PRINTED: 06/14/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY		
		345229	B. WING		03	C 3/23/2013	
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - SHELBY				11	EET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH MORGAN STREET BOX 2287 HELBY, NC 28150		The Control of the Co
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	06/14/13 following the Resolution results noting Medicare and Medicare immediate Jeopardy was 309 and 323 and the oreversed. The scope a was reduced from a "483.15 (F242) at J. Immediate Jeopardy by PM when facility staff of the scope and the staff of the scope and th	ce from the Centers for d Services. The period of as changed in tags F 242, rder of the examples was nd severity for tag F 520 J " to a " D ".  egan on 12/27/12 at 8:00 lid not honor Resident ot Resuscitate (DNR) ped breathing and citation (CPR) was started. informed of Immediate	FC	0000			14 27
;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;	Jeopardy was removed when the facility provide acceptable credible alle The facility remains out scope and severity of Eno actual harm with polyminimal harm that is no complete education and systems put into place and the facility staff did the facilit	c of compliance at a lower of (an isolated deficiency, dential for more than of immediate jeopardy) to do to ensure monitoring are effective.  In a significant of the significant of th					

Administrator

4-16-13 Revised

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 to days accelved 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 to 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 JUL 1 7 2013

program participation.

If continuation sheet Page 1 of 7

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A SECTION AND A SECTION ASSESSMENT	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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r f f	manner and in an environmanner and in an environmentances each resident full recognition of his or this REQUIREMENT is by: Based on record review nterviews the facility sta	onment that maintains or 's dignity and respect in her individuality.  In not met as evidenced and resident and staff ff failed to treat a resident	1			*		
	F 241 SS=D	F 000 Continued From page when the facility provio acceptable credible allifacility remains out of c scope and severity of I no actual harm with pominimal harm that is not complete education an systems put into place  483.25 (F323) at J Immediate Jeopardy be Resident #64 fell from I floor while being transp The Administrator was Jeopardy on 03/22/13 at Jeopardy was removed when the facility implem allegation of compliance of compliance at the low D (no actual harm with princimal harm that is not ensure monitoring systems completion of employee 483.15(a) DIGNITY ANI INDIVIDUALITY  The facility must promote manner and in an envirous enhances each resident full recognition of his or  This REQUIREMENT is by: Based on record review interviews the facility sta	NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - SHELBY    CAJ ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 000   Continued From page 1   When the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective.  483.25 (F323) at J   Immediate Jeopardy began on 02/06/13 when Resident #64 fell from his wheelchair to the van floor while being transported in the facility van. The Administrator was informed of Immediate Jeopardy on 03/22/13 at 10:39 PM. Immediate Jeopardy was removed on 03/23/13 at 4:50 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.  F 241   483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:  Based on record review and resident and staff interviews the facility staff failed to treat a resident with dignity for 1 of 3 residents reviewed for	NAME OF PROVIDER OR SUPPLER  PEAK RESOURCES - SHELBY  (A) ID PREFIX TAG  COntinued From page 1  when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of completion of care effective.  483.25 (F323) at J Immediate Jeopardy) to complete deducation and to ensure monitoring systems put into place are effective.  483.25 (F323) at J Immediate Jeopardy) when the facility implemented in the facility and resident for more than minimal harm that is not immediate leopardy to complete oducation and to ensure monitoring systems put into place are effective.  483.25 (F323) at J Immediate Jeopardy began on 02/06/13 when Resident #64 fell from his wheelchair to the van floor while being transported in the facility van. The Administrator was informed of immediate Jeopardy was removed on 03/23/13 at 4:50 PM when the facility implemented a credible allegation of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.  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PROVIDERS PLAN OF CORRECTION FREDRY TAG  FOOD Continued From page 1 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective.  483.26 (F323) at J Immediate Jeopardy began on 02/06/13 when Resident #84 fell from his wheelchair to the van floor while being transported in the facility van. The Administrator was informed of immediate Jeopardy was removed on 03/23/13 at 4:50 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.  F 241 483.15(a) DIGNITY AND RESPECT OF IT facility remains out of compliance. The facility remains out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.  F 241 483.15(a) DIGNITY AND RESPECT OF IT facility remains out of compliance at the facility and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:  Based on record review and resident and staff interviews the facility and resident reviewed for	IDENTIFICATION NUMBER:  345229  NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - SHELBY  SUMMARY STATELENY  SUMMARY  SUMMARY STATELENY  SUMMARY STATELENY  SUMMARY STATELENY  SUMMARY STATELENY  SUMMARY STATELENY  SUMMARY STATELENY  SUMMARY STAT

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F 24	The findings included: Resident #43 was adr with diagnoses which blindness. Review of I Minimum Data Set (M revealed she was cog review of the MDS ind needed extensive ass toileting. The MDS ass being occasionally inc Review of Resident #4 01/24/13 for urinary in goal was the resident urinary continence. Int incontinence manager toileting.  A form entitled Concer Form dated 03/12/13 v #43's name and reside reported the allegation concern/grievance rea of third shift employee bathroom. When resid use her brief. She also being sore." Follow up resident a gel cushion suggestion for resident refused." There was no form noting who took to  During an interview on Resident #43 she state not to ring her call bell	nitted to the facility 01/16/13 included glaucoma and Resident #43's Admission DS) dated 01/23/13 nitively intact. Further licated Resident #43 istance with transfer and sessed Resident #43 as ontinent of bladder.  13's care plan dated continence revealed the would maintain/regain erventions included ment program of prompted on the checked as having and taking resident to the ent asked she was told to complained of her bottom action read, "Therapy got for her chair also		Affected Resident:  For Resident #43  Staff were trained on dignity and respect.  All others with potential To be affected:  An interview sheet was developed To document any resident issues With regard to being treated With respect and dignity.  25 Residents were interviewed With regard staff treatment of residents i.e.: respect and dignity. No other resident voiced any concern regarding respect or dignity.  Measures/systemic changes:  An interview sheet was Developed to document Resident issues with regard to Being treated with respect And dignity.	4/8/13 Thru 4/17/13 3/20/13	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	works every weekend Resident #43 further stands a substant #5) has to concern the property of	#43 stated this person starting at 7:00 PM. atted if she (Nursing me back to take her to the to her" by stating I have ast you. Resident #43 the weekend come. It was the worked was the feel afraid. It was the worked was the feel afraid. It was the worked was the head spoken to the head spoken to the accused nursing the head denied the the incident with another was	F 24	In-service education was initiated On 4/9/13 With facility staff including nursing staff (Licensed and unlicensed), housekeeping, Dietary, administrative, activities Social service, maintenance and therapy by the SDC/RN. Inservice objectives included: Staff will treat residents with respect and dignity at all times, this includes meeting their individual personal needs.  For those staff members who are on Leave from the facility will be inserviced upon return to the facility prior to assignment. This will be done By the Staff Development Nurse/RN		4/9/13 Thru 4/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			0.000	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
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F 242 SS=J	only been taken to the Admission Coordinato reported she had want more frequently but no bell. The Admission Cothat Resident #43 reported her go the bathrood NA #5 was not available worked weekends 7:00 terminated on 03/22/13 483.15(b) SELF-DETE MAKE CHOICES  The resident has the rischedules, and health her interests, assessminteract with members inside and outside the about aspects of his or are significant to the resident for the resident for the resident and the resident for the resident for the resident for the resident for the residents and to honor an advanced directive for unresponsive residents (Residents #114 and #	as hurting and that she had bathroom once. The r stated Resident #43 ted to go to the bathroom one answered her call cordinator further stated orted to her that staff had om in her brief.  Ile during the survey as she of PM - 7:00 AM and was 3.  RMINATION - RIGHT TO ght to choose activities, care consistent with his or ents, and plans of care; of the community both facility; and make choices her life in the facility that is ident.  Is not met as evidenced w and staff interviews the resident's choice for an Do Not Resuscitate (DNR) esident's choice for an full code status in 2 of 2 status in 2 o	F 2	questionnaire for the next 3 months. 10% of residents will interviewed every other week the 3 month periods. If any resident had voiced a concern with regard to respect and digu this will be immediately report the DON/Administrator and an investigation will be initiated.	for nity tto iiii 4/17/13 f us.

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	cardiopulmonary result Immediate Jeopardy, v 6:10 PM when the faci implemented an accept compliance. The facilitic compliance at a lower (an isolated deficiency potential for more than immediate jeopardy) to ensure monitoring seffective. Example #2 status) was cited at a lisolated deficiency that with potential for more not immediate jeopard.  The findings included:  1. Resident #114 was adiagnoses that include pressure, dementia, kiewith left sided weaknes on 12/27/12 at 8:05 PM. A review of the admiss (MDS) dated 09/24/12 had impairment in shorm memory and was mode cognition for daily decisextensive assistance fridaily living.  A review of a yellow for the top left hand corner	scitation (CPR) was started. vas removed on 03/23/13 at ility provided and otable credible allegation of ty remains out of scope and severity of D r, no actual harm with minimal harm that is not o complete education and systems put into place are (Resident #148's code D level deficiency (an t constitutes no actual harm than minimal harm that is y).  admitted on 09/24/12 with d heart disease, high blood dney disease and a stroke ss. The resident expired ft.  ion Minimum Data Set indicated Resident #114 t term and long term erately impaired in sion making and required om staff for activities of		Credible allegation of compliance RESIDENT'S RIGHT TO BE INVOLVADVANCE DIRECTIVES PROCESS  1. AFFECTED RESIDENT CORREACTION  Resident #114 was admitted to facility on 9/24/12 with diagnosis included chronic kidney disease, blood pressure, stroke and demethe resident had a do not resusc (DNR) order dated 9/24/12.	CTIVE	4/17/13

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	A review of a document of Receipt of Advance dated 09/24/12 had ar copy to the facility" for signed by a family mere date of service of 09/2 Status: Do Not Attempt CPR).  A review of a Palliative 09/26/12 indicated Res NOT RESUSCITATE.  A review of a physician indicated DNR and nur and release body to fur and release	nt titled "Acknowledgement d Directives Information" n "x" next to "provided a DNR status and was mber.  n's Progress Note with a 5/12 indicated Code t Resuscitation (DNR/No e Care Progress Note dated sident #114 remains a DO e care and one of choice.  note dated 12/27/12 at 8:00 and (NA) was with encontinence care and om because the resident. The notes revealed ellow breathing and then CPR was started. The Resident #114's chart was proder was found and CPR of the continence care and continence care and ellow breathing and then corder was found and CPR of the continence care and continence care and and cod on a heart monitor and the cod on a h	F 242	stopped breathing cardiopulmonary resuscitation was started. The CPR was stopped the resident's chart was checked the DNR was noted.  2. CORRECTIVE A ACCOMPLISHED FOR RESIDENTS WITH THE POTE TO BE AFFECTED  On 3/12/12 "Admission Audit" started for all new resident admiss The Medical Records Information will use the audit and any concern be put on the "Admission Information" form and given to department that the concern pet to for correction and follow up. Admission Audit will be a conting with necessary changes or necessary chan	and (CPR) d after ed and CTION ALL ENTIAL  was ssions. Clerk ns will Audit to the rtains The nuous essity tee.  given ation The that with and rsing areas rsing tell
	"Events that have taker	place" a NA noted the		someone I have an advanced direct	

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		breathing. The report arrived and the resident not breathing and CPF revealed the nursing s CPR was discontinued.  During an interview on physician/medical direxpectation that nursing resident's chart for code was a DNR they should resident.  During an interview on Nurse #3 stated she reand a NA called her to because the resident wexplained she started the and the resident stopper Resident #114 rescue bag and had started changed and had started changed and had started changed everything. Since the weap of the resident we saw the yellow stop signstopped everything. Since the saw the should have code status first before it was Resident #114's stated she called the Descripted but after that no called her or talked to hand she was not aware	hallow respirations then not further indicated a nurse int was pulseless and was it was started. The report taff found a DNR order and it.  103/20/13 at 10:14 AM the ctor stated it was his it is staff should refer to the it is status and if the resident it in other indicates it is not resuscitate the  103/21/13 at 4:37 PM in it is many the resident's room assess Resident #114 it is the resident's room assess Resident #114 it is code status when she is further stated she was int's code status when she is form and then she in form and then she is further stated she was int's code status when she is room and reacted to start taught to treat the patient in responsive. She further verified the resident #114 is she did anything because choice to be a DNR. She ON after Resident #114 it in the resident #114 it in the code in the c	F2	"What role does my family p making my advanced directive", need to make an advanced directive", when should I make an advanced directive in a nursing facility", "Canurse or social worker explain the to me", "Do I have to have a law make an advanced directive" and I change my mind after I mal advanced directive". Adm Coordinator and/or Social William designee meets with resident responsible party to determine wishes regarding the code status.  Resident Council reviews a different right each month during monthly meeting.  On 3/20/13 education was proregarding advance directives and resident's right to choose their elife decisions. The objectives of lesson plan were a) Staff understand the resident right to choices on their, end of life decisions staff will understand document requirements related to the resident advanced directives c) Staff	"Do I ctive", vanced va	

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	During an interview on Director of Nursing (Do nursing staff to honor a and if the resident was not be started and 2 nuthe resident was not be started and 2 nuthe resident was not be and then call the doctor of the started and 2 nuther esident was not be and then call the doctor of the further confirmed discussion or Resident Administrative Nurse's confirmed there was not meeting minutes. She usual process when the should be discussed in Nurse's Meeting and actinterventions put in place stated she did not remet the monthly QA meeting status.  The Administrator was Jeopardy on 03/20/13 at #148. The following Cr Compliance was accepted.  Credible allegation of conception of the control of	a 03/21/13 at 5:03 PM the ON) stated she expected a resident's code status a DNR then CPR should urses should confirm that reathing and had no pulse or, family and funeral home. That there was no state that there was no state of the explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it go from the explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident it the weekly Administrative explained that it was their ere was an incident in the explain and incident it was their ere was an incident it was their ere was an incident it	F 242	provided to licensed nurses,	social issions pleted 23/13. leave upon ent on staff  staff  anced or the Any amily vill be prior year ation don is on any lon
9	9/24/12 with diagnosis t	hat included chronic ood pressure, stroke and		assigned to the floor.	100

