

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2014
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NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - SHELBY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150
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F 203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for</p>	F 203		6/6/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/06/2014
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	<p>Continued From page 1</p> <p>nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and record review the facility failed to involve and notify the resident and family of a residents discharge to a lower level of care for 1 of 1 sampled residents (Resident #160).</p> <p>The findings included:</p> <p>Resident #160 was initially admitted to the facility on 03/18/11 and discharged on 11/04/13.</p> <p>Resident #160 had diagnosis that included Alzheimer's disease, dysphagia, seizure disorder, above knee amputation (AKA), stage III kidney disease and peripheral vascular disease.</p> <p>A review of the most recent Minimum Data Set (MDS) dated 09/02/13 indicated Resident #160 experienced cognitive impairment and was dependent on staff for all Activities of Daily Living (ADL) which included extensive assistance with bed mobility, transfers and dressing and total dependence for toileting and hygiene. The MDS also revealed there was no active discharge planning occurring for Resident #160's return to the community.</p> <p>During a phone interview with the resident's family on 05/15/14 at 9:30 AM confirmed that resident and family were not notified of residents</p>	F 203	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that the alleged deficiencies did, in fact exist. This plan of correction is filed as evidenced of the facilities desire to comply with the requirements and to provide high quality care.</p> <p>"Resident #160 was discharged to the appropriate level of care on 11/4/13.</p> <p>"For those with potential:</p> <p>a)An audit tool was developed on 06/04/2014, which Addresses the discharge process. This tool Includes but is not limited to; Notice Of transfer in writing, location being Transferred to, and the right to appeal, etc.</p> <p>b)All residents discharged in the last 60 days Were reviewed/audited for compliance with</p>		

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F 203	Continued From page 2 move to an assisted living facility. The family stated the resident was a fifteen minute walk away from family that visited daily and now resident was a 45 minute drive by car. The family reported the facility had transferred Resident #160 to the assisted living facility in a nearby county and were notified by another family member who had attempted to visit and was told he had been moved. Family further stated there was no 30 day notice provided. During an interview on 05/15/14 at 10:10 AM the Social Services Director explained the facility discharge process. She stated she calls the family of the resident being discharged and then there was a care plan meeting with the resident/family and the day and time for discharge was set. The Social Service Director further stated this process did not happen for Resident # 160 and she did not offer an explanation as to why it did not happen. During an interview on 5/15/14 at 5:10 PM with the Administrator revealed his expectation would be for residents and families to be aware that the resident was being discharged.	F 203	Appropriate discharge procedures. This has been accomplished by the Social Services Director, DON, and other assigned administrative RNs. "Systemic Changes: a)The policy regarding Post Discharge Plan Which includes Notice of discharge has been Revised on 06/04/2014, to include Notice requirement before Discharge/Transfer. b)An in-service was completed 06/06/2014, regarding the Policy changes for the licensed nursing staff, the Admissions coordinator and the Social Services Director. For those staff who are on LOA or otherwise Out of the facility, the in-service will be completed prior to Returning to an assignment. The in-service was done By the Corporate Nurse and/or the staff development nurse. "Monitoring for future compliance: a)Will be done by auditing all discharges (The audit tool developed May 29, 2014 will be Utilized.) 100% of all residents discharged Will be reviewed for the next 4 weeks. 50% of Discharges will be audited for the following		

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PRINTED: 12/01/2014
FORM APPROVED
OMB NO. 0938-0391

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F 203	Continued From page 3	F 203	4 weeks, then 20% for the next 4 weeks. Ongoing audits Will be determined by the results of the prior months Audits. "QA: a)The Social Services Director, Director of Nursing, and/or designee will complete the required audits: (The audit tool developed May 29, 2014 will be Utilized.) 100% of all residents discharged Will be reviewed for the next 4 weeks. 50% of Discharges will be audited for the following 4 weeks, then 20% for the next 4 weeks. Ongoing audits will be determined by the results of the prior month's audits. b)Results of the audits will be reviewed at the QAPI meeting Each month. Changes in the Performance Improvement Plan (PIP) Will be accomplished as necessary.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement a physician's order for lab work for 1 of 3 sampled residents (resident	F 281	"For Resident #54, the attending physician was notified of omitted labs. Per physician orders, labs were obtained by	6/6/14	

