STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING ______ B. WING ______	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and medical record review, the facility failed to provide dressing changes for a wound as ordered for 1 of 3 residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 06/12/13 with diagnoses of anemia, hypertension, renal failure, diabetes, hemiplegia, cardiovascular disease, generalized pain and joint contractures. The most recent annual Minimum Data Set (MDS) on 08/21/15 indicated the resident was alert and oriented. Resident #1 needed extensive assistance with bed mobility, dressing, toileting, and hygiene, and was totally dependent for transfers and bathing. The MDS indicated that Resident #1 was a high risk for pressure ulcer development and a pressure relieving device for the bed and wheelchair were being used. Care plans for 09/10/15, revealed the presence of a diabetic foot ulcer with approaches listed as treatment as ordered, consult with wound specialist as needed, assess and record the condition of the skin surrounding the diabetic ulcer, and use pressure relieving mattress to relieve pressure on the heels. On 10/01/15 at 10:26 AM, Nurse #1 was	F 309	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility¿s desire to comply with the requirements and to continue to provide high quality of care. For Resident #1, the time frame for the treatment dressing change was extended for a 12 hour time frame to assure the dressing change is completed as ordered regardless of medical appointments or resident¿s dialysis schedule. 10/1/2015 For all residents, 100% of all treatments were audited to ensure that all residents received treatment and dressing changes as ordered by the physician. 10/16/15 Education was provided to all nurses by the Staff Development Coordinator regarding the importance of timely dressing changes per the physician order and proper skin care protocol. Any staff member on leave of absence will be educated prior to beginning work.	10/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/23/2015

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 309	Continued From page 1 interviewed. She stated that Resident #1 had received wound care treatment earlier this morning due to a medical appointment and would not return until that afternoon. Nurse #1 described the treatment to the left outer great toe which was validated per review of the physician order as correct. Review of the Wound Care Specialist Evaluation for Sept. 2015, indicated the resident had a diabetic wound of the left foot with light serous exudate. A wound culture on 09/01/15 showed infection in the wound bed requiring antibiotic treatment and surgical removal of the necrotic tissue. Resident #1 filed a grievance on 9/4/15 about the dressing not being changed. The dressing was changed later in the day, after a family member called the facility and voiced concerns. The completed investigation resulted in the education for the nurse to follow scheduled dressing changes and to notify oncoming nursing staff when treatment was not done. Review of the Physician's Orders indicated the following: · 09/01/15 - Cleanse area to left ball of foot with normal saline, pat dry, apply wound gel, cover with a dressing that wicks drainage away from the wound every day until healed. This order was discontinued on 09/07/15. · 09/07/15 - Cleanse left outer great toe area with normal saline or wound cleanser, apply a small amount of medihoney (a wound healing product) and cover with a dry dressing. Change dressing every other day until resolved. This order was discontinued on 09/21/15. · 09/22/15 - Apply a small amount of a debriding ointment and cover with dry dressing every day until healed. This order was still current as of 10/01/15.	F 309	10/6/15 An audit tool was developed to include if the treatment record validates that the treatment was completed per the physician order. 10% of all treatment administration records will be audited for compliance with following physician orders for dressing changes. Audits will be completed by the Director of Nursing or RN Supervisor weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring. 10/16/15 All audit information will be analyzed and reviewed by the Director of Nursing at the QA Committee Meetings. 10/23/15	

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F 309	Continued From page 2 Resident #1's family member filed a grievance on 9/24/15 that specified the dressing change was not administered. The completed investigation revealed that the treatment was not completed due to resident being at a medical appointment when dressing change was due. Education to staff was given to provide dressing changes prior to or after the resident returns from medical appointments. Review of the Treatment Administration Record (TAR) for September 2015, indicated that all orders for dressing changes were scheduled to be done between 7:00 AM to 3:00 PM. The resident had missed having the ordered dressing changes on 09/06/15 (Sunday), 09/19/15 (Saturday), 09/26/15 (Saturday) and 09/29/15 (Tuesday). Review of the TAR for 09/06/15 revealed the treatment was not done and no documentation was present for the reason of the missing treatment. Continued review of the TAR for 09/19/15 revealed the following documentation "not administered, resident unavailable, resident not yet returned from dialysis appt." Additional TAR review for 09/26/15 revealed the following documentation "not administered, patient out of facility." No documentation was made indicating whether the treatment has been completed upon the resident's return. The following documentation was noted on the TAR for 09/29/15 "resident unavailable - out of facility to dialysis". An unsuccessful attempt was made to contact Nurse #4 regarding the wound care treatment not being completed for 09/06/15 and 09/26/15. On 10/01/15 at 2:10 PM, Nurse #2 was interviewed. She stated that on 09/29/15 she was unable to complete Resident #1's wound care treatment due to resident being out of the facility for a medical appointment. Nurse #2 stated that	F 309		

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F 309	Continued From page 3 she did not realize before the resident had left for a medical appointment that the resident had an order for wound care treatment. Nurse #2 stated the resident returned to the facility after the treatment time had passed. On 10/01/15 at 2:47 PM, Resident #1 was observed in her room lying in bed on an air mattress. Upon interview, Resident #1 stated the dressing changes were not being done as they were supposed to be. Resident #1 expressed concerns that the wound had been getting well and was worried that it was getting worse. Resident #1 stated she was out of the building 3 times a week for dialysis on Tuesday, Thursday and Saturday, and returned late in the afternoon and her dressing changes were being missed. On 10/01/15 at 3:06 PM, Nurse # 3 was interviewed. She stated on 09/19/15 Resident #1 had gone to a medical appointment and did not return until after her shift ended. Nurse #3 stated she did not complete the dressing change since the resident came back from the appointment after it was due. On 10/01/15 at 3:34 PM, the Director of Nursing (DON) was interviewed. DON acknowledged the wound treatment orders had not been followed and her expectation was for wound care to be completed. DON acknowledged a change in the scheduled time for wound care was needed as Resident #1 is out of the facility several times a week for dialysis appointments. On 10/01/15 at 4:28 PM, the Wound Care Physician was interviewed. She was concerned that determination of a wound getting better or worse would be incorrect if treatment was not being provided as ordered. She had not been made aware that 4 dressing changes had been missed in the past 30 days. Her expectation was	F 309		

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F 309	Continued From page 4 for nursing staff to follow orders given and if there were any problems, including reasons the order was not being followed and she would expect a phone call as to why this happened.	F 309		