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	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150	
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F 242	dementia. The resider (DNR) order dated, 9/2 On 12/27/12 at 8:00 p breathing and cardiop (CPR) was started. The the resident's chart was noted.  2. CORRECTIVE ACFOR ALL RESIDENTS TO BE AFFECTED  Upon admission all resident and Family I reviewed. The handboth that address advanced of advanced directives work in a nursing facility the areas of "should I facility", "What if I am uhave an advanced directives an advanced directive in a nurse or sociation me", "Do I have to hadvanced directive" an after I make an advanced coordinator and/or Sociates with residents of determine their wishes	at had a do not resuscitate 14/12.  The Resident #114 stopped almonary resuscitation are CPR was stopped after as checked and the DNR  CTION ACCOMPLISHED SWITH THE POTENTIAL  Sidents are given the information Handbook" and ok includes multiple areas and how advance directive by The handbook covers bring a copy to the nursing anable to tell someone I inctive", "What role does my my advanced directive", "Under a lawyer to make an ded irective", "Can I inceed directive", "Admission contail Worker designee or responsible party to regarding the code status.  We a different resident right monthly meeting.	F 242	2:15pm from the hospital. The dia included (per discharge sum systolic congestive heart fischemic cardiomyopathy wit ejection fraction estimated around type 2 diabetes, mitral valve prohistory of emphysema, known of coronary artery disease, electholesterol, chronic peripheral and bilateral lower extremity promounds. The hospital records indicate the resident had established DC RESUSITATE (DNR). The reason fresident's admission to the facility wound care and rehabilitation ongoing physical therapy. The admission nurse's note indicate the resident was alert and orien approximately 2:30 PM. The Adm Coordinator met with the residents husband asked that his be a "full code" and signed	mately agnosis mary): failure, the an d 15%, plapse, history evated edema essure licated D NOT for the ty was with licated ted at hission dent's mately he the sanced d the hission ent to mately hission ent to mately hission

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****		345229	B. WING		03/23/2013	
	ROVIDER OR SUPPLIER SOURCES - SHELBY	y X	1	REET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH MORGAN STREET BOX 2287 HELBY, NC 28150		
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F 242	choose their end of lift of the lesson plan we the resident right to make the resident right to make the residents advanced dunderstand who make status when the residents advanced dunderstand who make status when the residents are well as the in-service was provided worker designee and shifts will be completed staff by 3/23/13. The on leave from facility prior that the inservice was provided worker designee and shifts will be done plated the staff by 3/23/13. The on leave from facility prior that will be done by a coordinator.  Ongoing education rewill be done quarterly orientation. Any emplifamily medical leave deducated on advance assigned to the floor, advanced directive educated on a being assigned to the seducated on a being assigned to the seducated on a being assigned to the coordinate of the seducated on a being assigned to the seducated on a seducated on a being assigned to the seducated on a being assigned to the seducated on a being assigned to the seducated on a seducated on a being assigned to the seducated on a being assigned to the seducated on a being assigned to the seducated on a being	and the resident's right to the decisions. The objectives are a) Staff will understand the choices on their end of will understand the ements related to the irectives c) Staff will the decisions regarding DNR the tis unable to the first to the control of the control the transport of the control of the control the control of the control of the control of the control the control of the control of the control of the control the control of the control of the control of the control the control of the control of the control of the control of the control the control of the c	F 242	During Resident #148's stay a facility there were episode confusion, delusions and hallucin validated by nurse's notes dated and 3/10/12. On 3/9/12 the motes stated "yelling at staff and saying needles are in her arms, are no needles in her arms, resident confused." On 3/10/12 a nurse' reflected resident stated "seeing like snakes in her bed."  Resident #148 was transported hospital by EMS on 3/11/12 deardiac arrest and respiratory fails.  The Admissions coordinator contacted by facility staff nu approximately 12:30 AM on 3 regarding Resident #148's acceptable.	chargy.  at the es of lations  3/9/12 hurse's spouse there dent is so note things  to the lue to lue to lue.  was rea at //11/12 dvance stated esident dinator 12 at twith ts for mission ospital	

Facility ID: 923377

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING COMPLET	(X3) DATE SURVEY COMPLETED	
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345229 B. WNG 03/23/	23/2013	
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - SHELBY  STREET ADDRESS, CITY, STATE, ZIP CODE  1101 NORTH MORGAN STREET BOX 2287  SHELBY, NC 28150		
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Directive Information" form and if the resident was a DNR that theyellow DNR form was in pace. She also checked to see if there were MD orders or other code status. There were not any other concerns identified.  An audit tool titled "Advanced Directive Audit" was developed on 3/20/13 which addressed the following: a) is the Advanced Directive Acknowledgement is in place, signed by the resident to unable to communicate wishes) and is on the chart b) if a DNR order is in effect does the "STOP" sign and the MD order match the advanced directive: 0) is ordered entered in the computer that matches the resident current code status.  On 3/20/13 100% of resident's currently in the facility were audited for a) The Advanced Directive Acknowledgement is in place, signed by the resident of Power of Attorney (PoA). PoA- if resident is unable to communicate wishes) and is on the chart b) The DNR orders are in effect does the "STOP" sign and the MD order match the advanced directive o) The orders entered in the computer that match the resident current code status. The results of the audit done on 3/20/13 revealed residents choices had been honored based on the "Acknowledgement of Receipt of Advanced Directive Information" and verified by the resident's signature on multiple "acknowledgement" forms.  4. QA  The Medical Records Information Clerk will report any "Admission Audit" concerns found on review		

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F 242	and/or the Administratis found. This includes "Acknowledgement of Directive Information" form) when there is an tool developed on 3/2 10% of the residents provided to the monthly for 3 months. Continue based on the months of audits. Resireviewed at the facility "Admission Audit" con the monthly QA meeting and recommendations are identified the QA comonthly for no less that directive compliance where the monthly QA program of the m	to the Director of Nurses for at any time the concern incomplete or missing Receipt of Advanced forms and DNR (Yellow order for DNR. The audit 1/13 will be completed on the week for 4 weeks, then every two weeks, then ev	F	242	An audit tool titled "Ad Directive Audit" was develop 3/20/13 which addressed the fol a) is the Advanced Di Acknowledgement is in place, sig the resident or Power of Ad (POA). POA- if resident is una communicate wishes) and is control of a DNR order is in effect the "STOP" sign and the MD match the advanced directive ordered entered in the compute matches the resident current status.  On 3/20/13 100% of recourrently in the facility were auditionally and the status.	ed on lowing: rective med by torney ble to on the ct does order c) Is er that code sident's ited for irective and is a are in the MD ctive c) mputer t code one on the had	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923377

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	CPR if the resident washould not start CPR orders.  Record reviews were accurate code status of the resident's medical Coordinator verified all have chart audits comensure the correct advistatus forms were preschart.  The new Advanced Direviewed and container reviewed and container reviews that had been records to confirm the directives, code status orders were in place of 2. Resident #148 was 03/06/12 with diagnose failure, mitral valve prowhich the valve that selower chambers of the not close), coronary and the small blood vessels oxygen to the heart.), themphysema and chronilegs with pressure would resident #148 was traited the control of t	also made to verify vas available in the front of record. The Admissions I new admissions would pleted and documented to ranced directives and code sent on the resident 's  rective Audit tool was I d documentation of record completed of resident; correct forms for advanced forms and physician's; in resident's charts.  admitted to the facility on se which included heart lapse (heart problem in parates the upper and left side of the heart does tery disease (narrowing of that supply blood and type 2 diabetes, ic swelling in her lower ruds on both lower legs. Insported to the hospital by rvices (EMS) on 03/11/12  was a bright yellow color the top left hand corner uscitate (DNR) order that		Advanced Directive Information verified by the resident's signature multiple "acknowledgement" form.  4. QA  The Medical Records Information will report any "Admission Aconcerns found on review of medical record to the Director Nurses and/or the Administrator a time the concern is found. This inclincomplete or mi "Acknowledgement of Receipt Advanced Directive Information" for and DNR (Yellow form) when there order for DNR. The audit tool develor on 3/21/13 will be completed on 10 the residents per week for 4 we then 10% of the residents every weeks, then monthly for 3 mor Ongoing audits will continue based the results of the prior 4 month audits. Results of the audits will reviewed at the facility monthly	" and are on is.  Clerk audit" the or of tany ludes ssing of orms is an oped low of eeks, two in this. It on is of be QA ludit" the life life life in the life life life life in the life life life life in the life life life life life life life lif			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING C 03/23/2013 NAME OF PROVIDER OR SUPPLIER PRINTED: 06/14/2013 FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION A. BUILDING C 03/23/2013 STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287

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	discharge from the hose A review of a hospital of 03/06/12 indicated Reshospitalized from 02/20 discharged to the facilithospital discharge sum a physician that indicate heart failure to both the they agreed to a DNR swished to pursue active failure if possible. The further indicated Reside enough progress by he 03/06/12 that Resident to rehabilitation with drewound care.  A review of a facility document with an and signed by the Aindicated Resident #148 hospital to the facility an procedures and admissing reviewed with Resident and the a DNR had been complete however, Resident #148 and she was no longer of and was changed to a furtie facility.  A facility document that witted Acknowledgment of orectives Information desired.	discharge summary dated sident #148 was 2/12 until she was 1/12 until	F	242	QA committee will monitor month no less than 3 months. Adv directive compliance will remain a of the monthly QA program congoing basis.	anced s	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	(X3) DATE SURVEY COMPLETED			
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l L	A review of "Medicare indicated Resident #14 and place.  A review of "Medicare indicated Resident #14 spouse and said needle there were no needles resident was confused.	Notes" dated 03/06/12 8 was alert and oriented. Notes" dated 03/07/12 8 was oriented to person Notes" dated 03/08/12 8 was yelling at staff and es were in her arms but in her arms and the Notes" dated 03/09/12 8 was crying and was	F2	242			
	A review of a physician 03/09/12 indicated Resoriented to person and with-short-term-memory year.  A review of the 5 Day Modicated Resident #148 was cognotally dependent on state outling and dressing.  A review of "Medicate Modicated Resident #148 A review of a nurse's not 12:15 AM indicated Resident Resident Resident Resident Resident #148 A review of a nurse's not 12:15 AM indicated Resident Re	's progress note dated ident #148 was alert and place but had difficulty rand did-not-know-the dinimum Data Set (MDS) dated 03/11/12 indicated nitively intact and was aff for transfers and stance from staff for dated 03/11/12 identification of the stance from staff for dated					,

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 8		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	his wife's condition. To when on the phone with (NA) informed the nurse not breathing. The not checked Resident #14 was no blood pressure spouse was informed condition and then CPI. A review of an EMS rejudicated EMS was call arrived at Resident #14 section of the EMS rep Resident #148 had sha nursing staff called the report revealed the nursthey had Resident #148 told them that she had	was called to inform him of the notes further indicated that he spouse a Nurse Aide that Resident #148 was the revealed the nurse B's vital signs and there or heart rate and the of Resident #148's R was started.  Doort dated 03/11/12 led at 12:44 AM and 18's room at 12:50 AM. A cort titled "Activity" indicated allow respirations and resident's spouse. The sing staff told the spouse B listed as a DNR but he	F	242			
	resident to the hospital.  A-review-of-a-facility-do- Summary Form" dated Resident #148's discha cardiac/respiratory failu  During a phone interviewith Nurse #1 she explacharge nurse) told her Foulse or blood pressure 03/11/12 and Nurse #2 spouse and told him the She stated Nurse #2 rep	cument-titled."Discharge 03/20/12 indicated rge diagnosis was re.  w on 03/19/13 at 3:54 PM sined Nurse #2 (night shift Resident #148 had no around 12:15 AM on called the resident's resident had expired. corted that the resident's was going to start CPR ing to their paperwork ated Nurse #2 told her	*				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/14/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED 345229 B. WING 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 PEAK RESOURCES - SHELBY SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 242 Continued From page 17 F 242 was a full code and should be resuscitated and Nurse #2 got off the phone and started CPR on Resident #148. During a follow up interview on 03/20/13 at 1:27 PM the Admissions Coordinator explained that during the admission process if a resident was alert and coherent enough then she talked to the resident about their admission forms which included advanced directives and code status but if they were not coherent she talked to the family/responsible party. She explained residents sometimes were compromised or confused and then a family member who was the responsible party signed the paper work for the resident. The Admission Coordinator verified the resident or responsible party could change the code status at any time and once the paperwork was signed it was recognized as a legally binding document by the facility. The Admissions Coordinator explained she routinely had the responsible party sign all of the resident's admission forms which included advanced directives and code status forms during the admission process and she was not concerned about Resident #148's spouse signing Resident #148's full code form because he was listed as her primary responsible party. She further explained she tried to talk to Resident #148 on 03/06/13 after she was admitted but she was very lethargic, kept her eyes closed and did not seem coherent enough to sign the forms.

Resident #148.

