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 ______	06/15/2017

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 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and properly store personal hygiene products and personal care equipment in 3 shared bathrooms on 1 of 3 halls. The findings included: 1. a. Observations of the shared bathroom for room 514 on 06/12/17 at 11:44 AM revealed an unlabeled roll on deodorant on top of the toilet tank cover and an unlabeled bottle of lotion and hair pick on the sink counter. Subsequent observations of the shared bathroom for room 514 on 06/13/17 at 10:07 AM and 06/14 17 at 4:00 PM revealed an unlabeled roll on deodorant, bottle of lotion and hair pick on the sink counter. An interview with the Director of Nursing (DON) 06/14/17 at 4:39 PM during observations of the shared bathroom for room 514 revealed she expected personal hygiene products to be labeled with the resident's name or stored in their personal cabinet in the bathroom. b. Observations of the shared bathroom for room 515 on 06/13/17 at 10:16 AM and 06/14/17 at 4:00 PM revealed an unlabeled emesis basin on the sink counter which contained three uncovered toothbrushes, a tube of toothpaste and two disposable razors which were also not labeled	F 253	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. F253 For residents residing in rooms 514, 515, and 516, the personal hygiene products and personal care equipment were properly labeled and stored in their personal cabinets on 6/14/17. For all residents, all shared resident bathrooms were reviewed for the proper labeling and storage of personal hygiene products and personal care equipment on 6/15/17. There were no other personal items without proper labeling and storage. All staff will be educated by the Staff Development Coordinator/ RN Designee regarding the proper labeling and storage of personal hygiene products and personal care equipment in shared resident bathrooms. An audit tool was developed to monitor resident shared bathrooms for proper labeling and storage of personal hygiene products and personal care equipment. The Personal Items audit tool includes observations that personal hygiene items	7/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/07/2017

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.

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 ______	06/15/2017

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 253	Continued From page 1 with a resident's name. Further observations revealed an unlabeled tooth brush holder, denture cup, shaving cream, and plastic bottle of mouthwash on the sink counter. An unlabeled wash basin was observed on the floor under the sink which contained an emesis basin and a tooth brush holder that were labeled but not for either resident residing in the room at the time of the survey. In addition, an unlabeled tube of toothpaste and bottle of mouthwash were observed in the wash basin. An interview with the Director of Nursing (DON) 06/14/17 at 4:33 PM during observations of the shared bathroom for room 515 revealed personal hygiene products and personal care equipment should not be stored on the floor. The DON stated she expected personal hygiene products and personal care equipment to be labeled with the resident's name or stored in their personal cabinet in the bathroom. c. Observations of the shared bathroom for room 516 on 06/12/17 at 11:55 AM, 06/13/17 at 1:19 PM and 06/14/17 at 4:00 PM revealed a cup with two tubes of toothpaste, two denture cups, two liquid hand soap containers, one bottle of hand sanitizer, and a plastic cylinder which contained three tooth brushes, three tubes of toothpaste, a bar of soap, and a hair brush. All of the items were unlabeled and stored on the sink counter. In addition, there was an unlabeled wash basin stored on the bathroom floor. An interview with the Director of Nursing (DON) 06/14/17 at 4:34 PM during observations of the shared bathroom for room 516 revealed personal hygiene products and personal care equipment should not be stored on the floor. The DON	F 253	are labeled, personal items are stored in the resident's personal cabinet in the bathroom, and that personal care equipment is not stored on the floor. Audits will be completed by the Nursing Supervisor/ Staff Development Coordinator weekly for all shared resident bathrooms for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting.	

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 ______	06/15/2017

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 253	Continued From page 2 stated she expected personal hygiene products and personal care equipment to be labeled with the resident's name or stored in their personal cabinet in the bathroom.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		7/13/17

