pm, Resident #3 was observed sitting upright in a lounge chair in her room, conversing with her roommate. The resident was alert and verbal with some confusion.</p> <p>During an interview on 5/11/11 at 3:28pm, NA#5 (Nursing Assistant) revealed Resident #3 was weightbearing and required one person assist with transfers. NA#5 stated that the resident was on the toileting program and was assisted to the bathroom every two hours. NA#5 also revealed that Resident #3 was able to ambulate to the bathroom with one person assist; but due to weakness, most of the time the resident was</p>	F 323	<ol style="list-style-type: none"> <li>2. The MDS nurse will complete the resident information sheet for each resident and make such changes whenever a significant change is warranted.</li> <li>3. Staff will be re-in serviced on where to find resident care information sheets and when the information sheets will be changed.</li> <li>4. The DON will continue to review MDSs and Care plans in addition to making rounds to ensure the information contained in MDS and care plan coincide with the visible assessment being made on her rounds. Maintaining for compliance will be as follows: <ol style="list-style-type: none"> <li>1. DON will conduct random reviews of assessments for the first 90 days, and continued reviews will be conducted based on the results of the initial 90 day assessments.</li> <li>2. Findings will be taken to QA meeting and continuation of assessment and frequency will be determined by the results of findings from assessments.</li> </ol> </li> </ol>		

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F 323	Continued From page 3 transferred to the wheelchair and assisted to the bathroom by one person.  During an interview on 5/11/11 at 4:00pm, the MDS Coordinator stated that Resident #3 required extensive assistance of two people per the resident's most recent comprehensive assessment. She revealed that this information was obtained from the resident's ADL (Activities of Daily Living) Flow Sheets and the MDS. The MDS Coordinator revealed that when the resident fell on 5/2/11, per the resident's assessments, there should have been two nursing assistants with the resident instead of one. She also revealed that the nursing assistants were informed of any changes in the resident's care from the hall nurses and/or MDS staff. The Resident Care Information Sheet was used as a second reference sheet by nursing assistants. After reviewing the resident's current "Resident Care Information Sheet", the MDS Coordinator stated that it was not an accurate reflection of the resident's needs.  The review of Resident #3's "Resident Care Information Sheet" which was maintained at the nursing station indicated the resident's bed and wheelchair mobility required self supervision; and, the resident required assistance with transfers. Also, the resident was continent of bowel and bladder, and was a "Fall Risk".	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329	F329  Corrective action for residents were: Residents #34 and #83 were assessed immediately after the omissions of BPs were identified. There were no negative outcomes as a result missed blood pressure	6/9/11

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F 329	<p>Continued From page 4</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to monitor blood pressures as ordered by a physician for 3 of 10 sampled residents for unnecessary medications. (Resident #83, #34 and #8)</p> <p>Findings include:</p> <p>1. Resident # 34 was admitted to the facility on 8/17/09 re-admit 9/24/10 Diagnosis included Hypertension and Cardio Vascular Accident with left Hemiparesis.</p> <p>A review of the electronic physician orders for the</p>	F 329	<p>readings. The attending physician for each resident was notified of the omission of blood pressures. Medication incident forms were filled out for both residents.</p> <p>For those with the potential to be affected , the following was completed:</p> <ol style="list-style-type: none"> <li>All administrative nurses (DON, MDS nurse, SDC, Clinical Coordinator and wound nurse) will ensure that each resident will receive the appropriate assessment and intervention to include Blood Pressure Monitoring as determined by the resident's attending physician.</li> <li>An audit tool has been developed to determine compliance. Each administrative nurse will conduct an audit of each resident to determine compliance with physician's orders, to include blood pressure monitoring.</li> <li>Any failure to comply with physician's orders will be brought to the attention of the DON immediately.</li> </ol>		

