STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING ______ B. WING ______	C 05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-OUTER BANKS	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the MDS (Minimum Data Set) for discharge on 1 of 3 discharged residents (Resident #78), failed to accurately code for behaviors for 1 of 1 residents reviewed for behaviors (Resident # 55), and failed to accurately code the use of an alarm for 1 of 3 residents reviewed for accidents (Resident # 55). Findings included: 1. Resident #78 was admitted on 3/6/18 with diagnoses that included: cerebral infarction (stroke), hypertension, hyperlipidemia, and muscle weakness. Resident #78's Discharge MDS (Minimum Data Set) was dated 3/23/18. The assessment indicated Resident #78 had been discharged to an acute hospital. Review of a progress note dated 3/23/18 revealed in part: "resident discharged home with meds with roommate. All discharge instructions explained. Follow up appointments noted." An interview was conducted with the MDS Coordinator on 5/3/18 at 8:45 AM. She stated that she coded the assessment based upon the information on the electronic census which indicated that the resident was discharged to an acute care hospital. She indicated that the MDS was accurate based upon this information. The MDS Coordinator stated she was unsure why a progress note would indicate the resident discharged home.	F 641	F641 Residents #78 and #55 did not experience any adverse effect related to coding inaccuracy. For resident #78, the MDS dated 3/23/18 was modified by the MDS nurse on 5/1/2018 to reflect the appropriate discharge code. For resident #55, the MDS dated 4/21/18 was modified by the MDS nurse on 5/1/2018 to reflect the appropriate codes for behaviors and alarms. The MDS coordinator audited all discharge MDS assessments of residents discharged from the facility during the past 30 days on 5/17/2018 to ensure coding accuracy. There were no additional modifications required on these MDS assessments. MDS coordinator audited 100% of all MDS assessments for residents with documented behaviors and wanderguard bracelets on 5/2/2018 to ensure coding accuracy. There were no additional modifications required on these MDS assessments. Root cause analysis: it was determined that coding inaccuracy on discharge MDS assessment was caused by MDS nurse not accurately reviewing medical record to determine discharge status. It was also determined that the inaccuracies on MDS coding on behaviors and alarms was caused by	5/21/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/18/2018

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 641	Continued From page 1	F 641		

F 641 — Summary Statement of Deficiencies (continued)

An interview was conducted with the DON on 5/3/18 at 9:15 AM. She stated she was familiar with Resident #78 and she discharged home. The DON stated that the information on the electronic census was incorrect. She further stated that the assessment was coded incorrectly. She indicated it was her expectation that assessments were coded appropriately based upon a resident's plan of care and progress notes.

2.a. Resident #55 was admitted on 3/23/17. Her diagnoses include: dementia, diabetes mellitus, hypertension and hyperlipidemia.

Review of a progress note dated 3/29/18 revealed in part: "resident really upset-hollering, cussing, increased confusion and demanding to call son". The note indicated while staff speaking with son Resident # 55 physically took phone from writer.

Resident #55's most recent MDS (Minimum Data Set), dated 4/2/18 was coded as an annual assessment. The assessment indicated that Resident #55 had no behaviors such as screaming or disruptive sounds.

An interview was conducted with the MDS Coordinator on 5/2/18 at 2:01 PM. She indicated that behaviors should have been coded on the assessment. The MDS Coordinator further indicated she would correct the assessment.

An interview was conducted with the Director of Nursing on 5/2/18 at 2:15 PM. She stated that it was her expectation that assessments would be coded correctly.

F 641 — Provider's Plan of Correction (continued)

MDS nurse not accurately reviewing the entire medical record to determine resident□s behaviors and use of wanderguard bracelet.

MDS Nurse Consultant and Administrator provided education to IDT (Interdisciplinary Team) on the importance of accurately coding the MDS assessment and comprehensively assessing in order to develop and implement a comprehensive care plan on 5/2/2018.