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 ______	06/15/2017

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 278	Continued From page 3 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the admission Minimum Data Set for range of motion (Resident #15) and Level II Preadmission Screening and Resident Review (PASRR) (Resident #27) for 2 of 14 sampled residents. The findings included: 1. Resident #15 was readmitted to the facility on 12/07/16 with diagnoses of arthritis and osteoporosis. Review of the admission Minimum Data Set (MDS) dated 12/14/16 revealed Resident #15 had no functional limitation in range of motion (ROM). Review of the medical record revealed a history and physical clinical note dated 12/08/16 indicated Resident #15 had decreased ROM of shoulders, limited ROM in wrists, and had finger deformities. An occupational therapy note dated 12/08/16 indicated Resident #15 had contractures of bilateral upper extremities, and his upper extremity ROM was limited to 75 percent in all planes passively. During an interview on 6/13/17 at 2:33 PM, the MDS nurse stated Resident #15 required extensive assistance with eating on readmit and had arthritic changes in his hands. The MDS nurse also stated that Resident #15 therapy notes and history and physical note on 12/08/17	F 278	F278 For Resident #15, the admission Minimum Data Set (MDS) dated 12/14/16 was modified on 6/13/17 to reflect upper extremity impairment on both sides for G0400 Functional limitation in range of motion. For Resident #27, the admissions MDS dated 5/10/17 was modified on 6/14/17 to reflect that the resident was a recipient of a Level II Preadmission Screening and Resident Review (PASARR). For all residents, an audit will be completed by the MDS Coordinator for 100% of all residents to verify that functional limitations in range of motion and PASARRs are accurately coded on the MDS assessment. The MDS Accuracy audit tool includes observing for functional limitations in range of motion in the upper and lower extremities, proper coding of any limitations in range of motion, and proper coding of the PASARR. Assessments will be modified as needed. Education will be provided to the Interdisciplinary Care Plan Team to include MDS Coordinators, Social Services, Activity Director, Dietary Manager, and Therapy Manager by the Director of Nursing (DON)/ RN Consultant regarding the assessment process and coding the MDS accurately. Education will be provided to the Business Office Manager and Admissions Director by the	

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 ______	06/15/2017

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 278	Continued From page 4 indicated he had decreased ROM in his upper extremities. The MDS nurse went on to say the admission MDS dated 12/14/16 was coded inaccurately. She indicated the MDS should have been coded for decreased ROM in both upper extremities. On 6/13/17 at 2:57 PM, the Administrator stated her expectations would be for the MDS for Resident #15 to be coded accurately for ROM. On 6/14/17 at 2:55 PM, the Therapy Manager stated Resident #15 had decreased ROM in his upper body when evaluated by therapy on 12/08/16. The Therapy Manager also indicated by his observations, Resident #15 had decreased ROM in his shoulders and upper body and required assistance with his activities of daily living (ADL). 2. Resident #27 was admitted to the facility on 05/03/17 with diagnoses including unspecified anxiety disorders. Review of Resident #27's admission Minimum Data Set (MDS) dated 05/10/17 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) to have a serious mental illness and/or another intellectual disability. The results of this screening and review are used in formulating a determination of need, determination of an appropriate care setting and formulating a set of determinations of services to help develop an individual's plan of care. During the survey on 06/12/17 the facility provided a list of residents who were considered to be Level II recipients. Resident #27 was on the	F 278	DON/ RN Consultant regarding communication to the MDS Coordinators of all residents that receive a Level II PASARR. An audit tool was developed to monitor MDS assessments for proper coding for functional limitations in range of motion and PASARRs. The MDS Accuracy audit tool includes observing for functional limitations in range of motion in the upper and lower extremities, proper coding of any limitations in range of motion, and proper coding of the PASARR. Audits will be completed by the Director of Nursing/ RN Consultant weekly for 20% of all resident assessments for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting.	

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 ______	06/15/2017

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 278	Continued From page 5 list determined to be a recipient. Interview with the Minimum Data Set Coordinator (MDSC) on 06/14/17 at 2:45 PM revealed she had completed MDS assessments for a total of about three years. The MDSC stated the Business Office Manager (BOM) or the Admissions Coordinator (AC) would typically inform her when a resident was admitted with a Level II PASRR, then she would code it on the MDS. The MDSC looked up the information on Resident #27 then stated she did not code it correctly. The MDSC then went to the BOM and asked her to clarify the Level II PASRR status on Resident #27. The BOM stated that Resident #27 was a Level II recipient but that she had neglected to inform the MDSC of it. Interview with the Administrator on 06/15/17 at 2:15 PM revealed both the BOM and the AC partnered in requesting the PASRR number for the residents and was unclear where the breakdown in communication happened, but if Resident #27 was considered a Level II PASRR then the MDS should have been coded to reflect that.	F 278		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to remove facial hairs and provide nail care for 1 of	F 312	F312 Resident #151 was shaved and received nail care including trimming and cleaning	7/13/17