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F 329	<p>Continued From page 5</p> <p>month of March, April and May 2011 revealed the resident was being treated for hypertension with Isosorbide 20mg daily for Hypertension and Lasix (diuretic) 80mg daily. Also the blood pressure was to be taken weekly on Wednesday.</p> <p>A review of the Medication Administration Record (MAR) for the months of March, April and May 2011 revealed that only one blood pressure was recorded for the month of March 2011 on 3/16/11. A review of the vital sign sheet and the nurses notes for March 2011 revealed no documentation of any other blood pressure for the month of March.</p> <p>The MAR for April 2011 where the blood pressure was to be recorded was blank for the entire month. A review of the vital sign sheet and the nurses notes for the month of April 2011 revealed no documentation of a blood pressure being taken.</p> <p>A review of the MAR for May 2011 revealed no recorded blood pressure from the 1st through the 11th. A review of the vital sheet record revealed no documentation of a blood pressure for the month of May 2011. A review of the nurses notes revealed a monthly summary dated 5/9/11 with a blood pressure of 108/58 recorded.</p> <p>A review of the pharmacy review recommendations for March, April and May 2011 identified the lack of blood pressure monitoring.</p> <p>An interview on 5/11/11 at 12:05pm with Nurse #1 revealed that Blood Pressures were either documented on the MAR for weekly Blood Pressure or in the chart under Vital signs. She also stated "I do not know of any other place the Blood Pressure would be recorded."</p>	F 329	<p>4. Each Staff member responsible for the identified omission will be individually educated to ensure continued compliance.</p> <p>5. Audits were completed on 100% of all current residents.</p> <p>Monitoring for compliance will be as follows:</p> <ol style="list-style-type: none"> <li>1. Audits will continue with 50% being done weekly for six weeks and then 25% every two weeks for one month.</li> <li>2. Future audits will be determined by the results of the prior ten weeks of audits. All audit results will be discussed in the facility QA Meeting.</li> </ol> <p>Systemic changes are as follows:</p> <ol style="list-style-type: none"> <li>1. A list of residents with routine vitals are now given to the CNAs at the beginning</li> </ol>		

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F 329	<p>Continued From page 6</p> <p>On 5/11/11 at 2:46pm Nurse #4 who works with Resident #34 revealed the weekly Blood Pressure should be recorded on MARS or in the nurses notes. Further discussion revealed a list was given to the aides and then they put the list on the wall so the nurses can record them.</p> <p>On 5/12/11 at 9:50am a telephone interview with the pharmacy consulted revealed that monitoring was part of her monthly; she checked for laboratory tests, behaviors and vital signs "We have had an issue with the blood pressure being documented. We have done 2 in-services regarding medication errors and documentation. I have talked to the facility about the blood pressures not being recorded. I tried to do an audit on all the residents when I was there in May but I may have missed some I left a general statement regarding my recommendations with the clinical coordinator."</p> <p>5/12/11 at 10:16am an interview with the clinical coordinator revealed a manager was assigned each hall to follow up on pharmacy recommendation. "When asked if there was a form used for the follow up; the response was no but "I usually write on the side of the form for the corrections." We are monitoring them and the nurses know but we do not have any forms or documentation for that.</p> <p>On 5/13/11 at 10:50am an interview with nurse #3 on the 400 hall revealed the process for recording the blood pressures was "that the nurse usually gets the blood pressures or they give a list to the aides to get them. The aides tape it to the</p>	F 329	<p>of his/her shift and must be returned to the nurse two hours prior to the end of their shift.</p> <p>2. For residents with parameters for vitals associated with certain medications, the charge nurse will be responsible for obtaining and documenting the vial sign.</p> <p>3. Staff has been in serviced on the importance of appropriately obtaining, monitoring and documenting Physician ordered blood pressures. Staff are aware through in services the systemic approach that must be followed in order to ensure continued compliance regarding achievement of all required physician orders.</p>	