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F 281	<p>Continued From page 4 #54).</p> <p>Findings include:</p> <p>A record review of annual Minimum Data Set (MDS) dated 03/06/14 revealed resident #54 was admitted on 10/24/08 with anxiety disorder. The resident's cognitive status was identified as severely impaired with altered level of consciousness and rarely understands verbal content.</p> <p>A record review of resident #54's care plan dated 03/19/14 revealed an identified problem at risk for altered nutrition and aspiration related to gastric tube status, history of vomiting, and abdominal discomfort. The goal identified resident was to maintain current weight within 5% over next review period of care plan. Interventions for resident #54 included Nutren 2.0 at 65 milliliters (mL) per hour for 19 hours (on at 2:00 PM and off at 9:00 AM). Head of bed elevated per electronic medical record specifications (EMAR), monitor tolerance to tube feeding, notify health care provider (HCP) and responsible party (RP) of significant changes in weights and registered dietician (RD) to review formula appropriateness. Another identified problem revealed resident #54 had weight loss of 20 pounds (lbs), (12%) over 175 days. The goal identified weight loss would be minimized over the next review period. Interventions for resident #54 revealed that albumin, protein, and basic metabolic panel (BMP), next day lab and check pre albumin as ordered.</p> <p>A record review of a physician's order dated 03/19/14 revealed albumin, protein, and BMP next lab day.</p>	F 281	<p>staff for this resident and results given to physician. Lab findings were within normal limits and no new orders were received related to laboratory findings.</p> <p>"For those with potential:</p> <ol style="list-style-type: none"> 1. In services for Charge Nurses was initiated on 06/04/2014, regarding facility policy and procedure for lab collections. This will be completed by the Director of Nursing and an RN designee in her absence. For Charge Nurses who are not available, they will be in serviced prior to accepting an assignment. This includes; reviewing physician orders, entering required labs into ELAB system, laboratory receipts and collection list, notification to physician of laboratory findings, and processing subsequent orders, if any. 2. 100% of the physician's orders requiring laboratory services since March 3, 2014, the day of the laboratory service change over, was then audited which revealed no other labs were omitted. <p>"Changes in system:</p> <ol style="list-style-type: none"> 1. For every physician's order or recommendation requiring laboratory services, a copy of the order will be made. The order will be entered into the ELAB system and a receipt will be printed. This will then be reconciled with the collection list on lab days. On the day of the laboratory services, the collections list will then be reconciled with the copies of the physician's orders to ensure completion of labs. 2. This will be reviewed daily by the Charge Nurse, or RN designee in the absence of the Charge Nurse. 		

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F 281	Continued From page 5 A review of resident #54's medical record revealed absence of lab results ordered by the physician for 03/19/14. Interview with Charge Nurse on 05/14/14 at 5:30 PM revealed that she did not enter resident #54's lab work as ordered by the physician on 03/19/14. Further interview revealed "the order got missed and the resident did not get labs drawn." Interview with Director of Nursing on 05/14/14 at 5:50 PM revealed that her expectations were that the nurse who received a physician's order was to follow through and initiate the order so that resident #54 would have received lab draw. Further interview revealed that charge nurse shared with DON today that physician's lab order was missed for resident #54 on 03/19/14.	F 281	"Monitoring: 3.An audit tool was developed for monitoring laboratory orders on 06/02/2014. 4.100% of orders requiring laboratory services will be audited every week for 4 weeks. Then 50% of a random sample of orders requiring laboratory services will be audited every week for 4 weeks. Then 20% of a random sample of orders requiring laboratory services will be audited every week for 4 weeks. Continued audits will be determined by the prior 3 months of audits. "QA: 1.The Director of Nursing and/or RN designee will complete 100% of orders requiring laboratory services will be audited every week for 4 weeks. Then 50% of a random sample of orders requiring laboratory services will be audited every week for 4 weeks. Then 20% of a random sample of orders requiring laboratory services will be audited every week for 4 weeks. 2.Continued audits will be determined by the prior 3 months of audits Results of audits will be discussed at weekly Standards/Nursing Meeting and monthly at QAPI meeting throughout the duration of the audit. Facility compliance will be determined at Standards/Nursing meeting to assess the need to change or discontinue audits after 3 months.		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		6/6/14	