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 ______	06/15/2017

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 312	Continued From page 6 1 dependent resident reviewed for activities of daily living (Resident #151). The findings included: Review of the medical record revealed Resident #151 was admitted on 04/04/17 with diagnoses including heart failure and chronic obstructive pulmonary disease (COPD). Review of the admission Minimum Data Set (MDS) dated 04/11/17 revealed Resident #151 had moderately impaired cognition and was able to make his needs known. The admission MDS also noted Resident #151 required extensive assistance with personal hygiene and bathing. Rejection of care was not noted as a behavior. Review of the Care Area Assessment (CAA) Summary for activities of daily living (ADL) dated 04/17/17 revealed Resident #151 was a new admission following a hospital stay for acute respiratory failure, pneumonia, and COPD. The CAA Summary noted Resident #151 had periods of weakness, shortness of breath, fatigued easily and required staff assistance with ADL care needs. The CAA Summary indicated Resident #151 would benefit from staff assistance as indicated to preserve his oxygen reserve. Review of a care plan for cognitive loss and dementia dated 04/20/17 revealed Resident #151 had impaired cognition, ADL function, and mobility which placed him at risk for further decline in cognitive status with unmet needs of daily living. The goal was for Resident #151 to maintain his current level of cognitive function and maximize ability to make his needs known with no unmet needs of daily living. Interventions	F 312	fingernails on 6/15/17. For all residents with potential to be affected, all residents were observed for proper nail care and shaving on 6/15/17. There were no other residents requiring shaving or nail care. All staff will be educated by the Staff Development Coordinator/ RN Designee regarding providing ADL care for dependent residents to include the policies for shaving the resident and care of fingernails/ toenails. An audit tool was developed to monitor that residents are provided with the proper ADL care to include shaving and nail care. The Grooming and Hygiene audit tool includes observing that the resident has been shaved as necessary, the resident is well groomed, the resident's nails are clean and trimmed, and any refusals are documented by the nurse. Audits will be completed by the Nursing Supervisor/ Staff Development Coordinator weekly for 20% of all residents for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting.	

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 ______	06/15/2017

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 312	Continued From page 7	F 312		

included: provide a calm therapeutic environment and instruct staff to follow the same structured routine when possible daily during care and explain all procedures and treatments to the resident and allow time to process and respond to the information, and monitor for changes or decline in cognitive status.

Review of the shower schedule in the nurse aide (NA) notebook revealed Resident #151 was scheduled for showers on Tuesday, Thursday, and Sunday.

During an interview on 06/13/17 at 9:13 AM Resident #151 stated he had showered last night but could not recall if he requested or was offered a shave or nail care. Observations during the interview revealed Resident #151 had approximately 5 days of facial hair growth and all ten fingernails extended well past his fingertips. Brown debris was observed under all ten fingernails.

Observations of Resident #151 on 06/14/17 at 4:25 PM revealed he had approximately 5 days of facial hair growth and all ten fingernails extended well past his fingertips. Brown debris was observed under all ten fingernails.

An interview with NA #1 on 06/15/17 at 10:44 AM revealed she had assisted Resident #151 with a shower on 06/14/17 during the 7:00 AM to 3:00 PM shift and stated he did not look like he needed to be shaved and she did not offer to shave him. NA #1 further stated she did not notice the condition of his fingernails on 06/14/17 and indicated she cleaned and trimmed residents' fingernails if she noticed and had time. NA #1 further explained the NAs on the weekends

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 ______	06/15/2017

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 312	Continued From page 8 usually did nail care because they had more time. A follow up interview with Resident #151 on 06/15/17 at 10:50 AM revealed he was assisted with a shower on 06/14/17 and could not recall if he requested or was offered a shave and nail care by the NA. Observations during the interview revealed he had not been shaved all ten fingernails extended well past his fingertips. Brown debris was observed under all ten fingernails. Resident #151 observed his fingernails during the interview and stated it would probably be good for his fingernails to be trimmed and cleaned. An interview with the Director of Nursing (DON) on 06/15/17 at 11:01 AM revealed she expected residents' fingernails to be cleaned and trimmed with showers and as needed. The DON indicated residents were typically shaved on shower days but expected them to be shaved according to their preference. The DON was accompanied to Resident #151's room at the completion of the interview at 11:09 AM and observed his fingernails. The DON stated the condition of his fingernails was not acceptable and confirmed they needed to be cleaned and trimmed. NA #1 was in the process of shaving Resident #151 at the time of the observation.	F 312		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 356		7/13/17