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F 329	<p>Continued From page 7</p> <p>wall and the nurses are to get them and document on the MAR" The list for the aides are destroyed after the blood pressures are recorded. Nurse #3 reviewed the MAR for Resident #34 and confirmed the blood pressure for this month was blank</p> <p>An interview with the DON (Director of Nurses) on 5/15/11 10:30am revealed that she did an audit on the 400 hall regarding the recording of the blood pressures but "I do not have documentation of it." "I know we did an in-service last month on this and it is still a problem."</p> <p>2. Resident #83 was admitted to the facility on 8/12/11 with diagnosis that included Hypertension and Anemia.</p> <p>A review of the electronic printed physician orders for the months of April and May of 2011 revealed the resident was being treated for hypertension with Novasc 5mg, Lotensin 20mg and Lopressor 20mg. Also the physician orders stated take the blood pressure weekly and document.</p> <p>A review of the MAR (Medication Administration Record) for the month of April 2011 revealed the blood pressure was recorded on April 4th and on April 11th. The blood pressure for April 18th and 25th were blank. A review of the vital sign sheet and the nurses notes had no documentation of a blood pressure for April 18th and 25th.</p> <p>A review of the MAR for May 2011 revealed the blood pressure for 5/2/11, 5/16/11 and 5/22/11 was blank. The blood pressure due on 5/9/11 was documented on the MAR. A review of the vital</p>	F 329		



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F 329	<p>Continued From page 8</p> <p>sign sheet and the nurses notes revealed no documentation of a blood pressure for May 2, 16 and 22 available.</p> <p>A review of the pharmacy review recommendations for April and May 2011 identified the lack of blood pressure monitoring.</p> <p>An interview on 5/11/11 at 12:05pm with Nurse #1 revealed that Blood Pressures were either documented on the MAR for weekly Blood Pressure or in the chart under Vital signs. She also stated "I do not know of any other place the Blood Pressure would be recorded."</p> <p>On 5/11/11 at 2:46pm Nurse #4 who works with Resident #83 revealed the weekly Blood Pressure should be recorded on MARS or in the nurses notes. Further discussion revealed a list was given to the aides and then they put the list on the wall so the nurses can record them.</p> <p>On 5/12/11 at 9:50am a telephone interview with the pharmacy consulted revealed that monitoring was part of her monthly; she checked for laboratory tests, behaviors and vital signs "We have had an issue with the blood pressure being documented. We have done 2 in-services regarding medication errors and documentation. I have talked to the facility about the blood pressures not being recorded. I tried to do an audit on all the residents when I was there in May but I may have missed some I left a general statement regarding my recommendations with the clinical coordinator."</p> <p>5/12/11 at 10:16am an interview with the clinical coordinator revealed a manager was assigned</p>	F 329		

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F 329	<p>Continued From page 9</p> <p>each hall to follow up on pharmacy recommendation." When asked if there was a form used for the follow up; the response was no but "I usually write on the side of the form for the corrections."</p> <p>We are monitoring them and the nurses know but we do not have any forms or documentation for that.</p> <p>On 5/13/11 at 10:50am an interview with nurse #3 on the 400 hall revealed the process for recording the blood pressures was "that the nurse usually gets the blood pressures or they give a list to the aides to get them. The aides tape it to the wall and the nurses are to get them and document on the MAR" The list for the aides are destroyed after the blood pressures are recorded. Nurse #3 reviewed the MAR for Resident #34 and confirmed the blood pressure for this month was blank</p> <p>An interview with the DON (Director of Nurses) on 5/15/11 10:30am revealed that she did an audit on the 400 hall regarding the recording of the blood pressures but "I do not have documentation of it." "I know we did an in-service last month on this and it is still a problem."</p> <p>3. Resident #8 was admitted 10/06/2010 with diagnoses that included Hypertension (HTN), Diabetes Mellitus, and Quadriplegia.</p> <p>A review of the electronic printed Physician Orders for 3/1-3/31/2011, 4/1-4/30/2011, and 5/1-5/31/2011 that indicated Resident #8 was receiving three medications daily for HTN and was to have Blood Pressures (BPs) documented weekly on Wednesdays.</p>	F 329			

