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 _____	05/12/2016

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 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		6/9/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/27/2016

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to comprehensively assess and analyze triggered areas including residents' strengths, weaknesses and contributing factors when completing the Minimum Data Set for 3 of 5 residents reviewed for comprehensive assessments related to psychotropic medications. (Resident #94, #105, #72). The findings included: 1. Resident #94 was admitted to the facility on 01/30/13 with current diagnoses of non-Alzheimer's dementia, anxiety, depression and schizophrenia. Review of the annual Minimum Data Set (MDS) dated 01/03/16 revealed Resident #94 was severely cognitively impaired and had no moods or behaviors during the 7 day look back period. The MDS further revealed Resident #94 had received an antidepressant and an antipsychotic 7 days during the 7 day look back period and she received and antianxiety medication 2 days during the 7 day look back period. Review of the Care Area Assessment (CAA) dated 01/03/16 from the annual MDS revealed there was no assessment related to the areas of behaviors, psychosocial or mood as these areas did not trigger for an assessment. The psychotropic medication use CAA stated	F 272	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. F272 For Residents #94, #105, and #72, the Care Area Assessments (CAA) will be modified to comprehensively assess and analyze triggered areas related to psychotropic medications to include the reasons for the medications, their effectiveness, and any needed changes or monitoring. For all residents with the potential to be affected, an audit will be completed for 100% of all residents receiving psychotropic medications to verify that the Care Area Assessments comprehensively assessed and analyzed the triggered area for psychotropic medications. CAAs will be modified as needed. For the systemic change, education will be provided to the Interdisciplinary Care Plan Team by the Director of Nursing/ RN Consultant regarding the process for completing a comprehensive Care Area Assessment to include the residents' strengths, weaknesses, and contributing factors.	

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F 272	Continued From page 2 Resident #94 received Seroquel, Ativan, Celexa and Trazadone for diagnoses of episodic mood disorder, anxiety, depression and insomnia. Will proceed to care plan to minimize risks for medication adverse effects. Psychiatric consult as needed. An interview conducted on 05/12/16 at 10:36 AM with the MDS nurse who completed the psychotropic medication CAA revealed she tried to paint a picture of the resident and her needs relating to the triggered area when completing the CAA. When asked about the reasons for the antianxiety and antidepressant medications, a description as to why she needed the medications and how the medications affected her, the MDS nurse stated that information was often in the behavior, mood or psychosocial CAAs. She also stated the resident's behaviors were monitored on the Medication Administration Records. She further stated that Resident #94 was a long term care resident and stable on the medications. The MDS nurse stated she needed to be more descriptive relating to the reasons Resident #94 was taking the medications, their effectiveness and any needed changes or monitoring. 2. Resident #105 was admitted to the facility on 06/22/15 with current diagnoses of anxiety and depression. Review of the significant change Minimum Data Set (MDS) dated 03/04/16 revealed Resident #105 was cognitively intact and had a mood score of 1 and no behaviors during the 7 day look back	F 272	Audits of 100% of all CAAs for those residents receiving psychotropic medications will be completed monthly for six months by the Director of Nursing or RN Consultant. Audits will continue quarterly and the results will determine the need for more frequent monitoring. All audit information will be analyzed and reviewed by the Director of Nursing at the QA Committee meetings.	

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F 272	Continued From page 3	F 272		

period. The MDS further revealed Resident #105 received an antidepressant 7 days during the 7 day look back period and received an antianxiety medication 5 days out of the 7 day look back period.

Review of the Care Area Assessment (CAA) dated 06/22/16 revealed there was no assessment related to the areas of behaviors, psychosocial or mood as these areas did not trigger for an assessment. The psychotropic medication use CAA stated Resident #105 currently received Xanax and Lexapro for diagnoses of anxiety and depression.

An interview conducted on 05/12/16 at 10:36 AM with the MDS nurse who completed the psychotropic medication CAA revealed she tried to paint a picture of the resident and his needs relating to the triggered area when completing the CAA. When asked about the reasons for the antianxiety and antidepressant medications, a description as to why he needed the medications and how the medications affected him, the MDS nurse stated that information was often in the behavior, mood or psychosocial CAAs. She also stated the resident's behaviors were monitored on the Medication Administration Records. She further stated that Resident #105 was a long term care resident and stable on the medications. The MDS nurse stated she needed to be more descriptive relating to the reasons Resident #105 was taking the medications, their effectiveness and any needed changes or monitoring.

3. Resident #72 was admitted to the facility on 04/05/11. Her diagnoses included unspecified

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psychosis, major depressive disorder, Alzheimer's disease and dementia.