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 ______	06/15/2017

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 356	Continued From page 9 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse	F 356		

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 ______	06/15/2017

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 356	Continued From page 10 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post the nurse staffing hours for two days, out of the four day survey and failed to complete the nurse staffing hours at the beginning of each shift for two days, out of the four day survey. The findings included: The annual recertification for the facility began on 06/12/17 and ended on 06/15/17. Observations on 06/13/17 (Tuesday) at 4:01 PM noted the posted nurse staffing hours were dated for Sunday June 11, 2017 and read as follows: Sunday 06/11/17 Census 48 7 AM-7 PM RN-1 and 12 hours LPN-3 and 36 hours NA-4 and 48 hours 7 PM-7 AM LPN-3 and 36 hours NA-3 and 36 hours Observation of posted nurse staffing hours on 06/13/17 at 5:30 PM revealed the same as noted above. Observation of posted nurse staffing hours on 06/15/17 at 8:05 AM revealed nurse staffing hours for 06/14/17 posted for the day, evening and night shifts. Interview with the Administrator and the Director	F 356	F356 The nurse staffing information was posted on 6/14/17. The nurse staffing information form is maintained by the Director of Nursing (DON) for a minimum of 18 months. The system will change for the nurse staffing information form to be posted at the central nurses station with the nurses completing the form. Education will be provided to all nurses by the Staff Development Coordinator/ RN regarding posting the nurse staffing information on a daily basis at the beginning of each shift. An audit tool was developed to monitor posting nurse staffing information to include that the nurse staffing information was completed on a daily basis at the beginning of each shift and turned in to the Director of Nursing (DON). Audits will be completed for each day during the week by the DON weekly for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting.	

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 ______	06/15/2017

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 356	Continued From page 11 of Nursing (DON) on 06/15/17 at 3:36 PM revealed the DON stated the Ward Clerk (WC), who was currently on vacation, was responsible for posting the nurse staffing hours but when she was not there it was her responsibility to post it. The DON continued to explain that the staffing forms were completed in the mornings and for all three 8 hour shifts or two 12 hour shifts at one time for the entire 24 hours. The DON stated she understood the facility was required to post the staffing at the beginning of each shift and they would need to change their process. The DON also explained the reason the nurse staffing hours were not posted on 06/12/17 and 06/13/17 was because she forgot to post them. The Administrator then stated she expected the nurse staffing hours to be posted according to the regulations.	F 356		
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to provide nectar thick liquids per a physician's order for 1 of 1 resident reviewed for therapeutic diet (Resident #78).	F 367	F367 For Resident #78, the thin liquids were removed from resident's room and the resident's administration notes were updated on 6/12/17. NA#2 was educated	7/13/17

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 ______	06/15/2017

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 367	Continued From page 12 The findings included: Review of the medical record revealed Resident #78 was admitted on 05/27/13 with diagnoses including cerebral vascular accident (CVA) and abnormal posture. Review of a Care Area Assessment (CAA) Summary for Nutritional Status dated 12/29/16 revealed Resident #78 had a history of diabetes mellitus (DM) and dysphagia and was ordered a mechanical soft diet with consistent carbohydrate diet restrictions due to these diagnoses. Review of a Speech/Language Pathology Certification form dated 06/07/17 revealed Resident #78 was referred to the Speech Therapist (ST) due to the nurse and Resident #78 reporting coughing with thin fluids. The same certification form indicated Resident #78 stated she did not feel safe drinking regular thin liquids. Her past medical history included pneumonia, aphasia, dysphagia, and hemiplegia affecting the non-dominant side. The ST noted Resident #78 exhibited moderate oropharyngeal dysphagia and skilled Speech Therapy intervention was needed to determine the least restrictive diet in order to maintain hydration/nutrition and prevent the risk of aspiration with oral intake. The ST indicated Resident #78's diet was changed to nectar thick liquids and the ST would provide intervention over the course of 30 days. Review of the medical record revealed a Physician's order dated 06/07/17 for a mechanical soft diet with nectar thick liquids. Review of a facility document titled "Standards of Care Meeting 06/09/17" revealed Resident #78	F 367	regarding thick liquids and a sign was placed in the resident's room on 6/13/17. The communication was already provided in the Resident Profile. For all residents with physicians orders for thickened liquids, the administration notes in the Medication Administration Record (MAR) and resident profiles were reviewed and updated if necessary and the proper signage in the resident room was reviewed and posted if necessary on 6/13/17. There were no necessary changes to be made. Education will be provided to all nursing staff by the Staff Development Coordinator/ RN regarding the rationale for thickened liquids, the importance of following the physician order, and the process for providing and receiving communication regarding physician orders for thickened liquids. An audit tool was developed to monitor that proper communication is provided to staff and staff are adhering to the physician orders for thickened liquids. The Thickened Liquid audit tool includes observing that the administration notes reflect the physician order, that the proper signage is in place for communication in the resident room, that there are no thin liquids on the resident's side of the room, and that the nursing staff only gives the resident the proper thickened liquids for hydration and medication passes. The audit tool will be completed by the Nursing Supervisor/ Staff Development Coordinator for all residents with physician orders for thickened liquids weekly for 8 weeks, then monthly for 4 months. The	