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F 329	Continued From page 10  Medication Administration Records (MAR) reviewed for the months of March, April, and May revealed that BPs were not recorded on 3/2/11, 3/9/11, 3/23/11, 3/30/11, 4/20/11, 4/27/11, or 5/4/11. The Vital Sign Sheet reviewed contained one BP for 10/06/10.  A review of the Pharmacist 's Medication Regimen Review for March 2011 found " many weekly BPs not documented on March MAR. " There was an additional note dated 5/5/11 that indicated nurses were aware of BP needs.  In an interview on 5/11/2011 at 12:05 pm the Clinical Coordinator and Nurse #2 stated that BPs were either on the MAR for weekly BP or in the chart on the Vital Sign sheet. Nurse #1 indicated at this time that she did not know of any other place BPs would have been recorded.  At 12:15 pm on 5/11/11 the Director of Nurses (DON) stated in an interview that BPs should be documented on the MAR or in Medicare Notes for residents on Medicare. Record review indicated that Resident #8 was not on Medicare.  On 5/12/2011 at 9:00 am NA #1 was asked who took BPs and how did they know which residents needed to have BPs taken. She responded that the nurses would leave a list of residents who needed to have BPs taken for the NA, the NA would take the BP and write it on the list and give it to the nurse.  In a telephone interview on 5/12/2011 at 9:50 am a facility Pharmacist when asked about monitoring being part of her review, stated that	F 329		

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

PRINTED: 06/01/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/12/2011
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F 329	Continued From page 11 pharmacists looked at the orders, checked labs, and vital signs. She also indicated that there was an issue with BPs not being documented resulting in two inservices regarding medication errors and documentation. The Pharmacist revealed that when a Physician signed the electronic sheets, they became orders and she had discussed with the facility about BPs not being recorded. She confirmed that she had done an audit on resident BPs and left a general statement for the Clinical Coordinator regarding her recommendations.  During an interview on 5/12/2011 at 10:16 am the Clinical Coordinator stated that she and the DON followed up on the pharmacist 's recommendations by dividing the responsibility for monitoring documentation of BPs among the managers. She indicated that they were monitoring the nurses, but had no forms or documentation for the monitoring.  In an interview on 5/12/2011 at 10:50 am Nurse #3 revealed that she remembered an in-service on documentation " a while back, " but can ' t remember when. She further stated " they do audits of the charts frequently. "	F 329			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371  Corrective Action:  1. Upon review of the findings indentified, the facility has set forth the following interventions: Immediately after the ice scoop handle was	6/9/11	

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

PRINTED: 06/01/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 371	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to serve cold beverages in 4 of 6 dining areas in a sanitary manner.</p> <p>Findings include:</p> <p>On 5/9/11 at 12:35pm an aide was observed scooping ice from large plastic container into glasses and then pouring liquids into the glasses. The ice scoop was placed on the tray that was used for pouring the liquids in to glasses for residents. The ice scoop was not covered or protected. The same ice scoop was then used again to scoop ice from the ice container in to glasses and then pouring liquid in to the glasses and delivering the glasses to deferent residents on the 300 and 400 hall at 12:38pm, 12:40, 12:42 and at 12:44pm. Each time the scoop was used it was set down on a tray used to hold the glasses while liquid was poured in to them.</p> <p>On 5/10/11 at 12:14pm the ice scoop was observed sitting on the lid to the ice container. The ice scoop was taken off the lid and used to scoop ice in to glasses by 2 different aides. The scoop was placed on the tray which was used to hold the glasses filled with ice while liquid was poured into them on the 300 hall.</p> <p>On 5/11/11 at 11:39am the aide was observed taking the ice scoop which was lying in the ice container flat against the ice and scooping ice in to several glasses then the scoop was placed on</p>	F 371	<p>noticed touching ice, the facility staff cleaned ice containers and ice scoops before continuing to serve to any residents.</p> <p>2. The staff members directly involved was educated immediately.</p> <p>For those with the potential to be affected, the following was completed:</p> <ol style="list-style-type: none"> <li>1. Policies and Procedures regarding the storage, distribution and preparation of food; and more specifically, the handling of ice, have been reviewed for accuracy by the Administrator.</li> <li>2. All staff have been educated regarding the policies and procedures related to the proper handling of ice.</li> </ol> <p>Monitoring: All staff were also observed by Administrator, Director of Nursing and Dietary Manager to ensure staff has a complete understanding of the procedure regarding distribution and handling of ice. The procedure is as</p>	