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F 312	<p>Continued From page 6</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review the facility failed to provide denture care to 1 of 3 residents reviewed for activities of daily living. (Resident #9)</p> <p>The findings included:</p> <p>Resident #9 was admitted to the facility on 07/25/12 with diagnoses which included diabetes hypertension and hemiparesis. The most recent Annual Minimum Data Set (MDS) dated 04/17/14 assessed Resident #9 as being cognitively intact and needing extensive to total assistance with all activities of daily living. The MDS further assessed Resident #9 as having impairment to one side of her upper extremities and both sides of her lower extremities for functional range of motion.</p> <p>An interview was conducted on 05/13/14 at 2:38 PM with Resident #9. Resident #9 stated she was unable to get out of bed on her own to go to the sink to remove her dentures to clean them. She further stated staff had never offered to remove and clean her dentures at night.</p> <p>On 05/14/14 at 3:35 PM an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated he had worked in the facility since October 2013. He stated he routinely cared for Resident</p>	F 312	<p>"Resident #9 was provided with oral care on 05/15/2014. Resident comfortable with no complaints.</p> <p>"For those with potential:</p> <p>1. In service for all staff was initiated on 05/15/2014, regarding facility policy and procedure for mouth care. This includes; review of resident care plan for resident information and preference, assembly of equipment, privacy, infection control protocol, and procedure for oral care. This will be done by Staff Development nurse (RN) and RN designee in her absence. Those staff members who are not available will be in serviced on mouth care prior to accepting assignments.</p> <p>2. Oral care will be added to new hire orientation for C.N.As and with annual competency reviews with Staff Development nurse on May 21, 2014.</p> <p>"Changes in system:</p> <p>1. Audit tool was developed on 05/16/2014 which includes; identifying resident needs based on the Resident information sheet and/or Resident Profile, staff observations regarding privacy and following the facility policy and procedures for mouth care.</p> <p>2. Mouth care has been added to new C.N.A orientation process and to the</p>		

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F 312	<p>Continued From page 7</p> <p>#9. He further explained he had provided mouth care a couple of times for residents since he had started to work at the facility but not on a routine basis. NA #1 stated Resident #9 had dentures but she usually sleeps with her dentures in place, so he rarely cleaned the resident's dentures during his shift. NA #1 further stated he thought first shift usually cleaned Resident #9's dentures.</p> <p>On 05/15/14 at 1:12 PM an interview was conducted with NA #2 who worked with Resident #9 during first shift. NA #2 stated Resident #9 is a total assist for most activities of daily living. She stated she provides morning care for Resident #9, giving her a bath and assists her to clean her dentures. She stated when she cares for Resident #9 in the morning she already has her dentures in place so she removes them and brushes her dentures.</p> <p>On 05/15/14 at 1:20 PM an interview was conducted with Resident #9. Resident #9 stated NA #2 had not cleaned her dentures that morning and furthermore had never cleaned her dentures.</p> <p>On 05/15/14 at 1:20 PM an observation was made of Resident #9's dentures. Resident #9's dentures were covered with a white film and food debris.</p> <p>An interview was conducted on 05/15/14 at 1:25 PM with NA #2. NA #2 stated she had not provided denture care that morning for Resident #9 nor could she recall if she had provided denture care for Resident #9 at anytime that week. NA #2 stated the dentures should be in a cup at night soaking but they are always already in her mouth in the morning.</p>	F 312	<p>annual competency reviews.</p> <p>3.Competency tool created for new C.N.A hires and will be completed prior to accepting independent assignment.</p> <p>4.New C.N.As will be observed to validate competency.</p> <p>"Monitoring:</p> <p>1.An audit tool was developed titled Oral Care Audit/Observation.</p> <p>2.10% of random sample of residents requiring total or partial assistance with oral care will be audited every week for 4 weeks. Then 5% of random sample of residents requiring total or partial assistance with oral care will be audited every week for 4 weeks, then 2% of random sample of residents requiring total or particle assistance with oral care will be audited every week for 4 weeks. Continued audits will be determined by the prior 3 months of audits.</p> <p>"QA:</p> <p>1. Administrative Nurses and/or designee will complete 10% of random sample of residents requiring total or partial assistance with oral care will be audited every week for 4 weeks. Then 5% of random sample of residents requiring total or partial assistance with oral care will be audited every week for 4 weeks, then 2% of random sample of residents requiring total or particle assistance with oral care will be audited every week for 4 weeks. Continued audits will be determined by the prior 3 months of audits.</p> <p>2. Results of audits will be discussed at weekly Standards/Nursing Meeting and monthly at QAPI meeting throughout the duration of the audit. Facility compliance</p>		

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F 312	<p>Continued From page 8</p> <p>On 05/15/14 at 2:07 PM an interview was conducted with Nurse #1 who was the nursing supervisor for the facility. Nurse #1 stated mouth care should be provided routinely in the morning and at night. She stated if a resident has dentures they should be taken out and brushed and put into a denture cup. She went on to explain the dentures should be taken out of the cup in the morning and given to the resident. She stated her expectation for Resident #9 was her dentures should have been taken out and cleaned each day.</p> <p>On 05/15/14 at 2:18 PM an interview was conducted with the Director of Nursing (DON). The DON stated her expectation for mouth care was it should be provided on each shift and as needed. The DON stated dentures should be removed by first shift, cleaned and put back into the resident's mouth.</p>	F 312	will be determined at Standards/Nursing meeting to assess the need to change or discontinue audits after 3 months.		