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 ______	06/15/2017

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 367	Continued From page 13 was on a list of residents with orders for nectar thickened liquids. Observations on 06/12/17 at 11:31 AM and 06/12/17 at 3:31 PM revealed Resident #78 had a clear plastic cup with regular thin water and a large insulated cup with regular thin water on the bedside table. The shared counter space across from the foot of Resident #78's bed had a soft cooler with several containers of nectar thick liquids inside. There was no signage posted in the room to indicate a resident was ordered thickened liquids. Observations on 06/12/17 at 3:36 PM revealed Nurse Aide (NA) #2 knocked on Resident #78's door, greeted her, and took the large insulated cup off her bedside table to the hydration in cart in the hall. NA #2 was observed putting fresh ice and water in the insulated cup and returning it to Resident #78's bedside table. An interview with NA #2 on 06/12/17 at 3:41 PM revealed this was her assigned hall and she passed ice and water at the beginning of her shift. NA #2 stated there was a list of residents with orders for thickened liquids in the NA assignment book at the nurse's station and the residents' had a cooler with thickened liquids in their room. Observations of Nurse #2 on 06/12/17 at 3:53 PM revealed she crushed Resident #78's medication, placed it in a medicine cup, and added apple sauce. Nurse #2 then filled a clear plastic cup with thin water from the pitcher on the medication cart and placed a straw in the cup. Nurse #2 proceeded into Resident #78's room and administered the medication followed by two drinks of thin water through the straw and placed	F 367	need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting.	

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 ______	06/15/2017

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 367	Continued From page 14 the cup with the remaining water on the bedside table. Resident #78 did not cough or choke on the thin water. An interview was conducted with Nurse #2 when she exited Resident #78's room on 06/12/17 at 4:00 PM. Nurse #2 stated Resident #78 used to have nectar thick liquids ordered but thought this had changed recently. Nurse #2 pulled up Resident #78's electronic Medication Administration Record (MAR) and observed the administration notes on the top left of the MAR indicated crushed medications in apple sauce with thin liquids. During an interview on 06/12/17 at 4:05 PM Nurse #1 confirmed she was working on 06/07/17 and received the order from the ST for Resident #78's diet order to be changed to nectar thick liquids. Nurse #1 indicated Resident #78 should not be getting thin liquids. Nurse #1 stated she entered the order in the computer which also communicated this information directly to the NA's electronic documentation system. Nurse #1 indicated the nurses were notified of orders for thickened liquids on the residents' administration notes on the MARs. Nurse #1 reviewed Resident #78's MAR and confirmed the administration notes on the top left of the MAR indicated crushed medications in apple sauce with thin liquids. Nurse #1 further stated she did not know the order for nectar liquids on 06/07/17 was not communicated to the administration notes on Resident #78's MAR when she entered the order and she would need to find out how to update the administration notes. The interview further revealed there should be a picture in Resident #78's room to indicate thickened liquids but Nurse #1 could not recall if anyone put the signage in	F 367		

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 ______	06/15/2017

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 367	Continued From page 15	F 367		

the room on 06/07/17.

A follow up interview with NA #2 on 06/12/17 at 4:11 PM revealed she meant to say she typically reviewed the resident profile in the NA's electronic documentation system for orders for thickened liquids and not the NA assignment book. NA #2 accessed Resident #78's profile during the interview and nectar liquids were indicated. NA #2 stated a family member had told her last week they were getting the order changed back to thin liquids but she was aware of the order for nectar liquids and should not have given Resident #78 thin water at her bedside.