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

PRINTED: 06/01/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 371	<p>Continued From page 13</p> <p>the tray next to the glasses while liquid was poured into the glasses on the 300 hall. At 11:42am an aide was observed on the 300 hall picking up the scoop which laye on the tray and re-used for a different resident, scooping ice in to a glass and then pouring liquid into the glass.</p> <p>On 5/11/11 at 11:50am an aide was observed scooping ice out of an ice container and filling glasses with ice pouring liquid into the glass and then laying the scoop down on the tray where she had just poured liquid into a glass. The aide was observed filling glasses with ice, filling them with liquid and delivering the glass of fluid to all residents on the 200 hall and on 100 hall.</p> <p>On 5/11/11 at 12noon an interview with nurse's aide #2 (NA) revealed she had been trained to have a plastic bag hanging from the ice container to place the scoop in it when not using the scoop to put ice in glasses. She indicated that the kitchen did not send a plastic bag up and she did not go and get one.</p> <p>On 5/11/11 at 12:03pm an interview with NA #3 revealed that she had never been trained or told anything about how the ice scoop was to be placed when not using it.</p> <p>On 5/11/11 at 12:04pm an interview with NA#4 on the 100 hall revealed that she was not sure how she was trained to use an ice scoop but that she would find out and get back with the answer. When asked if ever received training she then responded that she was not suppose to put the scoop in the ice because of cross contaminations. When asking what she was to do with the scoop when not using it she responded "I</p>	F 371	<p>follows: During distribution of ice, the ice scoop must remain on a clean surface or in the ice with handle turned upward with handle not touching the ice.</p> <p>Administrator, Director of Nursing and/or Dietary Manager will monitor using audit tool to ensure continued compliance through comprehensive rounds. Each person responsible for monitoring for compliance will observe each ice container on every hall. An audit will be conducted three times a day (at mealtimes) daily for 10 days and three times a week for 20 days, thereafter. Any negative findings will be reported to Administrator immediately and staff involved will be individually educated. All audit results will be reviewed in QA Meeting and the continuation of daily rounds past 60 days will depend upon the results of audits.</p>		

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

PRINTED: 06/01/2011  
FORM APPROVED  
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F 371	Continued From page 14 do not know.	F 371			
F 428 SS=D	<p>On 5/11/11 at 12:05pm the clinical coordinator watched the NA's using the ice scoop while serving fluids to residents on the 200 hall. The clinical coordinator stopped the NA's from using the scoop any more and provided them with instructions on how to use the scoop in a manner to prevent cross contamination. The clinical coordinator stated that all the NA's were trained on how to properly handle the ice scoop.</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, pharmacy consultant review and staff interviews the facility failed to respond to Pharmacist recommendation regarding Blood Pressure monitoring for 3 of 10 sampled residents. (Resident #34, #83, #8)</p> <p>Findings include:</p> <p>1. Resident # 34 was admitted to the facility on</p>	F 428	<p>F428</p> <p>Corrective Action for residents #34, #83 and #8 is as follows: Residents #34, #83 and #8 have been assessed for any negative outcomes as a result of omission of physician ordered blood pressures. There was no negative outcome. The attending physician for each resident was notified of the omitted blood pressures.</p> <p>For those having the potential to be affected, the following has been completed:</p> <ol style="list-style-type: none"> <li>All residents will be reviewed by the facility's pharmacist each month, through the pharmacist's recommendations.</li> <li>For any resident identified to have a missing blood pressure; the DON will immediately educate each</li> </ol>	6/9/11	