The annual Minimum Data Set dated 11/23/15 coded her with long and short term memory impairments, severely impaired decision making skills, and having no moods and no behaviors in the look back period. Resident #72 was coded to need extensive assistance with most activities of daily living skills, having had one fall and receiving an antidepressant 7 days in the previous 7 days and receiving an antianxiety medication 1 day in the previous 7 days.

Review of the Care Area Assessments (CAA) dated 11/24/15, there was no assessment related to the areas of behaviors, psychosocial or mood as these areas did not trigger for an assessment. The psychotropic medication CAA dated 11/24/15 stated Resident #72 received Celexa for depression and had the potential for medication adverse effects due to routine use. She was also noted to receive an antianxiety medication on an as needed basis for her anxiety disorder.

Interview on 05/12/16 at 10:36 AM with the MDS nurse who completed the psychotropic medication CAA revealed she tried to paint a picture of the resident and her needs relating to the triggered area when completing the CAA. When asked about the reasons for the antianxiety and antidepressant medications, a description as to why she needed the medications and how the medications affected her, the MDS nurse stated that information was often in the behavior, mood or psychosocial CAAs. She also stated the resident's behaviors were monitored on the Medication Administration Records. She further stated that Resdient #72 was a long term care

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F 272	Continued From page 5 resident and stable on the medications. MDS nurse stated that she needed to be more descriptive relating to the reasons she took the medications, their effectiveness and any needed changes or monitoring.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		6/9/16

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F 278	Continued From page 6 by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set for behaviors for 1 of 17 sampled residents (Resident #56). The findings included: Resident #56 was admitted on 11/11/15 with diagnoses including anxiety disorder, aphasia, and depression. Review of nurse's progress notes revealed on 11/11/15 at 7:00 PM Resident #56 was observed trying to leave the facility through an exit door. The nurse placed a wander alert bracelet on Resident #56's ankle to alert staff if she attempted to exit the facility again. On 11/15/15 at 2:30 PM a nurse documented that Resident #56 had removed her pad alarm from the seat of her wheelchair, shut the door, and was ambulating in her room. Resident #56 was confused and agitated and had put on her night gown. The nurse attempted to reorient and Resident #56 and offered several diversional activities without success. Resident #56 poured thickened liquids on her table top and asked for her bathrobe. Resident #56 was assisted with changing her clothes and the pad alarm was placed on the seat of her wheelchair. On 11/15/15 at 4:08 PM the nurse observed an increase in agitation and anxiety and noted Resident #56 had attempted to fall out of her wheelchair several times. The nurse notified the Nurse Practitioner and received orders for an antianxiety medication. Review of a progress note written by the Social Worker (SW) on 11/17/15 revealed Resident #56	F 278	F278 For Resident #56, the admission Minimum Data Set (MDS) dated 11/18/15 will be modified to accurately code the behaviors documented in the resident's medical record within the 7 day look back period. For all residents with the potential to be affected, an audit will be completed for 100% of all residents to verify that behaviors were accurately coded on the MDS assessment. Assessments will be modified as needed. For the systemic change, education will be provided to the Interdisciplinary Care Plan Team by the Director of Nursing/ RN Consultant regarding the assessment process and coding the MDS accurately. An audit tool will be utilized to complete audits of MDS assessments to verify that behaviors are coded accurately. 20% of all resident assessments will be audited weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring. All audit information will be analyzed and reviewed by the Director of Nursing at the QA Committee meetings.	

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was referred to geriatric neuropsychiatry services for an evaluation due to anxiety.

Review of the admission Minimum Data Set (MDS) dated 11/18/15 revealed Resident #56 had severely impaired cognition. The "Behavior" section of the admission MDS stated there were no behavioral symptoms or wandering noted during the 7-day look back period.

An interview was conducted with the SW on 05/12/16 at 11:11 AM. During the interview the SW stated she was responsible for completing several sections of the MDS assessments including Section E regarding Behavior. The SW indicated she typically reviewed the progress notes for behaviors when completing the MDS assessment and would code Section E accordingly. The SW stated she had been out sick on November 2015 and asked to check her notes to see if she had completed the assessment for Resident #56's admission MDS dated 11/18/15.

During a follow up interview on 05/12/16 at 11:34 AM the SW confirmed she had completed Resident #56's assessment for the admission MDS dated 11/18/15 and stated the MDS should have been coded to reflect the behavioral symptoms and wandering. The SW further stated she was not sure how she had made this coding error.