She confirmed she had Resident's 148's spouse sign all of the admission forms which included the Full Code form and verified she did not attempt any other conversations about code status with

During a follow up interview on 03/20/13 at 2:00

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	the white form titled "A of Advanced Directive: 03/06/12 that indicated code in the front of the first tab so the nurses also verified she didn't 148's chart but if she h form was on the chart. During an interview on Nurse #7 stated on 03/and Nurse #2 were at the NA came to the desk a Resident #148's room. one look at Resident # call the resident's spoulooked like she was alrexplained Resident #14 had no pulse. She stated	coordinator verified she put acknowledgment of Receipt is Information" dated it Resident #148 was a full it resident's chart behind the could flip to it quickly. She look through Resident ad realized the yellow DNR she would have removed it.	F 242			
	phone-with-the-resident Resident #148 was gor the spouse was very up Resident #148 was a fur resuscitate her and so the spouse was very up and the code for the code status and she resident #148's choice the code and interview on the code and an interview on the code and intervi	ill code and they better they started CPR. Nurse for Resident #148 was a ne confusion regarding to was concerned that of code status was not  03/21/13 at 5:03 PM the N) stated she expected resident's code status a full code then CPR				

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F 242	confirmed that there we Resident #148's code occurred on 03/1,1/12 Nurse's Meeting on 03 was no documentation. She explained that it when there was an incidiscussed in the week Meeting and action pland interventions put it also stated she did not	vas no discussion of status or the events that in the weekly Administrative 8/16/12 and confirmed there in the meeting minutes. vas their usual process	F	242			
E 070	#148's code status. 483.20(b)(1) COMPRE	HENOWE		272	F 272 Comprehensive Assessment	1	3/27/13
	ASSESSMENTS	TIENOIVE		212	F272 Comprehensive Assessment		
	The facility must condust a comprehensive, according reproducible assessment functional capacity.  A facility must make a assessment of a resider resident assessment in	comprehensive ent's needs, using the estrument (RAI) specified essment must include at egraphic information;  tterns; g; d structural problems;			There was no adverse affect to resident #125 repressure ulcer status. The resident was readmit with a stage 4 pressure ulcer on 2/11/13(sacrun MD wound notes indicated from readmission the 3/21/13 "Improved" noted under the "wound progress" question.	ted ! n). All	

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	Continued From page Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sum the additional assessm areas triggered by the Data Set (MDS); and Documentation of parti  This REQUIREMENT by: Based on observations interviews, the facility fa assess the pressure uld residents with pressure The findings included: Resident #125 was adm 07/26/12. His diagnose injury, traumatic crush in tension and acute hemo hypertension, anxiety, dulcer on his sacrum.	d procedures; mary information regarding tent performed on the care completion of the Minimum cipation in assessment.  is not met as evidenced as, record review and staff ailed to comprehensively per for 1 of 3 sampled ulcers. (Resident #125).  initted to the facility on as included anoxic brain injury of the chest with prhage from the lungs, lysphasia, and decubitus in Data Set (MDS) dated at #125 with no speech, understands, and no		272	Residents with potential:  1. One to one in-service was completed the facility MDS nurse with regard to completion of the CAA and the care by the Corporate MDS trained RN.  2. Any staff member who is assigned to MDS/CAA's completion will be trained to being assigned to work.  3. Those MDS's completed in the month March 2013 were reviewed for approach description of the resident problem, and contributing factors to specific reproblems. Updates and revisions were completed as necessary. Care plans we developed/updated/revised as necessary. Monitoring:  An audit tool was developed to monitor the appropriateness of the CAA and care plan. The to included questions related to: does the CAA descriptions, causes and contributing factors reto resident problems; is there analysis of the speresident issue/problem; is there a care plan developed for resident specific issues identified by the CAA analysis. This tool will be completed by the Director Nurses and in his absence an MDS prepared/trained RN will complete the audit.  All regularly scheduled MDS'CAA's and care plans be reviewed/audited weekly over the next 60 day Then 50% of all regularly scheduled MDS'S CAA's care plans will be reviewed/audited over the next days for a total of 3 months. Continued audits will determined by the results of the prior 3 months of the prior 4 mo	d with oplans  d plans  d plans  d prior  h of priate!  causes  esident  re  vere  ssary.   pool  cribe lated  cific cloped  tor of  ned  s will  ys.  and  t 30	3/27/13
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	ROVIDER OR SUPPLIER SOURCES - SHELBY			REET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150		
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	assistance for all activ (ADLS) and having 2 with one present on ac Assessment (CAA) rel was dated 08/10/12 ar stage 2 ulcer on his sa an indwelling urinary care.  Per record review, Rest to the hospital on 08/3 degrees Fahrenheit. Hog/06/12. A significant 09/12/12 coded Reside pressure ulcer on read Assessment (CAA) relivas dated 09/25/12. U"Analysis of findings" von sacral area. See corelated to cognition state sacral decub ulcer." Trecent hospitalization for tracheostomy, tube fee communicate, his very he was receiving pallia weight loss despite tub The CAA did not docur problem, causes and cators related to press analysis of the resident special needs to conside no care plan would be per record review, Reshospitalized on 02/03/11 the facility on 02/11/13 sepsis and a stage 4 present care in the	ities of daily living skills stage 2 pressure ulcers, dmission. The Care Area ated to pressure ulcers and stated the resident had a corum, was tube fed, had atheter and required total sident #125 was admitted 1/12 due to a fever of 102.7 de was readmitted on the change MDS dated ent #125 with 1 stage 3 mission. The Care Area ated to pressure ulcers Under the section for was in total "stage 3 wound gnitive caa". The CAA ted he had a "stage 3 his CAA also noted his or sepsis, the use of a ding, inability to stiff body posture at times, tive care, and recent e feeding calorie increase. Inent the description of the contributing factors and risk ure ulcers. There was no its strengths, weaknesses, ther and why the CAA noted developed.	F 272	The results of the monthly audits be reviewed at the monthly QA committee meeting for the next 3 months and continued evaluation will be based on results. System changes will be evaluated and discussed and changes will be marif necessary.		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 272	02/22/13 coded Resid short term memory im impaired decision make extensive to total care stage 4 pressure ulcer.  On 3/20/13 at 10:30 Al area was observed wit. The sacral wound was with granulation tissue wound.  On 03/22/13 at 2:09 Pl was interviewed. She the pressure sore section Resident #125. She fur completed Resident #125 countries with the second resident with the second resident reside	ent #125 with long and pairments, severely ing skills and requiring for all ADLS and having a  M Resident #125's sacral h the Wound Care Nurse. clean, moist, beefy red surrounding the open  M the MDS coordinator stated that she completed on of the MDS for or ther stated she also 25's CAAs. She stated ald not move himself, turn as stiff, had weight loss and	F2	272				
F 280 SS=D	r(DON)-stated the MDS training with MDS 3.0 in prescheduled class.  On 03/23/13 at 5:32 PM nurse reviewed the pre- 09/25/12. She stated the picture of Resident #12 admitted with the press size increased and why ulcer. She confirmed the analysis information. 483.20(d)(3), 483.10(k) PARTICIPATE PLANNI	ssure ulcer CAA dated nat the CAA should paint a 5, including if he was ure ulcer, if the stage or he had the pressure ne CAA needed more  (2) RIGHT TO NG CARE-REVISE CP	F 28	30			4/10/13	
	The resident has the rig	ht, unless adjudged						

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION		TE SURVEY MPLETED
	8		345229	B. WING	B. WING			C 3/23/2013
The second second		ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150			0/20/2013
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  CH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  ULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)			(X5) COMPLETION DATE		
		within 7 days after the comprehensive assess interdisciplinary team, physician, a registered for the resident, and ot disciplines as determin and, to the extent practithe resident, the reside legal representative; and revised by a team each assessment.  This REQUIREMENT by: Based on observations interviews, the facility factore care plan to include recommendations for 1 reviewed for pressure until the findings included: Resident #125 was admontally from the properties of the pressure of th	ise found to be e laws of the State, to care and treatment or eatment.  plan must be developed completion of the sment; prepared by an that includes the attending nurse with responsibility her appropriate staff in ed by the resident's needs, ticable, the participation of int's family or the resident's nd periodically reviewed of qualified persons after  is not met as evidenced a, record review and staff alled to update a pressure e wound care physician's of 3 sampled residents elicers. (Resident #125).  initted to the facility on es included anoxic brain njury of the chest with	F		Resident # 125 had the care plan revised reflect specific positioning requirements.  There was no adverse effect to resident #: regarding pressure ulcer status. The reside readmitted with a stage4 pressure ulcer of 2/11/13 (sacrum).  All wound MD notes indicated From readmission through 3/21/13 "Improved" noted under "wound Progress".  Residents with potential:  A "Wound Recommendation Review" Form was developed to document The following:  Wound MD recommendations ordered by Attending MD; the resident care plan updated and has the care plan been revised; etc. 4/This will be completed by The wound RN weekly post the Wound MD visit.  The wound nurse (BSN) reviewed All of the wound Physicians Recommendations and appropriate Follow up was accomplished.  3/22	: 125 ent was n tes 10/13	3/22/13

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/14/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_\_\_\_ COMPLETED 345229 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 PEAK RESOURCES - SHELBY SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 24 F 280 The admission Minimum Data Set (MDS) dated Monitoring/systemic changes: 08/06/12 coded Resident #125 with no speech, being rarely understood, understands, and no "The wound recommendation" form cognitive assessment per resident interview or Will be completed weekly for 3 months staff interview for mental status. He was coded For all resident who are seen by as being nonambulatory, requiring extensive The wound physician. Ongonig assistance for all activities of daily living skills Reviews will be determined by the (ADLS) and having 2 stage 2 pressure ulcers, Prior 3 month review results. with one present on admission. Care plans will be updated and revised Per record review, Resident #125 was admitted Based on physician orders and facility to the hospital on 08/31/12 due to a fever of 102.7 Protocol. degrees Fahrenheit. He was readmitted on 09/06/12. A significant change MDS dated 09/12/12 coded Resident #125 with 1 stage 3 pressure ulcer on readmission. Results of the "Wound Recommendation Review" form will be discussed and reviewed Review of the wound physician's weekly notes at the monthly QA committee meeting . This revealed from 01/02/13 through 01/16/13 the will be done over the next 3 months. physician recommended the facility staff off load Continued monitoring will done based on wound, limit sitting to 60 minutes and reposition the prior 3 months of monitoring. Followthe resident per facility protocol. Review of the up/Further action will be taken as necessary. wound physician's weekly notes revealed from 01/23/13 to 01/31/13 the physician recommended the facility staff off load wound, limit sitting to 2 hours except during treatments and reposition the resident per facility protocol. Per record review, Resident #125 was hospitalized on 02/03/13 and was readmitted to the facility on 02/11/13 with the diagnoses of sepsis and a stage 4 pressure ulcer (on his

sacrum).

The care plan dated 02/12/13 which addressed the current stage 4 pressure ulcer had goals to minimize the potential for infection and to manage discomfort associated with altered skin condition.

#### PRINTED: 06/14/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 345229 B. WNG 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 **PEAK RESOURCES - SHELBY** SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 280 | Continued From page 25 F 280 Interventions included weekly skin assessments. indwelling urinary catheter, air mattress, wound physician with weekly consults, turn and reposition frequently during rounds and as needed, and the specific treatment of Collasorb with dressing every other day as ordered by the physician. The wound care physician's recommendation for off loading the wound and to limit sitting to 2 hours was not added to the care plan: The most recent quarterly MDS dated 02/22/13 coded Resident #125 with long and short term memory impairments, severely impaired decision making skills and requiring extensive to total care for all ADLS and having a stage 4 pressure ulcer. The wound care physician's recommendation for off loading the wound and to limit sitting to 2 hours was not added to the care plan at this time. Review of the wound physician's weekly notes revealed from 02/14/13 through 03/07/13 the physician recommended the facility staff off load wound, limit sitting to 2 hours except during treatments and reposition the resident per facility protocol. The care plan was updated on 02/28/13 with a new treatment order of Ca Alginate and Santyl to the sacrum wound. The care plan was also updated on 03/14/13 for the treatment change to Hydrogel gauze to sacral wound.

Review of the undated Resident Care Information Sheet used by the nurse aides for reference for care plan interventions revealed instructions to assist the resident to turn and reposition, use an air mattress, and use a gel pad in the gerichair.

#### PRINTED: 06/14/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING C 345229 B. WING 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 PEAK RESOURCES - SHELBY SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 26 F 280 There were no instructions related to limiting the time Resident #125 stays up in a chair. On 3/20/13 at 9:14 AM Nurse Aide (NA) #2 and the Wound Nurse were observed transferring Resident #125 from bed to a gerichair which contained a full length gel cushion. Resident #125 was observed sitting in the gerichair on 03/20/13 at 10:05 AM and 1:06 PM. On 3/20/13 at 10:30 AM Resident #125's sacral area was observed with the Wound Care Nurse. The sacral wound was clean, moist, beefy red with granulation tissue surrounding the open wound. On 03/20/13 at 1:12 PM NA #2 stated Resident #125 had been in the gerichair since she transferred him into the chair this morning. She stated she had repositioned him upright because he tended to lean to the side. She confirmed he had not been out of the chair since the earlier observation. NA #2 stated she did not get Resident #125 up everyday and the amount of time she left him up in the gerichair depended on his pain level. When asked if Resident #125 had any time restrictions on being up in the chair, NA #2 stated she was unaware of any limitations. On 03/20/13 at 1:45 PM, Resident #125 was

observed in bed lying on his back.