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

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F 428	<p>Continued From page 15</p> <p>8/17/09 re-admit 9/24/10 Diagnosis included Hypertension and Cardio Vascular Accident with left Hemiparesis.</p> <p>A review of the electronic physician orders for the month of March, April and May 2011 revealed the resident was being treated for hypertension with Isosorbide 20mg daily for Hypertension and Lasix (diuretic) 80mg daily. Also the blood pressure was to be taken weekly on Wednesday.</p> <p>A review of the Medication administration Record (MAR) for the months of March, April and May 2011 revealed that only one blood pressure was recorded for the month of March 2011 on 3/16/11. A review of the vital sign sheet and the nurses notes for March 2011 revealed no documentation of any other blood pressure for the month of March.</p> <p>The MAR for April 2011 where the blood pressure was to be recorded was blank for the entire month. A review of the vital sign sheet and the nurses notes for the month of April 2011 revealed no documentation of a blood pressure being taken.</p> <p>A review of the MAR for May 2011 revealed no recorded blood pressure from the 1st through the 11th. A review of the vital sheet record revealed no documentation of a blood pressure for the month of May 2011. A review of the nurses notes revealed a monthly summary dated 5/9/11 with a blood pressure of 108/58 recorded.</p> <p>A review of the pharmacy review recommendations for March, April and May 2011 identified the lack of blood pressure monitoring.</p> <p>On 5/12/11 at 9:50am a telephone interview with</p>	F 428	<p>employee responsible for the omission.</p> <p>3. In addition, all administrative nurses (DON, MDS nurse, SDC, Clinical Coordinator and wound nurse) will routinely monitor to ensure that appropriate assessment and intervention occurs for each resident to include Blood Pressure Monitoring.</p> <p>Systemic changes are:</p> <ol style="list-style-type: none"> <li>The Pharmacist's recommendations will be reviewed by the DON prior to being given to Clinical coordinator.</li> <li>The clinical coordinator will ensure recommendations for medications for medications are discussed with attending physician and with assistance of the DON will determine what in service education needs to be completed for omissions</li> </ol>		



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

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FORM APPROVED  
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F 428	<p>Continued From page 16</p> <p>the pharmacy consulted revealed that monitoring was part of her monthly; she checked for laboratory tests, behaviors and vital signs "We have had an issue with the blood pressure being documented. We have done 2 in-services regarding medication errors and documentation. I have talked to the facility about the blood pressures not being recorded. I tried to do an audit on all the residents when I was there in May but I may have missed some I left a general statement regarding my recommendations with the clinical coordinator."</p> <p>5/12/11 at 10:16am an interview with the clinical coordinator revealed a manager was assigned each hall to follow up on pharmacy recommendation." When asked if there was a form used for the follow up; the response was no but "I usually write on the side of the form for the corrections." We are monitoring them and the nurses know but we do not have any forms or documentation for that "I know it is still a problem to get the nurses to document the blood pressures."</p> <p>An interview with the DON (Director of Nurses) on 5/15/11 10:30am revealed that she did an audit on the 400 hall regarding the recording of the blood pressures but "I do not have documentation of it." "I know we did an in-service last month on this and it is still a problem."</p> <p>2. Resident #83 was admitted to the facility on 8/12/11 with diagnosis that included Hypertension and Anemia.</p> <p>A review of the electronic printed physician orders</p>	F 428	<p>of Blood Pressures or other clinical issues identified by the pharmacist.</p> <p>3. The pharmacist's recommendations will be discussed monthly during the administrative nurses meeting. The recommendations will be discussed the first week of each month.</p> <p>4. Based on the findings from pharmacist's recommendations, the DON will determine the staff that require immediate in service education.</p> <p>Monitoring is as follows: Education records will be reviewed by DON each month to ensure improved compliance with blood pressure monitoring. Results will be reviewed at the QA Meeting over the next three months.</p>	