A monitoring tool was developed to monitor MDS assessments for proper coding for sections A, P and E. MDS coordinator or designee will utilize monitoring tool and will audit 10% of MDS assessments for coding accuracy for discharges, behaviors and alarms weekly x 4 weeks, then monthly x 3 months. The results of these audits will determine the need for further monitoring.

Audit results will be brought to QAPI meeting by the MDS nurses monthly x 4 months and will be reviewed and analyzed by the QAPI team.

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F 641	Continued From page 2	F 641		

An interview was conducted with the Administrator on 5/2/18 at 2:19PM who stated that it was her expectation that corrections were made immediately once an error was discovered.

2.b. Resident #55 was admitted on 3/23/17. Her diagnoses include: dementia, diabetes mellitus, hypertension and hyperlipidemia.

Review of a physician's order dated 3/29/18 revealed Resident #55's elopement alarm was to be checked every shift.

Review of Resident #55's care plan dated 4/1/17 indicated Resident # 55 was to wear an electronic device that monitors movement and alerts staff when movement is detected.

Resident #55's most recent MDS (Minimum Data Set), dated 4/2/18 was coded as an annual assessment. The assessment indicated Resident #55 did not utilize any type of alarm to monitor her movement.

An interview was conducted with the MDS Coordinator on 5/2/18 at 2:01 PM. She stated that she did not believe that the alarm needed to be coded as it was not a restraint. After review of the assessment form the MDS Coordinator stated the alarm should have been coded on the assessment.

An interview was conducted with the Director of Nursing on 5/2/18 at 2:15 PM. She stated that it was her expectation that assessments would be coded correctly.

An interview was conducted with the

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F 641	Continued From page 3 Administrator on 5/2/18 at 2:19PM who stated that it was her expectation that corrections were made immediately once an error was discovered.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow physician orders for a peripherally inserted central catheter (PICC) line flush administration for 1 of 1 residents reviewed (Resident #71). Findings included: Resident #71 had been admitted on 11/15/13. Her diagnoses included sepsis, muscle weakness, major depressive disorder, anxiety, migraine, peptic ulcer disease, systemic lupus erythematous and hypertension. A care plan dated 12/28/17 indicated "resident has a PICC line. Goal: resident PICC line will be maintained without complications. Interventions included: administer medications and fluids per PICC per physician orders. Flush PICC per physician order." Resident #71's most recent quarterly assessment	F 684	F684 Resident #71 continues to reside at facility with no adverse effects. DON reviewed current residents in facility with an IV/PICC line to ensure that correct orders are in place for flushing procedure. All PICC line flushing orders were in place and correctly written. DON completed random audits on flushing procedure with nursing staff and no concerns were identified. DON educated Nurse #3 on proper procedure for following physician orders and PICC line flushing technique using the SASH method on 5/1/2018. Nurse #3 was able to return demonstrate the proper technique for flushing PICC line using SASH method. DON or designee will educate all licensed nurses on following	5/21/18

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F 684 Continued From page 4

dated 4/08/18 indicated she was alert and oriented. She did not walk, was independent with eating and required extensive to total assistance with all other activities of daily living (ADLs). She received anticoagulant, antibiotic and intravenous medications.

1. A physician order was dated 4/24/18 for meropenem (an antibiotic) 1 gram intravenous, three times a day.
2. A physician order was dated 4/25/18 for normal saline flush (sodium chloride 0.9%); amount 10 milliliters (ml). Special instructions: flush both lumens of PICC line with 10 ml normal saline (NS) followed by 5 ml heparin three times a day.
3. A physician order was dated 4/25/18 for heparin (an anticoagulant) flush-10; 10 units/ml; amount: 5 ml intravenous. Special instructions: flush both lumens of PICC line with 10 ml NS followed by 5 ml heparin three times a day.

The PICC line facility policy dated 3/2017 indicated if a resident were receiving intermittent medications, they should receive the SASH (saline-administer infusion, saline, heparin) method: S- 10 ml of NS, A-administer medication, S-10 ml of NS, H- 5ml of Heparin 10 unit/ml.