On 03/21/13 at 10:32 AM the wound care physician was interviewed. He stated that he had been following Resident #125's wounds weekly since November. The physician stated that his recommendation for Resident #125 to sit up in a chair no longer than 2 hours was needed to

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F 280	promote wound healing present with the wound stated she was aware and had told the nurse weekend wound care in nurse further stated Reand staff had to be care positioning him.  During interview on 03, stated there are no gui	g. The wound care nurse d care physician at this time of this recommendation aides, nurses and the nurse. The wound care esident #125 was very rigid	F	280	- 37		
	stated she cared for Re Thursday. NA #3 state was up in the gerichair and she left him up a lit back to bed. When ask specific time frames or	d sometimes the resident when she started her shift tle then transferred him	,				
	the wound care nurse dimplemented Resident applan. Per the MDS Cooupdated by the wound coopdated by the wound coopdated at 4:05 PM. Sonformed all pertinent nuresidents with wound arrelated to care needs. Sonformed all nurses and \$125 needed to be limited.	#125's pressure ulcer care ordinator the care plan was care nurse.  vas interviewed on the stated she verbally ursing staff of the ad what needs to be done					

	MENT OF DEFICIENCIES LAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- S		CONSTRUCTION	(X3) DA	ATE SURVEY
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F	plan used by the Care Information on 03/22/13 at (DON) stated the followed through made by the wind stated she expronented she expressed and plan of care she expressed and plan of care she expressed she e	ut this rehe nurse on Sheet the nurse on Sheet the wourd call the would call the would be the work of the wore of the work of	ecommendation on the care as and on the Resident at used by the nurse aides.  If the Director of Nursing and care nurse normally any recommendations are physician. She further are recommendation to be at the Resident Care.  E/SERVICES FOR Grain and services to attain practicable physical, all well-being, in an apprehensive assessment.  If and staff interviews the adiopulmonary are resident whose cated Do Not Resuscitate do to implement and start CPR and with an advanced.	F 30	009   1   1   1   1   1   1   1   1   1	PROCESS TO ESTABLISH CODE STATUS ON ADMISSION  1. AFFECTED RESIDENT CORRECTIVE ACT Resident #114 was admitted to the facility 0/24/12 with diagnosis that included chron sidney disease, high blood pressure, stroke dementia. The resident had a do not resuscible DNR) order dated 9/24/12.  On 12/27/12 at 8:00 pm Resident #114 stop reathing and cardiopulmonary resuscitation CPR) was started. The CPR was stopped aftine resident's chart was checked and the DI was noted.	on ic and citate	4/17/13

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が行った。	STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SUF COMPLETE	RVEY
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1000	NAME OF F	ROVIDER OR SUPPLIER		ls.	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0312-312	
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		Immediate Jeopardy w. 6:10 PM when the facility compliance. The facility compliance at a lower set (an isolated deficiency, potential for more than immediate jeopardy) to to ensure monitoring sy effective. Example #2 (I status) was cited at a D isolated deficiency that with potential for more than immediate jeopardy). The findings included:  A review of a facility police of the following facility will not use cardicated related emergency refunctions on a resident were suscitate Order in effects.	ot Resuscitate (DNR) ped breathing and citation (CPR) was started. as removed on 03/23/13 at ity provided and table credible allegation of remains out of scope and severity of D no actual harm with minimal harm that is not complete education and stems put into place are Resident #148's code level deficiency (an constitutes no actual harm than minimal harm that is ).  cy titled "Do Not a revised date of March ving policy statement "our pulmonary resuscitation measures to maintain life when there is a Do Not ect."	F 30	Resident #148 was admitted to the faci 3/6/12 at approximately 2:15 PM from hospital. The diagnosis included (per dissummary): systolic congestive heart fail ischemic cardiomyopathy with an ejecti fraction estimated around 15%, type 2 cmitral valve prolapse, history of emphysical known history of coronary artery diseas chronic peripheral edema and bilateral extremity pressure wounds. The hospital indicated the resident had established DRESUSITATE (DNR). The reason for the readmission to the facility was wound care rehabilitation with ongoing physical them.  On 3/6/12 the admission nurse's note in the resident was alert and oriented at approximately 2:30 PM. The Admission Coordinator met with the resident's husband asked wife be a "full code". The Admission Coo and the husband went to the resident's rapproximately 4:30PM. At that time the Admission Coordinator observed the resident's lunable to communicate and would not o eyes due to her lethargy. The Admission Coordinator is unable to recall any other the room and verified the resident's husbasigned the Acknowledgement of Advance Directive Information which indicated the	the scharge ure, on diabetes, sema, e, ower I records O NOT esident's e and capy. dicated  pand on office at that his rdinator oom at dent pen her visits to pand d	
	F	Resuscitation (CPR) date	ed October 2006		resident was a full code. During Resident	#148's	1
	i	ndicated the facility routi	nely instructs staff with		stay at the facility, there were episodes of		
	r	egard to who is respons	ible for providing CPR,		confusion, delusions and hallucinations va	lidated	1
	ti	he location of emergenc	y equipment and contact		by nurse's notes dated 3/9/12 and 3/10/1	2. On	١.
	ir	nformation for outside se	ervices (i.e. Emergency		3/9/12 the nurse's notes stated "yelling a	t staff	
	l N	Medical Services (EMS)/	911).		and spouse saying needles are in her arms	there	
			3 3		are no needles in her arms, resident is		.  -
		. Resident #114 was adi		1 1	confused." On 3/10/12 a nurse's note ref	ected	
	l d	lagnoses that included h	eart disease, high blood	1	resident stated "seeing things like snakes	n her /	1

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	with left sided weaknes on 12/27/12 at 8:05 Pi A review of the admiss (MDS) dated 09/24/12 had impairment in sho memory and was mod cognition for daily decreatensive assistance fidally living.  A review of a yellow for the top left hand corner Resuscitate (DNR) Or expiration date.  A review of a documer of Receipt of Advanced dated 09/24/12 had an copy to the facility" for signed by a family mer A review of a Physician date of service of 09/28 Status: Do Not Attempt CPR).  A review of a Palliative 09/26/12 indicated Res NOT RESUSCITATE.  A review of a physician indicated DNR and nurand release body to fur	idney disease and a stroke iss. The resident expired M.  sion Minimum Data Set indicated Resident #114 interm and long term erately impaired in ision making and required from staff for activities of indicated Do Not indicated Information in indicated in information in it itiled "Acknowledgement in indicated Do Not indicated Information in it itiled "Acknowledgement in itilized "Acknowledgement in itilize	F	Resident #148 was transported to the by EMS on 3/11/12 due to cardiac arrespiratory failure.  The Admissions coordinator was confacility staff nurse at approximately 1 3/11/12 regarding Resident #148's addirectives and the staff stated specific DNR (yellow form) was on the chart the resident's husband had requested full status for Resident #148. The Admission Coordinator verbalized she would be facility in the morning to review chart resident code status. The Admissions Coordinator came into facility on 3/1 approximately 9:30 AM and met with nurse to review charts for correct coordinator also spoke with hospital and obtained a faxed copy of original advance directive at 10:08 AM been sent to the hospital with EMS. Of the Admission Coordinator then review of the resident medical records to valid advanced directive paper work were in the forms included "The Acknowledg Advanced Directive Information", yell form, and MD orders for DNR and/or status.	acted by 2:30 AM on lyance cally the ut the l code on at the s for 1/12 at charge e status. h staff at the f that had n 3/11/12 wed 100% date all n place. ment of ow DNR	3/11/12

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	Resident #114 giving is called a nurse to the rowas not breathing right. Resident #114 had she stopped breathing and notes further indicated checked and the DNR was stopped at 8:05 P. Emergency Medical Teresident #114 was platthere was no heart beart beart was no heart beart beart for control and the funer 9:15 PM that Resident. A review of a Coroner/Idated 12/27/12 indicate "Events that have taken resident was having shoreathing. The report from a rrived and the resident of breathing and CPR revealed the nursing stream of the provident was discontinued. During an interview on physician/medical direct expectation that nursing resident's chart for code was a DNR they should resident.  During an interview on the Nurse #3 stated she remand a NA called her to the because the resident was breathing right. She exassess Resident #114 and stopping was a stated she remand a NA called the resident was breathing right. She exassess Resident #114 and stopping was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the resident was a stated she remand a NA called the r	ncontinence care and from because the resident to the notes revealed allow breathing and then CPR was started. The Resident #114's chart was order was found and CPR M. The notes revealed echnicians arrived and the noted on a heart monitor and at and family was notified at all home was notified at allow respirations then not further indicated a nurse at was pulse less and was was started. The report aff found a DNR order and constant of the estatus and if the resident of the estatus and if the resident of the resident was breathing but wasn't	F	809	2. CORRECTIVE ACTION ACCOMPLISHER ALL RESIDENTS WITH THE POTENTIAN AFFECTED  Education was provided to licensed nurse the Admission Coordinator on 5/8/12 regithe right to make choices in regards to what Advanced Directives should be made, who makes the advanced directive decisions at changing the advanced directive after it has been established and end of life decision on Monday morning, 3/12/12 the Admiss Coordinator discussed with the Director on Nurses (DON) the conflicting code status of Resident #148, and plans to address these concerns. They discussed auditing of all new the secondary of the conflicting code status of the secondary of the conflicting code status of the secondary of the se	s and arding nen o nd as making. ions of	5/8/12

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	ROVIDER OR SUPPLIER SOURGES - SHELBY			REET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150	03/23/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
; ;	it as a firm and vigorous resident's chest to stime breathe but she did no stated she then gave Foreathing with an ambit do chest compressions her the resident's chart stop sign form and she further stated she then family, the physician arrand told them Resident During an interview on Director of Nursing (DC remember if Nurse #3 or regarding Resident #11 should not have started ambu bag or performed chest compressions unland determined what the was.  The Administrator was in Jeopardy on 03/20/13 are was accept on the compliance was	a sternal rub and described as pressure of the nulate the resident to t start breathing. She Resident #114 rescue u bag and was starting to swhen someone brought and she saw the yellow stopped everything. She called the resident's and the Director of Nursing #114 had expired.  03/21/13 at 5:03 PM the DN) stated she did not called her on 12/27/12 4. She stated Nurse #3 if rescue breathing with an it the sternal rub or started till she checked the chart he resident's code status.	F 309		by the t form and a ced or the ent Clerk ance,		
1 1 1	ADMISSION  AFFECTED RESIDACTION	ISH CODE STATUS ON DENT CORRECTIVE					
F	Resident #114 was adm	itted to the facility on					

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 100		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
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NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - SHELBY					STRE	EET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH MORGAN STREET BOX 2287 HELBY, NC 28150	<u> </u>	03/23/2013
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
		dementia. The residen (DNR) order dated 9/2- On 12/27/12 at 8:00 probreathing and cardiopted (CPR) was started. The the resident's chart was was noted.  2. CORRECTIVE ACT FOR ALL RESIDENTS TO BE AFFECTED  On 3/20/13 education valvance directives and choose their end of life of the lesson plan were the resident's right to more file decisions by staff documentation requirent residents advanced directives and choose their end of life of the lesson plan were the resident's right to more file decisions by staff documentation requirent residents advanced directives and communicate their healtin-service was provided worker designee and acts of the staff by 3/23/13. Those on leave from facility will return to facility prior to the staff by 3/23/13. Those on leave from facility prior to the staff by 3/23/13. Those on leave from facility prior to this will be done by Sta Coordinator.	that included chronic lood pressure, stroke and thad a do not resuscitate 4/12.  In Resident #114 stopped almonary resuscitation of CPR was stopped after schecked and the DNR  TION ACCOMPLISHED WITH THE POTENTIAL  Vas conducted regarding the resident's right to decisions. The objectives a) Staff will understand ake choices on their end will understand ments related to the actives c) Staff will decisions regarding DNR at is unable to the care choices. This to licensed nurses, social limissions coordinator. All including the weekend a staff members who are I be in-serviced upon assignment on the floor. If Development	F	309	On 3/20/13 education was conducted regarding advance directives and the resident's right to choose their end of life decisions. The objectives of the lesson plan were: a) Staff will understand the resident's right to make choices on their end of life decisions b) staff will understand documentation requirements related to the residents advanced directives c) Staff will understand who makes decisions regarding DNR status when the resident is unable to communicate their health care choices. This inservice was provided to licensed nurses, social worker designee and admissions coordinator. All shifts will be completed including the weekend staff by 3/23/13. Those staff members who are on leave from facility will be inserviced upon return to facility prior to assignment on the floor. This will be done 1 by Staff Development Coordinator.  Ongoing education regarding advanced directives will be done quarterly for the next year and on orientation. Any employee who is on vacation, family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor. Each year following, advanced directive education will be done twice a year and on orientation. Any employee who is on vacation, family medical leave or any other leave will be educated on advanced directives prior to being assigned to the floor.  Advanced Directive Information is also reflected in the "Resident and Family Information Handbook" which is provided to all admission and readmission residents/families.		3/23/13

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 100 100	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - SHELBY				TREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150	03/23/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	educated on advanced assigned to the floor. I advanced directive ed year and on orientation vacation, family medic will be educated on adbeing assigned to the Advanced Directive Infinithe "Resident and Flandbook" which is pre-admission residents.  3. MEASURE/SYSTI The "Admission Audit" Medical Records Informational Records Informadvance directive issue for all new admissions. Medical Records Information on the audit for "Acknowledgement of the "Acknowledgement of the "Acknowledgement Information" and all DN chart. If there is any coinformation she reports Coordinator and/or Soothen follows up with a vithe area which is out of involved with any compensate then gives the corand dated notice back to Information Clerk.	ar any other leave will be a directives prior to being Each year following, ucation will be done twice a man any employee who is on al leave or any other leave wanced directives prior to floor.  Formation is also reflected amily Information ovided to all admission and affamilies.  EMIC CHANGES  tool is completed by the mation Clerk to identify any es. The audit is completed and re-admissions. The mation Clerk checks the mation check checks the mation are in the mation code status this to the Admission check the Admission check the modern compliance; the member dilance issues, corrects the mation completed written, signed to the Medical Records advanced Directive Audit //13 to address the	F 309	The "Admission Audit" tool is completed by Medical Records Information Clerk to Identify any advance directive issues. The audit is completed for all new admissions and readmissions. The Medical Records Information Clerk checks the section on the audit form "Acknowledgement of Advanced Directive if the "Acknowledgement of Advanced Directive if the "Acknowledgement of Advanced Directive information" and all DNR information are it chart. If there is any conflicting code status information she reports this to the Admissi Coordinator and/or Social Worker designed then follows up with a written note that describes the area which is out of compliant the member involved with any compliance issues, corrects the chart then gives the completed written, signed and dated notice to the Medical Records Information Clerk.  A new audit tool titled Advanced Directive was developed on 3/21/13 to address the following: 1. Resident has received documentation regarding advance directive Has the resident been given an opportunity make a decision about his or her end of life Advanced directive care plan has been inition admission and reviewed quarterly. 4. Do the physician order reflect the resident wish 5. Has advanced Directives been discussed any significant change.	tify  lon titled "only ective n the still ion e. She  loce;  atco atcd es hes.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	SOURCES - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150	
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Taa oo aa is ""	Has the resident been make a decision about Advanced directive car on admission and revie physician order reflect advanced Directives be significant change.  Since 3/12/12 approximately have been compadmitted resident's and or Do Not Resuscitate, orders in place. There with the policy on advanced updated and revised to included health decision establishing advanced deducating the resident and vanced care planning.  QA  The Medical Records Infiny "Admission Audit" confined includes in Acknowledgement of Refirective Information" for my when there is an or old developed on 3/21/1 of resident's currently ill continue and be compaliated.	ng advance directives. 2. given an opportunity to his or her end of life. 3. e plan has been initiated ewed quarterly. 4. Does the the resident wishes. 5. Has sen discussed with any nately 175 "Admission pleted on all newly had advanced directives full code and doctor's were no concerns  directives has been include the CMS lated 9/27/2012 which making capacity, lirectives, informing and bout these rights, and legal representative.  formation Clerk will report oncerns found on review the Director of Nurses at any time the concern complete or missing eccipt of Advanced ms and DNR (Yellow der for DNR. The audit 3 was completed on 100 in the facility. Monitoring	F 30	Hard State Control	3/20/13