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

PRINTED: 06/01/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 428	<p>Continued From page 17</p> <p>for the months of April and May of 2011 revealed the resident was being treated for hypertension with Novasc 5mg, Lotensin 20mg and Lopressor 20mg. Also the physician orders stated take the blood pressure weekly and document.</p> <p>A review of the MAR (Medication Administration Record) for the month of April 2011 revealed the blood pressure was recorded on April 4th and on April 11th. The blood pressure for April 18th and 25th were blank. A review of the vital sign sheet and the nurses notes had no documentation of a blood pressure for April 18th and 25th.</p> <p>A review of the MAR for May 2011 revealed the blood pressure for 5/2/11, 5/16/11 and 5/22/11 was blank. The blood pressure due on 5/9/11 was documented on the MAR. A review of the vital sign sheet and the nurses notes revealed no documentation of a blood pressure for May 2, 16 and 22 available.</p> <p>A review of the pharmacy review recommendations for April and May 2011 identified the lack of blood pressure monitoring.</p> <p>On 5/12/11 at 9:50am a telephone interview with the pharmacy consulted revealed that monitoring was part of her monthly; she checked for laboratory tests, behaviors and vital signs "We have had an issue with the blood pressure being documented. We have done 2 in-services regarding medication errors and documentation. I have talked to the facility about the blood pressures not being recorded. I tried to do an audit on all the residents when I was there in May but I may have missed some I left a general statement regarding my recommendations with</p>	F 428		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 428	<p>Continued From page 18 the clinical coordinator."</p> <p>5/12/11 at 10:16am an interview with the clinical coordinator revealed a manager was assigned each hall to follow up on pharmacy recommendation." When asked if there was a form used for the follow up; the response was no but "I usually write on the side of the form for the corrections." We are monitoring them and the nurses know but we do not have any forms or documentation for that "I know it is still a problem to get the nurses to document the blood pressures."</p> <p>An interview with the DON (Director of Nurses) on 5/15/11 10:30am revealed that she did an audit on the 400 hall regarding the recording of the blood pressures but "I do not have documentation of it." "I know we did an in-service last month on this and it is still a problem."</p> <p>3. Resident #8 was admitted 10/06/2010 with diagnoses that included Hypertension (HTN), Diabetes Mellitus, and Quadriplegia.</p> <p>A review of the electronic printed Physician Orders for 3/1-3/31/2011, 4/1-4/30/2011, and 5/1-5/31/2011 that indicated Resident #8 was receiving three medications daily for HTN and was to have Blood Pressures (BPs) documented weekly on Wednesdays.</p> <p>Medication Administration Records (MAR) reviewed for the months of March, April, and May revealed that BPs were not recorded on 3/2/11, 3/9/11, 3/23/11, 3/30/11, 4/20/11, 4/27/11, or 5/4/11. The Vital Sign Sheet reviewed contained</p>	F 428		

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

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F 428	<p>Continued From page 19 one BP for 10/06/10.</p> <p>A review of the Pharmacist ' s Medication Regimen Review for March 2011 found " many weekly BPs not documented on March MAR. " There was an additional note dated 5/5/11 that indicated nurses were aware of BP needs.</p> <p>At 12:15 pm on 5/11/11 the Director of Nurses (DON) stated in an interview that BPs should be documented on the MAR or in Medicare Notes for residents on Medicare. Record review indicated that Resident #8 was not on Medicare.</p> <p>On 5/12/11 at 9:50am a telephone interview with the pharmacy consulted revealed that monitoring was part of her monthly; she checked for laboratory tests, behaviors and vital signs "We have had an issue with the blood pressure being documented. We have done 2 in-services regarding medication errors and documentation. I have talked to the facility about the blood pressures not being recorded. I tried to do an audit on all the residents when I was there in May but I may have missed some I left a general statement regarding my recommendations with the clinical coordinator."</p> <p>5/12/11 at 10:16am an interview with the clinical coordinator revealed a manager was assigned each hall to follow up on pharmacy recommendation." When asked if there was a form used for the follow up; the response was no but "I usually write on the side of the form for the corrections." We are monitoring them and the nurses know but we do not have any forms or documentation for that "I know it is still a problem to get the nurses to document the blood</p>	F 428			

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

PRINTED: 06/01/2011  
FORM APPROVED  
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F 428	Continued From page 20 pressures."  An interview with the DON (Director of Nurses) on 5/15/11 10:30am revealed that she did an audit on the 400 hall regarding the recording of the blood pressures but "I do not have documentation of it." "I know we did an in-service last month on this and it is still a problem."  In an interview on 5/12/2011 at 10:50 am Nurse #3 revealed that she remembered an in-service on documentation " a while back, " but can ' t remember when. She further stated " they do audits of the charts frequently. "	F 428			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345429	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____	(X3) DATE SURVEY COMPLETED  06/14/2011
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NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - PINELAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 PINEHURST AVENUE CARTHAGE, NC 28327
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K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:00 am onward, the following items were noncompliant, specific findings include: supply room door on 100 hall would not close and latch and nourishment door on special care unit did not close and latch for smoke tight seal.</p>	K 018	<p>Filing the plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.</p> <p>K018</p> <p>The following corrections were completed: The 100 hall supply room door and the nourishment room door in the special care unit have been adjusted and both close and latch for smoke tight seal.</p> <p>In regard to other potential life safety issues, the ESD has inspected all doors in the facility to ensure that each door does indeed close and latch for smoke tight seal.</p> <p>The following measures have been put in place to maintain compliance: The ESD will perform monthly inspections on each door to ensure continued compliance.</p> <p>Corrective actions will be monitored by a review of the inspections each month in facility's safety meeting.</p>	7/29/11
K 029 SS=E	<p>42 CFR 483.70(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with 3/4 hour</p>	K 029	<p>K029</p> <p>The following correction was completed: A magnetic locking mechanism was installed to the dry storage door in the dietary department. The lock will release upon activation of fire alarm system.</p>	7/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Bernad B...* TITLE: *Administrator* DATE: *6/30/11*