An interview with the ST on 06/13/17 at 10:28 AM revealed once he made the recommendation for nectar liquids on 06/07/17 Resident #78 should not have consumed thin liquids and they should not be in her room. The ST indicated Resident #78 was a special case as she had asked to see him herself due to difficulty swallowing. The ST further stated the only time Resident #78 should have thin liquids was when he was working with her due to the risk of possible aspiration.

An interview was conducted with the Director of Nursing (DON) on 06/14/17 at 9:34 AM. The DON stated once the nurse entered an order for thickened liquids it was automatically communicated to the resident's profile in the NA's electronic documentation system. The DON noted the order for thickened liquids was not automatically communicated to the administration notes on the resident's MAR when the order was entered and she would expect the nurse taking off the order to change this information on the MAR as well. The interview further revealed the nurse or the ST could put the card indicating

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 ______	06/15/2017

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 367	Continued From page 16 thickened liquids on the resident's bulletin board but there would be no way to know who put the sign in the room unless they communicated this to each other. The DON further stated the staff should not have given Resident #78 thin liquids and expected them to follow the Physician's order. During a follow up interview on 06/14/17 at 9:53 AM the DON shared the facility document titled "Standards of Care Meeting 06/09/17" and stated the information sheet was updated weekly after the meeting and included information including residents' with orders for thickened liquids. The DON explained a copy of the document was placed in the front of the NA assignment book and she expected the NAs to review the sheet daily.	F 367		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance	F 520		7/13/17

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 ______	06/15/2017

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 520	Continued From page 17 committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification survey of 05/12/16. This was for one deficiency that was originally cited in May of 2016 and was subsequently recited on the current recertification survey of 06/15/17. The repeated deficiency was in the area of assessment accuracy. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program.	F 520	F520 For Resident #15, the admission Minimum Data Set (MDS) dated 12/14/16 was modified on 6/13/17 to reflect upper extremity impairment on both sides for G0400 Functional limitation in range of motion. For Resident #27, the admissions MDS dated 5/10/17 was modified on 6/14/17 to reflect that the resident was a recipient of a Level II Preadmission Screening and Resident Review (PASARR). Education will be provided to the facility Quality Assurance & Performance Improvement (QAPI) committee members	

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 ______	06/15/2017

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 520	Continued From page 18 The findings included: This tag is cross referenced to: F 278: Assessment Accuracy: Based on record review and staff interviews the facility failed to accurately code the admission Minimum Data Set for range of motion (Resident #15) and Level II Preadmission Screening and Resident Review (PASRR) (Resident #27) for 2 of 14 sampled residents. During the recertification survey of 05/12/16 the facility was cited at F 278 for failing to accurately code the Minimum Data Set for behaviors for 1 of 17 sampled residents. An interview with the Administrator on 06/15/17 at 4:34 PM revealed the facility audited MDS assessments for accuracy for the time period designated in their plan of correction and did not have any inaccuracies so they had discontinued the monitoring.	F 520	to include the Medical Director, Staff Development Coordinator, Treatment Nurse, Therapy Manager, and Dietary Manager by the Administrator and Director of Nursing (DON) regarding the QAPI committee and program. The education includes the objectives of the QAPI program including to identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan as needed, the purpose of the QAPI program to provide a means for resident care and safety issues to be resolved, and how the committee monitors issues and follows up with unresolved issues that have been identified. The QA policy was reviewed by the Administrator. The policy states that the facility shall develop, implement, and maintain an ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care, and to resolves identified problems. No changes to the policy were necessary. An audit tool was developed to monitor the QA committee and its functions. The QA Self Evaluation tool includes if the committee has a current plan in place, if the committee identifies who is responsible to oversee the plan, if the plan is working, if it is not working have changes been put in place to improve, if the outcome is measurable, if the project has been successful, and if the plan can be considered resolved. The audit tool will be completed by the sub-committee to include the DON, Staff	

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 ______	06/15/2017

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 520	Continued From page 19	F 520	Development Coordinator, and Therapy Manager twice a month for 6 months. Ongoing use of the Self- Evaluation tool will be determined based on the results of the audits for the prior 6 months. The results of the QA Self- Evaluation tool will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting and changes or recommendations will be discussed as necessary.	