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER SOURCES - SHELBY	<i>;</i> ·		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150		
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	months. Ongoing audithe results of the prior of the audits will be revenenthly QA meeting. A concerns will be presented in the committee of the control of the committee of the control of the con	seks, then monthly for 3 ts will continue based on 4 months of audits. Results viewed at the facility Any "Admission Audit" Inted at the monthly QA Ittee input and Incerns or problems are nittee will monitor monthly Interest will monthly QA Interest will will be a series of the monthly QA Interest will monthly QA Interest will will be a series of the monthly QA Interest will be a	F 30	The Medical Records Information Clerk wireport any "Admission Audit" concerns for review of the medical record to the Direct Nurses and/or the Administrator at any tir concern is found. This includes incomplete missing "Acknowledgement of Receipt of Advanced Directive Information" forms an (Yellow form) when there is an order for D The audit tool developed on 3/21/13 was completed on 100 % of resident's currently the facility. Monitoring will continue and b completed on 10% of the residents per we 4 weeks, then 10% of the residents every tweeks, then monthly for 3 months. Ongoin audits will continue based on the results of prior 4 months of audits. Results of the audit will be reviewed at the facility monthly QA meeting. Any "Admission Audit" concerns where the monthly QA meeting for it committee input and recommendations. If concerns or problems are identified the QA committee will monitor monthly for no less 3 months. Advanced directive compliance where it is a month of the monthly QA program ongoing basis.  The new audit tool has not identified any trend or pattern regarding advanced directives	und on or of ne the er or of ne the er or of ne the er or or of ne the er or	
1	eviewed and contained eviews that had been c	documentation of record ompleted of resident		- 8		

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			*	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER SOURCES - SHELBY		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150			37		7.207.2010
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	directives, code status orders were in place of the code of the co	correct forms for advanced forms and physician's in resident's charts.  admitted to the facility on es which included heart plapse (heart problem in eparates the upper and left side of the heart does tray disease (narrowing of s that supply blood and type 2 diabetes, nic swelling in her lower unds on both lower legs. Insported to the hospital by ervices (EMS) on 03/11/12	F	309		nana.		
	A review of a hospital of 03/06/12 indicated Reshospitalized from 02/20 discharged to the facilithospital discharge sum a physician that indicate the situation to both the agreed to a DNR status to pursue active managif possible. The dischardicated Resident #14 progress by her dischard Resident #148 could be	o/12 until she was ty on 03/06/12. The amary contained a note by ed in part, after explaining a patient and spouse, they s, although they still wished gement of her heart failure rge summary further 8 had had shown enough rge date of 03/06/12 that						

STATEMENT OF DEFICIENCIES (X1) I		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUII			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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I TROPING T	ROVIDER OR SUPPLIER SOURCES - SHELBY	3,0210	D. WIING	STRE 11	EET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH MORGAN STREET BOX 2287 HELBY, NC 28150	<u>1 0</u>	3/23/2013
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	PM and signed by the indicated Resident #14 hospital to the facility a procedures and admis reviewed with Residen notes revealed code st length and detail and to a DNR had been comp stated since her condit was admitted to the fac Resident #148 wanted  A review of the 5 Day Micharge Assessment	ocument titled "Social " dated 03/06/12 at 2:00 Admissions Coordinator 8 was admitted from the and the facility policy and sion paperwork were t #148's spouse. The tatus was reviewed in great the spouse was aware that toleted in the hospital but he coin had improved and she coility for rehabilitation that to be a full code.  Minimum Data Set (MDS) to dated 03/11/12 indicated gnitively intact and was aff for transfers and	F	309			
	titled "Acknowledgment Directives Information" an "x" next to the stater am a full code."  A review of "Medicare N Indicated Resident #146 A review of a nurse's no 12:15 AM indicated Resident Shallow breathing and w the resident's spouse w his wife's condition. The	8 "expired."					

	TMENT OF HEALTH AN	ND HUMAN SERVICES			FOI	ED: 06/14/2013 RM APPROVED	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER SOURCES - SHELBY		110	EET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH MORGAN STREET BOX 220 IELBY, NC 28150		3/23/2013	
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	not breathing. The not checked Resident #14 was no blood pressure spouse was informed of condition and then CPI indicated Emergency Mand the physician were approximately 5 minute continued CPR while R transported to the hosp.  A review of an EMS repindicated EMS was call arrived at Resident #14 section of the EMS repindicated EMS was call arrived at Resident #14 had sha nursing staff had called The report revealed the spouse they had Resident the told them that shout he told them t	see that Resident #148 was tes revealed the nurse 8's vital signs and there or heart rate and the of Resident #148's R was started. The notes Medical Services (EMS) ocalled and EMS arrived in os, assisted with CPR and desident #148 was offital.  Dort dated 03/11/12 led at 12:44 AM and 8's room at 12:50 AM. A ort titled "Activity" indicated flow respirations and the resident's spouse. In oursing staff told the ent #148 listed as a DNR lee had been changed to a they send the resident to the further revealed the roximately 20 minutes were in the room with on they went back in her and was not breathing the report indicated led on a heart monitor but heart beat, her face and dent #148 was progress to the	F 309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER SOURCES - SHELBY			11	EET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH MORGAN STREET BOX 2287 HELBY, NC 28150	03	/23/2013
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	report further indicated response to treatment unsuccessful.  A review of a facility do Summary Form" dated Resident #148's discha cardiac/respiratory failu.  During a phone interviewith Nurse #1 she state weekend from 7:00 AM told about Resident #14 report by Nurse #2 on Cexplained Nurse #2 told no pulse or blood press Nurse #2 called the resident thad ex #2 reported that the resident she was going to start according to their paper	r breathing earlier. The Resident #148 had no and CPR was  recument titled "Discharge 03/20/12 indicated urge diagnosis was are.  www on 03/19/13 at 3:54 PM and she worked every until 11:00 PM and was 18 when she was given 13/11/12 at 7:00 AM. She I her Resident #148 had ure around 12:15 AM and ident's spouse and told pired. She stated Nurse ident's spouse asked her CPR and she told him	F	809			
t t t t t t t t t t t t t t t t t t t	#148's spouse asked if and they should go said she told had fibrillator but she got of CPR on Resident #148. It is a resident was found un supposed to go look at the resident's code statuull code they were suppoverhead and take the cotart CPR right away.	they had a defibrillator ck her and do everything fe. She further stated him they did not have a soff the phone and started. She further explained if responsive they were he chart first to see what is was and if they were a osed to page code blue rash cart to the room and the further explained the ty during the code was to enurse needed, call					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PEAK RESOURCES - SHELBY		. 11	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150				
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	Medical Record Inform Scheduler explained s to 7:00 AM shift on 03 called in and she could cover the shift. She st hearing a code paged 03/11/12 and did not g or provide care to her.  During a phone interviewith Nurse #2 she verifat the facility but confin 03/11/12 during the 11 and remembered Resident was found unr NA came and told her.	n 03/20/13 at 8:15 AM the nation Clerk/ Nurse he had to work the 7:00 PM /11/12 because a NA had do not find anyone else to ated she did not remember during the night of o in Resident #148's room lew on 03/20/13 at 8:42 AM fied she no longer worked med she worked there on 1:00 PM to 7:00 AM shift dent #148. She stated the esponsive by a NA and the She explained she went	F	309				
	blood pressure and the She stated she then we chart to check the residual saw a yellow form with said DNR. She further was a bright yellow colowhen she opened the conot see a white form for Resident #148's chart. resident had a DNR ord family when the resider Resident #148's spouse were doing anything to stated she told him they her because she was a upset and told her Residual says the stated she told her Residual she told her she told her Residual she told her s	and there was no pulse or resident did not respond. The resident's dent's code status and she a red stop sign on it that stated she remembered it or and it caught her eye thart. She verified she did if full code status in She explained if a der they usually called the not expired so she called a and he asked her if they resuscitate her. She were not resuscitating DNR and he got very dent #148's DNR had code. She explained she						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER			11	EET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH MORGAN STREET BOX 2287 HELBY, NC 28150		120/2013
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	least 8-10 minutes from Resident #148 unresponded pressure to the least further stated she did not be a stated after Resident for a stated Nurse for a state of the fort full code status when stated of the DNR for Coordinator explained directive forms in great directive forms in great for a stated of the DNR for Coordinator explained directive forms in great for a stated and a state of the DNR for Coordinator explained directive forms in great for a stated and a state of the DNR for Coordinator explained directive forms in great for a stated and a state of the DNR for Coordinator explained directive forms in great for a stated and a state of the DNR for Coordinator explained directive forms in great for a state of the DNR for Coordinator explained directive forms in great for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator explained for a state of the DNR for Coordinator expl	ted she estimated it was at m the time she found onsive with no pulse or beginning of CPR. She chest compressions while breathing with an ambu MS arrived while they were continued CPR and #148 to the hospital. She #148 left with EMS she Coordinator and the or confirmed that Resident if been changed and she of verified Nurse #2 called anight on 03/11/12 and for the DNR yellow stop #148's chart and did not a full code until the her. The Admissions the yellow-DNR form-withhe form the resident had be pital and it should not of Resident #148's chart and been changed to a he was admitted to the ted the white full code in the front of the chart m. The Admissions she reviewed the advance a detail with Resident #148 e unless she was in a since she had made to the facility for	F	309			

PRINTED: 06/14/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING\_ 345229 B. WNG 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 **PEAK RESOURCES - SHELBY** SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 309 Continued From page 43 F 309 During an interview on 03/20/13 at 9:40 AM the Director of Nursing (DON) explained a resident's code status was supposed to be determined on admission. She stated when a resident was found unresponsive it was her expectation for nurses to check the resident's code status in the resident's chart first and if the resident was a full code they should call code blue immediately, start CPR and call 911. She explained nursing staff has a basic crash cart available with a suction machine, IV start kit and ambu bag. She stated when 911 was called EMS usually arrived within 5 minutes because the hospital was only 2 blocks away. She explained nursing staff was supposed to page code blue overhead on the call system and all nurses and nurse aides should go to the resident's room and nurses should do chest compressions and rescue breathing with the ambu bag and the nurse aides should get equipment or supplies for the nurses. During an interview on 03/20/13 at 10:14 AM the physician/medical director stated it was his expectation when a resident was found unresponsive and was a full code that nursing staff should attempt CPR. He further stated the nursing staff should refer to the resident's chart for code status and if the resident was a full code they should resuscitate the resident but if the

the resident.

resident was a DNR they should not resuscitate

During a follow up interview on 03/20/13 at 2:00 PM the Admissions Coordinator verified she put the white form titled "Acknowledgment of Receipt of Advanced Directives Information" dated 03/06/12 that indicated Resident #148 was a full

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150	
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F 309	so the nurses could fli verified she didn't look	e chart behind the first tab p to it quickly. She also through Resident 148's en the yellow DNR form	F 30		
	Nurse #6 she stated sinurse on weekends ar nurse usually reported Nurse #2 was the nigh 03/11/12 and told her to Resident #148 around	n 03/23/13 at 12:00 PM with the was the day shift charge and the night shift charge off to her. She verified at shift charge nurse on when they checked on 12:30 AM she was not esponsive. She explained			
	the paddles out and ie was a full code. Nurse reported to her that sh then started CPR on R stated Nurse #2 also re	se and he told them to get suscitate her because she #6 stated Nurse #2 e hung up the phone and lesident #148. Nurse #6 eported to her that she saw in the resident's chart and			
	and Nurse #2 were at a NA came to the desk a Resident #148's room. one look at Resident # call the resident's spoul looked like she was go Resident #148 was uniquise. She explained sto the nurses station to for code status and Nu with the resident's spoul	the nurses station and a and told them to come to She explained she took 148 and told Nurse #2 to see because Resident #148			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 309 F 314 SS=D	Continued From page was upset and told the her. She stated they sand left with CPR in prout the code was a nig 483.25(c) TREATMEN PREVENT/HEAL PRE  Based on the compreh resident, the facility must who enters the facility must does not develop pressindividual's clinical continey were unavoidable; pressure sores receive services to promote her prevent new sores from This REQUIREMENT is by:  Based on observations interviews, the facility face.	am they better resuscitate tarted CPR and EMS came ogress on Resident #148 htmare.  T/SVCS TO SSURE SORES  ensive assessment of a set ensure that a resident without pressure sores sure sores unless the dition demonstrates that and a resident having a necessary treatment and aling, prevent infection and a developing.  In the serior of th	F 304	DEFICIENCY)		
1	with pressure ulcers. (F The findings included: Resident #125 was adm 07/26/12. His diagnose injury, traumatic crush in tension and acute hemo hypertension, anxiety, d ulcer on his sačrum.	of 3 sampled residents Resident #125).  hitted to the facility on s included anoxic brain hijury of the chest with rrhage from the lungs, ysphasia, and decubitus		Residents with potential:  In-service was provided to nursing staff regarding prevention of pressure ulcers thi included but was not limited to: turning and positioning, off-loading pressure areas, use cushions and mattresses, reporting skin chartolicensed nurses/MD and incontinence cathis was done by the Staff Development Nurse/RN.	d 4/17/13 of anges	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	08/06/12 coded Resider peing rarely understood	it #125 with no speech, understands, and no				