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.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345429	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____	(X3) DATE SURVEY COMPLETED  06/14/2011
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NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - PINELAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 501 PINEHURST AVENUE CARTHAGE, NC 28327
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K 029	Continued From page 1 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:00 am onward, the following items were noncompliant: door to dry storage room in kitchen held open with a box.	K 029	In regard to other potential life safety issues, all doors throughout the facility have been inspected by the ESD for compliance.  The following measures have been put in place to maintain compliance: The ESD will conduct a monthly inspection for all doors throughout the facility to ensure continued compliance.  Corrective actions will be monitored by a review of the inspections each month in facility's safety meeting.	
K 066 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066	K066  The following corrections were completed: Ashtrays and a self-closing container, all which meets NFPA guidelines, were appropriately placed in the designated smoking area outside of the special care unit.  In regard to other potential life safety issues, the ESD has inspected all other designated smoking areas to ensure that all areas had proper ashtrays and self-closing containers placed appropriately in the designated smoking areas.	7/29/11

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345429	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____		(X3) DATE SURVEY COMPLETED  06/14/2011
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - PINELAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 801 PINEHURST AVENUE CARTHAGE, NC 28327		
(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
K 066	Continued From page 2 (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:00 am onward, the following items were noncompliant: sitting area out of special care unit has excessive amounts of cigarette butts on ground. Facility had proper ashtrays and self-closing container. However they were hidden on side of building.	K 066	The following measures have been put in place to maintain compliance: Education will be provided to staff that the appropriate materials, i.e., proper ashtrays and self-closing container must be readily accessible and appropriately placed at all designated smoking areas. The ESD and the Administrator will conduct weekly inspections to ensure continued compliance.  Corrective actions will be monitored by weekly inspections being reviewed in the facility's monthly safety meetings.	7/29/11
K 104 SS-E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:00 am onward, the following items were noncompliant: return damper in duct	K 104	X104  The following correction was completed: The return damper in duct in smoke barrier wall on 100 Hall has been serviced and is working properly.  In regard to other potential life safety issues, the ESD has inspected the entire duct system to determine that all smoke dampers work properly.  The following measures have been put in place to maintain compliance: The ESD will conduct a monthly inspection of all ducts to ensure continued compliance.  Corrective actions will be monitored by review of the inspections each month in the facility's monthly safety meeting.	



**CENTERS FOR MEDICARE & MEDICAID SERVICES**

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345429	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____	(X3) DATE SURVEY COMPLETED  06/14/2011
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NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - PINELAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 PINEHURST AVENUE CARTHAGE, NC 28327
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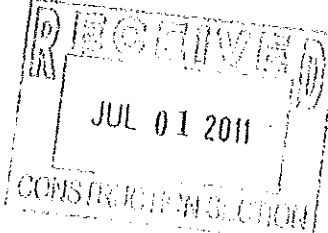
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 104	Continued From page 3 in smoke barrier wall on 100 hall was in the closed position on activation of fire alarm system.  42 CFR 483.70(a)	K 104		

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345429	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW REHAB ADDITION B. WING _____	(X3) DATE SURVEY COMPLETED  06/14/2011
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NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - PINELAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 PINEHURST AVENUE CARTHAGE, NC 28327
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(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)	(X6) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 27871 Based on observations and staff interview at approximately 11:00 am onward, no LSC deficiencies were noted at time of survey.</p> <p>42 CFR 483.70(a)</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Paul Gust* TITLE *Administrator* (X6) DATE *6/30/11*

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