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	SUMMARYSTA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	0.55
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	staff interview for men- as being nonambulato assistance for all activi (ADLS) and having 2 with one present on act  Per record review, Rest to the hospital on 08/3 degrees Fahrenheit. Hospital on	per resident interview or tal status. He was coded ry, requiring extensive lities of daily living skills stage 2 pressure ulcers, imission.  Sident #125 was admitted 1/12 due to a fever of 102.7 He was readmitted on the change MDS dated ent #125 with 1 stage 3 mission.  Physician's weekly notes a through 12/19/12 the ed the facility staff off load the resident per facility wound physician's weekly /02/13 through 01/16/13 ended the facility staff off per facility protocol. The facility protocol ity staff off load wound, except during treatments lent per facility protocol.  Ident #125 was 3 and was readmitted to with the diagnoses of	F 314	Any employee who is on vacation, medical leave, etc will be educated prior to their return to work.  A "Wound Recommendation Review" Form was developed to document The following: Wound MD recommendations ordered by Attending MD; the resident care plan updates and has the care plan been revised as well as were the NA can find the recommendations/facility protocols necessary to implement for their assigned resident.  4/10/13  The wound nurse (BSN) reviewed All of the wound Physicians Recommendations and appropriate Follow-up-was accomplished.  3/22/13  Monitoring/systemic changes:  An audit tool was developed which addresses observation of residents for turning and positioning, proper positioning with cushions, wedges, etc. shifting weight while in a chair, Incontinence care and off- loading.	
10	coded Resident #125 w	rly MDS dated 02/22/13 with long and short term everely impaired decision		e e e e e e e e e e e e e e e e e e e	

	TMENT OF HEALTH A RS FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES	921 18		FORM APPROVI	E
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION 3	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	9
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t t	for all ADLS and having the current stage 4 presenting included interventions included indwelling urinary cather physician with weekly of reposition frequently deneeded, and the specific with dressing every other physician. This care ploud in the care plan was most recommended and santyl to the care plan was most recommended in the treatment changes acral wound.  Review of the wound place and santyl in the care plan was most recommended wound, limit sitting to 2 treatments and reposition protocol.  Review of the undated in the care plan interventions in the care plan interventions in the care plan interventions in the care were no instruction in the Resident #125 stay in the resident #125 stay in the care plan intervention in the Resident #125 stay in the resident #125 stay in the care plan intervention in the Resident #125 stay in the care plan intervention in the Resident #125 stay in the care plan intervention in the Resident #125 stay in the care plan intervention in the Resident #125 stay in the care plan intervention in the Resident #125 stay in the care plan intervention in the Resident #125 stay in the care plan intervention in the Resident #125 stay in the care plan intervention in the Resident #125 stay in the care plan intervention in the Resident #125 stay in the care plan intervention in the	iring extensive to total care g a stage 4 pressure ulcer.  2/12/13 which addressed ssure ulcer had goals to for infection and to manage with altered skin condition. weekly skin assessments, eter, air mattress, wound consults, turn and uring rounds and as id treatment of Collasorb er day as ordered by the an was updated on atment order of Ca he sacrum wound. The ently updated on 03/14/13 eto Hydrogel gauze to invisician's weekly notes through 03/07/13 the did the facility staff off load thours except during on the resident per facility.  Resident Care Information enades for reference for everaled instructions to an and reposition, use an gel pad in the gerichair, as related to limiting the	F 314	The observation audit will be completed wound nurse or other RN in her absence of the resident weekly for 8 weeks, then the resident every 2 weeks for 1 month a 25% of the resident monthly for the next months. Ongoing audits will be determin the prior 5 months of observational audit. The "Wound Recommendation Review" will be completed on 100% of the resider by the wound physician. This will be done over the next 3 months.  OA:  Results of the Resident Observation audit discussed and reviewed at the monthly Occommittee meeting. Ongoing audits will be based on the prior 3 months of audits. Further changes will be reviewed monthly a QA committee meeting. Ongoing reviews completed based on the prior 3 months of audits.  Further changes will be made as appropriate.	on 25% 3/22/13 25% of and then 2 ed by ts.  form the seen e weekly 4/10/13  t will be A be done wither the will be of	

the Wound Nurse entered Resident #125's room to provide care and transfer him to a gerichair.

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	bilateral upper and low movements. Residenthe gerichair, which wagel pad, via a total me On 3/20/13 at 10:30 A area was observed with granulation tissue wound.  Resident #125 was obgerichair on 03/20/13 at 1:12 P #125 had been in the granulation that transferred him into the stated she had reposithe tended to lean to the had not been out of the observation. NA #2 st Resident #125 up ever time she left him up in his pain level. When a any time restrictions of #2 stated she was una On 03/20/13 at 1:45 P observed in bed lying on 03/21/13 at 10:32 / physician was interview been following Reside since November The recommendation for R chair no longer than 2	onverbal and exhibited stiff over extremities and jerky it #125 was transferred to as covered by a full length chanical lift.  M Resident #125's sacral the the Wound Care Nurse. It clean, moist, beefy redustrounding the open served sitting in the at 10:05 AM and 1:06 PM.  M NA #2 stated Resident gerichair since she is chair this morning. She is inceed him upright because e side. She confirmed he is chair since the earlier ated she did not get ryday and the amount of the gerichair depended on asked if Resident #125 had in being up in the chair, NA ware of any limitations.  M, Resident #125 was on his back.  AM the wound care wed. He stated that he had int #125's wounds weekly physician stated that his esident #125 to sit up in a	F:	314			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		(X3) DATE	<u>0. 0938-0391</u> ESURVEY PLETED
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F 314	present with the wound stated she was aware and had told the nurse weekend wound care in nurse further stated Reand staff had to be car positioning him.  During interview on 03 stated there are no gui	d care physician at this time of this recommendation aides, nurses and the nurse. The wound care esident #125 was very rigid	F	314				
	During interview on 03/ stated she cared for Re Thursday. NA #3 state was up in the gerichair and she left him up a lit back to bed. When ask specific time frames or	d sometimes the resident when she started her shift tle then transferred him						
	the wound care nurse d implemented Resident a	#125's pressure ulcer care ordinator the care plan was						
( i r r r !!	related to care needs. Someoned all nurses and \$125 needed to be limited to be the sound care.	he stated she verbally ursing staff of the and what needs to be done						al

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	v v		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150	03/23/2013	
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1	plan used by the nurse Care Information Shee She confirmed that she Care Information Shee The wound care nurse normally did not write a recommendations made physician and staff knoresident with a pressur spent in a chair.  On 03/22/13 at 4:14 PM (DON) stated the wound can stated she expected the on the care plan and or information Sheet. The #125 should not have be than 2 hours.	es and on the Resident at used by the nurse aides, a had updated the Resident at since the survey began, also stated that she a physician's order for be by the wound care w to minimize the time a be ulcer on their sacrum  If, the Director of Nursing d care nurse normally my recommendations are physician. She further be recommendation to be at the Resident Care book stated Resident een in his gerichair longer	F3			
SS=J	as is possible; and each adequate supervision as prevent accidents.  This REQUIREMENT is by:  Based on observations, interviews, and resident failed to secure 1 of 6 sa	ON/DEVICES  I that the resident afree of accident hazards aresident receives and assistance devices to  I that the resident hazards are sident receives and assistance devices to  I that the resident hazards are sident receives are devices to assistance devices to a sident receive as evidenced record reviews, staff interviews, the facility	F 32	AFFECTED RESIDENT CORRECTIVE ACTION  Resident #64 was admitted on 10/4/12 with disincluding end stage renal disease, high blood pland on hemodialysis. On 2/6/13 while transported in the facility van from dialysis resident became unconfortable and shifting are the wheelchair. When the driver stopped at the sign the resident slid from the wheelchair to the and bumped his head. Investigation by administrator and DON revealed seatbelt unbuckled. Neurochecks were initiated and we normal limits. Resident had no complaints of from incident.	being when when e stop e floor the was	

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	Immediate Jeopardy b Resident #64 fell from floor while being transp Immediate Jeopardy w 4:50 PM when the faci allegation of compliance of compliance at the lo D (no actual harm with minimal harm that is no ensure monitoring syst completion of employe The findings included: Nursing notes dated 08 revealed that a residen the facility van when Va resident back to facility backwards out of whee notified and made away back of head raised."  The Administrator was 1:23 PM regarding the occurred on 08/03/12 a implemented by the fact reoccurrence. The Adm driver involved with the not sure how the straps resident's wheelchair at Administrator stated the straps were not correct wheelchair, and maybe bars and slid when the	egan on 02/06/13 when his wheelchair to the van ported in the facility van. The removed on 03/23/13 at lifty implemented a credible be. The facility remains out wer scope and severity of potential for more than of immediate jeopardy) to ems are in place and the e education.  20/03/12 at 6:35 AM at was being transported in an Driver #1 "brought due to resident falling lichair. On call Dr. (doctor) are of small area noted to interviewed on 03/21/13 at transport incident that had the measures were attached to the any of the points. The at he had to assume the	F 323	CORRECTED ACTION ACCOMPLISHED FOR RESIDENTIAL TO BE AFFECTED  All residents who are transported in the facilitation have the potential to be affected.  Corrective action for event on 2/6/13: On 2/6/1 inspected for proper mechanical function resident wheelchair securement system includin tracks, tie downs, shoulder straps and lift mechanical problems were found. If the invest was done by administrator and maintenance of and no mechanical problems were found. If the invest was completed. A drug test of the employee it development coordinator on 2/6/13 was negation transportation staff were given a written quize safety" which included information on seaton 2/6/13-2/7/13. A return demonstration wheelchair securement and in-servicing completed on 2/6/13-2/7/13.  MEASURES/SYSTEMIC CHANGES  Corrective action for event on 2/6/13:  The New transportation safety program implement on 2/6/13 included new videos, "Doing it "Driving Safety," and "Braun Lift". Transposition observation audit tool was utilized to include following: Were proper techniques used to plant in the facility of the proper techniques used to plant in the facility of the proper techniques used to plant in the facility of	13, Van ing of ng floor hanism director Specific driving eigation by staff five. All (driving elts on of the was  On 2/6/13 right," rtation le the	

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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t t s	*Van Driver #1 was subsequently not perm *An investigation was a possible cause of the interpretation of the i	ons were put into place: spended, drug tested and litted to drive again; initiated to determine the incident; d for proper mechanical lichair was inspected and d on the wheelchair; were re-educated with legarding proper use of "tie le Administrator; had to view the video s with Special Needs." d to take a quiz. Review of one question specifically dents and wheelchairs in lo with "seat belts are river and all passengers"; lool was developed echniques used to place n; were proper techniques dent such as seat belts, tie hniques used to operate lent from the van; and is le employee has been loer use of the lool was used randomly vice a week for six weeks, less and then monthly for lited to the facility on lited to the facility on litel, hypertension,	F 323	resident into the van, were proper tech, used to resident i.e. attach seat belts, ties downs, etc. proper techniques used to operate hydraulic v were proper techniques used to unload the refrom the van, is there documentation the em has been educated regarding proper use of equipment/van. All transportation staff was eduland observed an additional return demonstrat transportation observation audit tool. Transportstiff was randomly audited by the administrate maintenance director monthly.  On 3/22/13 all in-house facility resident transported on 3/22/13 to include the folic additions:  Are tie downs observed at approximately degrees?  Are the tie downs secured at each corner of wheelchair?  The transportation staff was re-educated transportation policy and procedures to include videos, "Doing it right," "Driving Safely," and "B Lift" and a completed revised transportation wheelchair securement in the van. The transportation all training has been completed.	esident ployee of the ucated clon of rtation or and  sports n tool owing  ty 45  of the eraun ation of ethe craun ation of ethe craun

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	10/11/12, coded Residunderstood, having cleand requiring extensive most activities of daily MDS noted "No" on the brief interview for ment for staff assessment for he had long and short and had some difficulty new situations only. Times and short term ment having moderately impabilities. His ADLS ren MDS assessments included a Review of nursing note AM revealed Resident wheelchair in facility valued back to the facility. The wheelchair was locked resident stated "I slid on (and) hit my head" and for) changed + (and) go nursing note indicated in noted on head and no prove wheelchair locked down or reports of pain.  Review of the Resident slid while chair locked down or reports of pain.	am Data Set (MDS), dated ent #64 as usually being ar speech, understanding, at to total assistance with living skills (ADLS). The essection for conducting a sal status and the section of mental status indicated term memory impairments with decision making in the most recent quarterly coded Resident #64 with amory impairments and aired decision making nained the same. Both suded he received dialysis.  Is dated 02/06/13 at 6:20 #64 slid out of the nation while being transported anote stated the down. Per this note, the stated to dialysis. The se had no raised areas sain with range of motion.  Incident/Accident report out of chair on facility van "There were no injuries"	F3	323	The transportation observation tool involving drivers will be done five times a week for two the administrator or maintenance director.  Then, three times a week for four week administrator or maintenance director.  Then, weekly for three months by the administrator of the director.	o weeks by ks by the	4/1//13

#### PRINTED: 06/14/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES . AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG 345229 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 PEAK RESOURCES - SHELBY SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 323 Continued From page 54 F 323 QA #64 taken by the DON. The van was inspected The revised transportation audit tool includes: on 02/06/13 and noted 2 seat buckle clips were bent and clip tracks were cleaned out. Van Driver Were proper techniques used to place the 3/23/13. #2 was suspended. Per interview with the resident into the van? Administrator on 03/21/13 at 1:23 PM, these seat Were proper techniques, used to secure resident buckle clips were not used at the time of the i.e. attach seat belts, ties downs, etc.? incident and were found in the van in a box of spare equipment. Were proper techniques used to operate hydraulic van lift? Van Driver #2's written statement dated 02/06/13 Were proper techniques used-to unload the stated she picked up Resident #64 from dialysis resident from the van? and was returning him to the facility because he Is there documentation the employee has been had to use the bathroom. The statement said "I educated regarding proper use of the locked to (sic) chair down and strapped him with equipment/van? all four ties. I got out of dialysis parking lot got to Are tie downs observed at approximately 45 stop sign and he slid out of the chair. I don't degrees? know whether he was shifting in the chair Are the tie downs secured at each corner of the because he was still having a BM (bowel wheelchair? movement) because he kept saving I'm still doing it, or if he hit the chair lock." Handwritten The transportation observation tool involving multiple questions and answers written by the DON dated drivers will be done five times a week for two weeks by 02/06/13 under Van Driver #2's signature were as the administrator or maintenance director. follows: "Did you have the shoulder + lap straps in place?" Then, three times a week for four weeks by the "No." administrator or maintenance director. "Why didn't you?" "afraid I would get 'poop' on me because he kept saying 'still doing it." Then, weekly for three months by the administrator or The DON stated during interview on 03/21/13 at maintenance director. 2:52 PM that she asked these questions for clarification of Van Driver #2's written statement and these were her responses. On 03/21/13 at 5:40 PM, a telephone interview was conducted with Van Driver #2. Van Driver #2

stated she started driving the van in August 2012 and received training which included watching videos, training in the van, riding with another driver and having to demonstrate securing a

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	ROVIDER OR SUPPLIER SOURCES - SHELBY			REET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150	
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	staff member sitting in last week. According to residents to dialysis Memornings. She stated she had been called by Resident #64 was sick bathroom. Resident #64 was sick bathroom. Resident #64 was sick bathroom. Resident #64 wery squirmy. She des "chaotic" and stated it worning. She recounte wheelchair to the van brecall putting the lap be place. She described the diligent using the lap/st Driver #2, Resident #64 incontinent when she p She said she did not recother than he slid out or read-Van-Driver #2 the written by the DON on I she really could not remupset about the incident #64 was very alert and been physically able to shoulder belt. A follow 3/21/13 at 5:59 PM with Resident #64 had never lap/shoulder belt before being very agitated say burning.	in in front of the ther stated the erved her securing another a wheelchair in the van o Van Driver #2, she drove onday through Friday on the day of 02/06/13, ack to dialysis because and needed to use the 64 had diarrhea and was cribed the time as was dark at that time of the dithat she secured the out could not specifically she and shoulder belt in herself as being very noulder belts. Per Van it had already begun to be icked him up from dialysis, member what happened if the chair. The surveyor questions and answersher statement. She said hember and was very the stated Resident oriented and would have unfasten his lap and up phone interview on Van Driver #2 revealed runfastened his but she recalled him ng his bottom was	F 323	The results of the transportation audit tool reviewed by the administrator any time a colidentified. This includes any need for guiderrors noted when completing the transportation. The audit tool was completed on transportation staff on 3/23/13. The remitransportation staff members will be auditereturn to the facility. These 2 transportation members will not be permitted to drive education, transportation audit tool and demonstration have been satisfactory complete. All concerns/problems will be presented monthly QA meetings for committee inprecommendations. If any concerns or probleted identified system changes will take place transportation observation tool will remain as the monthly QA program on an ongoing basis.  The transportation audit tool and return demonthave been satisfactorily completed with the redrivers (1) the 2 <sup>nd</sup> driver will no longer to resident per her request.	oncern is dance or ion audit 6 of 8 aining 2 ed upon ion staff until all return ed.  at the out and ems are the part of istration maining

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STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		E SURVEY PLETED
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	SOURCES - SHELBY			11	EET ADDRÉSS, CITY, STATE, ZIP CODE 01 NORTH MORGAN STREET BOX 2287 HELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	The DON stated she as shoulder or lap belt we think so and she stated hands soiled. The DO a mistake or misjudger driver. The van driver was rushing her.  Review of the stateme PM taken by the DON revealed she asked if happened and the resi of chair real slow like we barely moving." The since he was asked if he rembelt on when the van since stated "I don't think moving because I had wiggling around trying wouldn't budge." There he was asked if he puse and he stated "I don't trup interview with Resid 11:00 AM by the DON sthought he had slid out because seat belt not a	DON he slid to the floor. Isked the van driver if the stee in place and she didn't dishe was afraid to get her N stated she looked at it as ment on the part of the van told the DON the resident at the death of the the the could tell what dent stated "I just slid out when we stopped, we were statement continued stating membered having his seat that at dialysis clinic and so, I know chair wasn't to go really bad and I was to hold it in and chair in the statement indicated hed any button or straps hink so." The written follow ent #64 on 02/12/13 at stated "Explained we of w/c (wheelchair) ttached and he was	F	3323			
1 5 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	right, cause I knew I ha On 03/21/13 at 9:17 AN interviewed. He stated slid out of the chair but stated he was not strap lap belt. He stated he no the time. He stated this dialysis center was very	I, Resident #64 was the van stopped and he					ń

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 1000		LE CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
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	ROVIDER OR SUPPLIER SOURCES - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150		_  03/23/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
; ; ;	her interview with the resident was rushing Van Driver. She stated she was care morning of 02/06/13 to She stated when she eresident was sitting on in front of the wheelchair wan to have looked at that Resident #64 stated he assessment revealed in was incontinent and state cleaned up and returned Resident #64 did not known the van driver told Nurst the van driver told Nurst the resident and then to on the floor.  Interview with the Administrator stated she or shoulder belts were constructed if the lap or shoulder belts were constructed if the lap or should in the lap or	M, the DON stated during resident, he admitted he of #2 to hurry.  It wed on 3/22/13 at 8:38 AM. Illed to go to the van on the assess Resident #64. Intered the van, the his bottom on the van floor air. She could not recall a secured and she would aspect of the situation. In hit his head but no evidence of bumps. He ated he just wanted to be ated to dialysis. Per Nurse #4 now what happened and he #4 she was talking to burned around and saw him an instrator on 03/21/13 at the arrived at the facility, remonstrate for him how thair. She demonstrated belchair properly. The second not recall if the lap on and the resident could houlder belts were on. The instrator on Resident for the not confirm the van driver houlder belts on Resident further stated an action inplemented on 02/06/13	F	323			

F 323  Continued From page 58 *An investigation was initiated; *The Van and Resident #64's wheelchair was inspected and no problems or concerns were noted; *Van Driver #2 was suspended, drug tested, and put on a performance improvement plan for "failure to put seat belt straps on resident during"		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
PEAK RESOURCES - SHELBY  STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150  (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 323  Continued From page 58 *An investigation was initiated; *The Van and Resident #64's wheelchair was inspected and no problems or concerns were noted; *Van Driver #2 was suspended, drug tested, and put on a performance improvement plan for "failure to put seat belt straps on resident during  STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150  PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  F 323  F 323  F 323  F 323			345229	B. WING			and the same of th	
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 323  Continued From page 58  *An investigation was initiated; *The Van and Resident #64's wheelchair was inspected and no problems or concerns were noted; *Van Driver #2 was suspended, drug tested, and put on a performance improvement plan for "failure to put seat belt straps on resident during  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLETION  TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  TO THE APPROPRIATE  TO THE APPROPRIATE  CROSS-REFERENCED TO THE APPROPRIATE  CROSS-REFERENCED TO THE APPROPRIATE  CROSS-REFERENCED TO THE APPROPRIATE  TO THE AP		SOURCES - SHELBY			1101 NORTH MORGAN STREET BOX 2287			
*An investigation was initiated;  *The Van and Resident #64's wheelchair was inspected and no problems or concerns were noted;  *Van Driver #2 was suspended, drug tested, and put on a performance improvement plan for "failure to put seat belt straps on resident during	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	BE	(X5) COMPLETION DATE	
*3 new videos were obtained on 02/06/13 for educational purposes, one relating to securement of wheelchair bound residents;  *All transportation staff watched the videos, took a quiz, and were visually observed and noted competent on attaching "Tie Down" straps and attaching seat belts properly; and  *Monthly observation audits already in place after a van incident in August 2012 regarding wheelchair securement remained the same and continued monthly.  The video for the Sure Lok securement system was observed on 03/22/13 at 2:00 PM by a surveyor, the Administrator and a corporate staff member. The video identified the different tract fittings in the van floor and the different straps available. The Administrator identified the van floor fittings and straps used by the facility. The video indicated the wheelchair should face forward, the wheels should be between the floor tracks, the wheelchair brakes should be locked, the rear strap should be attached then the front straps and tightened. The Video noted the straps should form a 45 degree angle when attached to the wheelchair and once secured, the wheelchair should move no greater than 2 inches side to side or front to back. In regards to securing the wheelchair occupant, the video revealed the lap belt should be over the pelvic zone and the snap		*An investigation was *The Van and Resider inspected and no prob noted; *Van Driver #2 was su put on a performance i "failure to put seat belt transport"; *3 new videos were ob educational purposes, of wheelchair bound re *All transportation staff a quiz, and were visual competent on attaching attaching seat belts pro *Monthly observation a a van incident in Augus wheelchair securement continued monthly.  The video for the Sure was observed on 03/22 surveyor, the Administr member. The video ide fittings in the van floor a available. The Administ floor fittings and straps video indicated the whe forward, the wheels sho tracks, the wheelchair b straps and tightened. T should form a 45 degree the wheelchair and once should move no greater or front to back. In regal wheelchair occupant, th	initiated; In #64's wheelchair was Ilems or concerns were  spended, drug tested, and Improvement plan for Istraps on resident during Itained on 02/06/13 for Itained on 02/06/13 for Itained on oescurement Istaliant Itained on 02/06/13 for Itained on oescurement Itained on oescurement Itained on oescurement Itained on oescurement Itained the videos, took Itained on otted In "Tie Down" straps and Itained of perly; and Itained the same and Itained the same and Itained the same and Itained the different tract Itained the different tract Itained the different straps Itained the different straps Itained the different tract Itained the different tract Itained the different straps Itained the floor Itained the floor Itained the straps	F 3	323			

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	hook attached to the In The shoulder belt was also present as this demonstrational checks plan. The wheelchair and 2 straps connected at this time he that the straps should be at fearful of the wheelchair point due to some being Driver #2 then placed the upper portion of his store and the wheelchair of the straps should be at fearful of the wheelchair point due to some being Driver #2 then placed the upper portion of his store and to the floor behind proceeded to apply the connected it to the clip of shoulder belt was then placed the middle of his stomaconce completed, the Adnstructions on the positive moved the lap belt and owards the resident's his around ensuring the clip	oring in back on the floor.  In the over the shoulder of belt. There was no end to accompany this video.  It is bound resident in the van, for the revealed that the action follows:  In the Administrator is was one of the story of the quality assurance was secured by straps to ent's wheelchair under the citing to floor in the front of raps connecting to the hair. The Administrator ought the video showed seat level but he was reframe's strength at this is made of plastic. Van he lap belt across the mach and secured the two the wheelchair. She shoulder strap and on the lap belt. The positioned over his the front of his chest to the She then tightened it. Iministrator provided it on of the lap belt, it reapplied it down in and moved the lap belt.	F 323			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	301
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	ROVIDER OR SUPPLIER		(31)	REET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150	1 03/23/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		N.
	hip. The administrator straps of the wheelchal On 03/22 at 10:02 AM Van Driver #2 was in a normally she had the lacorrectly applied. He sadditional instruction the need to make more free in the future.  On 03/22/13 at 3:15 PM the maintenance direct the van how they secure in the van by placing the locations on the wheelch straps used were those administrator during the placed the straps on the wheelchair and the maintenance the front straps to the anof the wheelchair. Neith angle. The Administrate exact way to secure the the Administrator was in Jeopardy on 03/22/13 at 149 and Resident #64. A Credible Allegation of accepted on 03/23/13 at Credible Allegation of Caffected Resident Correct Resident #64 was admit fliagnosis including end	onnected closer to his right then tightened the back ir tighter, removing slack.  the Administrator stated hurry this morning and ap and shoulder belts stated he had to provide his morning and he would quent observations of her  M, the Administrator and or each demonstrated in red wheelchairs differently e straps at different shair. The floor fittings and identified by the evideo. The Administrator e frame under the intenance director secured im rests close to the seat her were at a 45 degree for stated there was not an exheelchair.  Informed of Immediate to 10:39 PM for Resident  Compliance was to 4:50 PM as follows:	F 323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER SOURCES - SHELBY			11	EET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH MORGAN STREET BOX 2287 HELBY, NC 28150	1 03	3/23/2013
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	dialysis when resident and shifting around in driver stopped at the s from the wheelchair to head. Investigation by DON revealed seatbell Neurochecks were initilimits. Resident had no incident.  Corrected Action According to the All residents who are trovan have the potential to the Corrective action for evolutional to the Corrective action for evolutional for resident wheelchair sincluding floor tracks, tiend lift mechanism was and maintenance directoroblems were found.	d in the facility van from became uncomfortable the wheelchair. When the top sign the resident slid the floor and bumped his the administrator and twas unbuckled. In the administrator and to complaints of pain from a mplished for Residents of pain from mplished for Residents of AFFECTED ransported in the facility to be affected. The paint of the facility to be affected. The paint of the paint	F	323			
t c c d "" s c d ii M C T ir	the administrator until the completed. A drug test development coordinate all transportation staff with driving safety" which in seatbelts on 2/6/13-2/7/demonstration of the whoservicing was completed. The New transportation in plemented on 2/6/13 in Doing it right," "Driving	ne investigation was of the employee by staff or on 2/6/13 was negative. Were given a written quiz cluded information on 13. A return neelchair securement and sted on 2/6/13-2/7/13.					

#### PRINTED: 06/14/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING\_ 345229 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 **PEAK RESOURCES - SHELBY** SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 323 Continued From page 62 F 323 to include the following: Were proper techniques used to place the resident into the van, were proper tech, used to secure resident i.e. attach seat belts, ties downs, etc., were proper techniques used to operate hydraulic van lift. were proper techniques used to unload the resident from the van, is there documentation the employee has been educated regarding proper use of the equipment/van. All transportation staff was educated and observed an additional return demonstration of transportation observation audit tool. Transportation staff was randomly audited by the administrator and maintenance director monthly. On 3/22/13 all in-house facility resident transports were suspended. The transportation observation tool was revised on 3/22/13 to include the following additions: Are tie downs observed at approximately 45 degrees? Are the tie downs secured at each corner of the wheelchair? The transportation staff was re-educated on transportation policy and procedures to include the videos, "Doing it right," "Driving Safely," and

completed.

"Braun Lift" and a completed revised transportation observation tool and return demonstration of wheelchair securement in the van. The transportation staff will not be allowed to transport any resident until all training has been

The audit tool was completed on 6 of 8 transportation staff on 3/23/13. The remaining 2 transportation staff members will be audited upon return to the facility. These 2 transportation staff members will not be permitted to drive until all education, transportation audit tool and return demonstration has been satisfactory completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000 1000	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES - SHELBY				STREET ADDRESS, CITY, STATE, ZIP CODE  1101 NORTH MORGAN STREET BOX 2287  SHELBY, NC 28150				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	9 10	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	Continued From page 63 The transportation observation tool involving multiple drivers will be done five times a week for two weeks by the administrator or maintenance director. Then, three times a week for four weeks by the administrator or maintenance director. Then, weekly for three months by the administrator or maintenance director.  QA The revised transportation audit tool includes: Were proper techniques used to place the resident into the van? Were proper techniques, used to secure resident i.e. attach seat belts, ties downs, etc.? Were proper techniques used to operate hydraulic van lift? Were proper techniques used to unload the resident from the van? Is there documentation the employee has been educated regarding proper use of the		F	323				
	degrees? Are the tie downs secu wheelchair? The transportation obsomultiple drivers will be a two weeks by the admidirector. Then, three times a we administrator or mainte Then, weekly for three administrator or mainte The results of the trans reviewed by the administrator or the results of the trans	done five times a week for nistrator or maintenance ek for four weeks by the nance director. months by the nance director. portation audit tool will be strator any time a concern des any need for guidance						

#### PRINTED: 06/14/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING\_ C 345229 B. WNG 03/23/2013

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 PEAK RESOURCES - SHELBY SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 64 F.323 F 323 transportation audit tool. All concerns/problems will be presented at the monthly QA meetings for committee input and recommendations. If any concerns or problems are identified system changes will take place. The transportation observation tool will remain as part of the monthly QA program on an ongoing basis. Immediate Jeopardy was lifted on 03/23/13 at 4:50 PM. The facility provided evidence of additional inservice training for all transportation staff. Interviews and observations of transportation staff securing wheelchair bound residents in the facility van per the video were completed. Interviews of transportation staff revealed each staff had been securing the wheelchairs differently and now they were aware of the proper technique for safe transport. F 520 483.75(o)(1) QAA F 520 F 520 4/17/13 QUALITY ASSURANCE COMMITTEE COMMITTEE-MEMBERS/MEET SS=D QUARTERLY/PLANS-AFFECTED RESIDENT CORRECTIVE ACTION Resident #114 was admitted to A facility must maintain a quality assessment and the facility on 9/24/12 with assurance committee consisting of the director of diagnosis that included chronic nursing services; a physician designated by the kidney disease, high blood facility; and at least 3 other members of the pressure, stroke and dementia. The resident had a Do Not facility's staff. Resuscitate (DNR) order dated 9/24/12. The quality assessment and assurance committee meets at least quarterly to identify On 12/27/12 at 8:00pm Resident issues with respect to which quality assessment #114 stopped breathing and

and assurance activities are necessary; and

develops and implements appropriate plans of

action to correct identified quality deficiencies.

A State or the Secretary may not require

Cardiopulmonary Resuscitation

(CPR) was started. The CPR was

stopped after the resident's chart was checked and the DNR

was noted.

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (1) 345229	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED  B. WING  C  C  C  C  C  C  C  C  C  C  C  C  C
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC. 28150
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F 520	compliance of such co requirements of this se Good faith attempts by and correct quality def a basis for sanctions.	rds of such committee a disclosure is related to the ammittee with the	F 520  2. CORRECTIVE ACTION ACCOMPLISHED FOR ALL RESIDENTS WITH THE POTENTIAL TO BE AFFECTED  All staff will be in-serviced by the staff development coordinator starting 3/23/13 in regards to the Quality Assurance Committee and Program. This in-service objective is:  • The facility staff will understand
	by: Based on observations interviews and resident failed to develop and in after 1 of 2 sampled reschoices for advanced of honored (Resident #11 The findings included: Resident #114 was admidiagnoses that included pressure, dementia, kid with left sided weakness on 12/27/12 at 8:05 PM A review of the admission for daily decision and impairment in short memory and was mode cognition for daily decision at the side of the sid	s, record reviews, staff t interviews, the facility inplement plans of action sidents did not have their lirectives for code status 4).  Interviews for code status 4).	the purpose of the QA program: to provide means for a resident care or safety issues to be resolved.  Staff will know how the QA program works and who to contact with any actual or potential issues that are identified.  Staff will understand how the QA program monitors and develops the plan to address any potential or actual problem.  Staff will understand how the QA committee monitors the potential or actual problem identified.  The staff will understand who and how to contact/discuss any potential or actual problem so that the QA committee will follow up.  MEASURE/SYSTEMIC CHANGES  The QA policy was reviewed on 3/23/13, this policy states the facility shall develop, implement, and maintain an ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
	ROVIDER OR SUPPLIER SOURCES - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150	03/23/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E (X5) COMPLETION DATE	
iii a A-F-F-F-F-F-F-F-F-F-F-F-F-F-F-F-F-F-F-F	of Receipt of Advanced dated 09/24/12 had an copy to the facility" for signed by a family men. A review of a Physician date of service of 09/25 Status: Do Not Attempt CPR).  A review of a Palliative 09/26/12 indicated Resi NOT RESUSCITATE.  A review of a physician's not review of a physician's not release body to fundated DNR and nurse and release body to fundated a nurse to the rook as not breathing right. Resident #114 giving included a nurse to the rook as not breathing right. Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing and Cotes further indicated Resident #114 had shall topped breathing an	at titled "Acknowledgement of Directives Information" "X" next to "provided a DNR status and was ober.  I's Progress Note with a si/12 indicated Code Resuscitation (DNR/No  Care Progress Note dated dent #114 remains a DO  s order dated 09/26/12 to may pronounce expired the eral home of choice.  It dated 12/27/12 at 8:00 to de (NA) was with continence care and m because the resident The notes revealed ow breathing and then the eral home of choice.  PR was started. The tesident #114's chart was oder was found and CPR  dedical Examiner report in a section titled blace" a NA noted the low respirations then not ther indicated a nurse	F 52	program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care, and to resolve identified problems.  All staff will be in-serviced by the staff development coordinator starting 3/23/13 in regards to the Quality Assurance Committee and Program. This in-service objective is:  The facility staff will understand the purpose of the QA program: to provide means for a resident care or safety issues to be resolved.  Staff will know how the QA program works and who to contact with any actual or potential issues that are identified.  Staff will understand how the QA program monitors and develops the plan to address any potential or actual problem.  Staff will understand how the QA committee monitors the potential or actual problem identified.  The staff will understand who and how to contact/discuss any potential or actual problem so that the QA committee will follow up.  The Staff Awareness of QA Program audit was developed on 3/23/13 to verify staff awareness of QA Program audit was developed on 3/23/13 to verify staff awareness of QA Program. The audit will:		

CENTE	RS FOR MEDICARE 8	AND HUMAN SERVICES  MEDICAID SERVICES	· <del></del>		PRINTED: 06/14 FORM APPRO OMB NO: 0938-	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
······································		345229	B. WNG	The state of the s	C 03/23/2013	
AME OF	PROVIDER OR SUPPLIER	# NO PROPERTY NAME	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
<u> </u>	ESOURCES - SHELBY	u <sup>n</sup>	110	1 NORTH MORGAN STREET BOX 2287 ELBY, NC. 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X6) COMPLETI DATE	
F 520	Continued From page		F 520	<ul> <li>Monitor staff awareness of the</li> </ul>	.]	
. 14.	not breathing and CPI	R was started. The report		QA program and the purpose		
	revealed the nursing s	taff found a DNR order and	1	of the program.	1	
	CPR was discontinued			<ul> <li>Monitor that the facility staff will</li> </ul>	man .	
			1	understand the purpose of the		
.	A review of Administra	tive Nurse's Meeting	1	QA program: to provide means for a resident care or safety		
i	minutes dated 01/04/13	3 indicated there were no	1	issues to be resolved.	1	
*	notes regarding Reside	ent #114.		Monitor if staff know how the	1 .	
. 1		ž		QA program works and who to		
ŀ	During an interview on	03/21/13 at 4:37 PM	1 1	contact with any actual or .	1	
- 1	Nurse #3 stated a NA o	alled her to Resident	1 1	potential issues that are		
	#114's room because ti	ne resident wasn't		Identified.	-	
1	breathing right. She ex	plained she started to	1 1	<ul> <li>Monitor if staff understands how</li> </ul>	1	
1	assess Resident#114 a	and the resident stopped		the QA program monitors and		
	breathing so she tried to	reposition the resident	1	develops the plan to address any potential or actual problem.		
- 1:	and gave the resident a	sternal rub and described		Monitor if staff understands how		
li	t as a firm and vigorous	rub of the resident's	. * •   •	the QA committee monitors the	1 .	
1	chest to stimulate the re	sident to breathe but she		potential or actual problem	2	
	did not start breathing a	nd she then gave		Identified.		
	Resident#114 rescue b	reathing with on ambu		<ul> <li>Monitor if staff understands who</li> </ul>	ŀ-	
l i	an She stated she ha	d started to begin chest		and how to contact/discuss any	f	
	compressions when son	d started to begin thest	1	potential or actual problem so	1	
	ocidont's chart and she	saw the yellow stop sign		that the QA committee will	1	
	orm and she stopped ex	saw trie yellow stop sign		follow up.		
["	tated she then called th	eryuning. She tunner			1	
5	hydiolog and the Direct	e residents family, the		The Staff Awareness of QA	1 .	
P	hysician and the Director	or or Nursing and told	1 "	Program audit will be started on	1	
u	iem Kesident#114 nad	expired. She stated no		3/23/13 with all staff to include new staff on orientation and	1	
0	ne irom administration d	called her or talked to her	1	staff on leave to be audited by	1 1	
a	bout Resident #114 and	she was not aware that		staff development coordinator		
w	nything changed to veri as correct on resident's	ty that the code status charts.		and administrative RN upon return to the facility.		
1		* * · ·		ictoria to the facility.		
D	uring an interview on 03	8/21/13 at 5:03 PM with		e e		
th	e Director of Nursing (D	ON) stated she did not		* v	1 1	
re	member that CPR was	initiated with Resident		8	1 1	
		er if Nurse #3 çalled her		8		
on	12/27/12. She stated	Nurse #3 should not	i	25 (N) (N) (N) (N) (N) (N)		
ha	ve started rescue breat	hing with an ambu bag				
1	performed the stornel s	ub until she checked	1		1 1	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/14/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED C 345229 B. WNG 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PEAK RESOURCES - SHELBY 1101 NORTH MORGAN STREET BOX 2287 SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID. (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION. PREFIX (X6) COMPLETION PREEIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 520 Continued From page 68 F 520 Then 20% of staff randomly the chart and determined what the resident's weekly for 4 weeks by the staff code status was. development coordinator and administrative RN. Then 20% of staff randomly During an interview on 03/22/13 at 5:38 PM the biweekly for 4 weeks by the staff Administrator confirmed the QA Committee met development coordinator and monthly and verified the QA committee met on administrative RN. 03/27/13 at noon and there was no discussion: Then 20% of staff randomly about Resident #114's code status. He stated monthly for 3 months by the the weekly Administrative Nurse's meeting was staff development coordinator considered to be a sub-committee of the QA : and administrative RN. committee and he expected that the events OA surrounding Resident #114's code should have been discussed in the weekly nurses meeting and Results of the Staff Awareness of then should have been brought to the QA QA Program audit will be committee. He stated that the QA committee had reviewed, analyzed and discussed advanced directives in past QA discussed by the QA committee meetings but there was no specific information : monthly at the QA meeting for discussed regarding Resident #114 and the chart the committee input and audits that had been done had not been recommendation. presented to the QA committee. concerns or problems identified system changes will A review of admission audits on 03/23/13 at take place. The QA committee -1-1:00-AM-revealed-202-total-audit-sheets-with will monitor monthly for no less columns that listed each document that was to be than 3 months. filed in each resident's chart and whether the Awareness of QA Program audit information was complete in the chart, not will remain as part of the complete, the responsible department, problems monthly QA program on an and date of correction. The list of documents ongoing basis. included advanced directives and DNR and Full Code forms. A further review of the audits QA committee minutes will be revealed 11 audit sheets that were incomplete reviewed and 3 of these audits did not have documentation monthly representative regarding advanced directives and/or DNR Peak of Resources Corporate Office for 6 checked as complete as follows: months. 09/24/12 Acknowledgement of Advanced

complete.

Directives and DNR were not checked as

01/28/13 Acknowledgement of Advanced

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/14/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED C 345229 B. WING 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 PEAK RESOURCES - SHELBY SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 520 Continued From page 69 F 520 Directives was not checked as complete. 02/19/13 Acknowledgement of Advanced . The new audit tool has not identified Directives and DNR were not checked as Any issues regarding staff awareness complete. of the QA program focus. 4/17/13 During a phone interview on 03/23/13 at 11:45 AM the Medical Record Information Clerk stated she started the admission audit when a resident was admitted. She explained she would complete the first part of the form the same day or the next day if the resident was admitted late in the afternoon. She stated she usually went to the department and talked with the responsible person to let them know that their forms were not complete in the chart and then checks the chart again in a couple days to see if its been completed. She explained she communicated to the responsible party either verbally, or by a note or on the audit form. She stated she kept the forms in a notebook but the findings were not tallied and the information was not passed on to anyone else for review or discussion. During a follow up interview on 03/23/13 at 5:05 PM the DON verified there was not a discussion or evaluation of the occurrence of Resident #114's code. She further verified there were no notes in the weekly nursing meeting minutes dated 01/04/13 because it was not discussed in the meeting.

During an interview on 03/21/13 at 5:03 PM the Director of Nursing (DON) stated she expected nursing staff to konor a resident's code status and if the resident was a DNR then CPR should not be started and 2 nurses should confirm that the resident was not breathing and had no pulse and then call the doctor, family and funeral home.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/14/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED C 345229 B. WNG 03/23/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET BOX 2287 **PEAK RESOURCES - SHELBY** SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 520 Continued From page 70 F 520 She further confirmed that there was no discussion or Resident #114's code in the weekly Administrative Meeting dated 01/04/13 and confirmed there was no documentation in the meeting minutes. She explained that it was their usual process when there was an incident it should be discussed in the weekly meeting and action plans developed with interventions put in place to monitor. She also stated she did not remember any discussion at the monthly QA meeting of Resident #114's code status.