The May 2018 medication administration record was reviewed and indicated 1. meropenem 1 gram intravenous, three times a day scheduled for 8 AM, 2 PM and 9 PM. 2. Normal saline flush 10 ml was scheduled for 8 AM, 2 PM and 10 PM. 3. Heparin 5 ml flush was scheduled for 8 AM, 2 PM and 10 PM.

An observation of Nurse #3 was conducted on 5/01/18 at 4:11 PM. The nurse was observed to remove the antibiotic ball pump from Resident

F 684

physician orders and proper SASH flushing procedure for IV/PICC lines by 5/21/2018. DON reviewed IV flushing competencies for all licensed nurses and all licensed nurses had completed PICC line flushing competencies. PICC line flushing competency will be completed on all new hires during orientation and then annually. IV class was conducted on 5/17/18 by Pharmacy Nurses Consultant to review proper PICC line flushing technique with licensed nurses. Root cause analysis: Nurse #3 did not follow proper technique for flushing of IV/PICC.

A monitoring tool was developed to complete an observation for flushing technique procedure for nurses who have residents requiring IV/PICC line therapy. DON or designee will utilize monitoring tool to audit 5 licensed nurses on all shifts flushing technique of IV/PICC lines weekly for 4 weeks, then monthly x 3 months. The need for continued audits will be determined based on the results of the prior 4 months of audits.

The results of the audits will be brought to the monthly QAPI meeting by the DON. Results will be reviewed by the QAPI committee to ensure continued compliance.

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F 684	Continued From page 5 #71's PICC line. She then flushed the PICC line with 10 ml of normal saline. An interview with Nurse # 3 was conducted on 5/01/18 at 4:15 PM. The nurse stated the SASH method was used when flushing the PICC line. She stated SASH stood for saline-antibiotic-saline-heparin. She stated before administration of the antibiotic, the PICC line was flushed with 10 ml of normal saline (NS) and 5 ml of heparin. The nurse stated heparin had been administered to keep the PICC line from clotting, open and patent. The antibiotic was then started. When the antibiotic was completed, the line was then flushed with 10 ml of NS to clear the line and to make sure the end of the antibiotic had been received. The nurse then stated this method did not really follow SASH because the heparin was administered before the antibiotic. On 5/01/18 at 4:33 PM an interview with the Director of Nurses (DON) was conducted. The DON stated Resident #71 had heparin ordered after every dose of antibiotic. The nurse should flush with saline, administer the medication, flush with saline and flush with heparin to keep the line patent. The DON stated she would expect the nurse to understand and use the SASH method to flush PICC lines when ordered.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		5/21/18

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F 689	Continued From page 6 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review the facility failed to provide the assistance of two staff while providing incontinent care which resulted in a fall without injury for 1 of 3 residents reviewed for accidents (Resident #278). Findings included: Resident #278 was admitted to the facility on 5/28/17. Her active diagnoses included adult failure to thrive, muscle weakness, chronic kidney disease, urinary tract infection, heart failure, osteoarthritis, and type 2 diabetes mellitus, weakness, dementia, and Alzheimer's disease. Review of Resident #278's quarterly Minimum Data Set (MDS) assessment dated 1/21/18 revealed Resident #278 was assessed as severely cognitively impaired. Resident #278 had no behaviors and required extensive assistance by two staff members for bed mobility. Resident #278 was always incontinent of bowel and bladder. Review of Resident #278's care guide dated 1/30/18 revealed the resident was care planned as at risk for falls and required two staff members to assist with bathing and dressing. Review of Resident #278's progress note dated 4/1/18 at 8:15 AM revealed Resident #278's nurse called the resident's Responsible Party (RP) to let him know that his mother fell. She further documented that she informed him	F 689	F689 Resident #278 was discharged from facility on 4/9/2018. At time of fall resident received a skin tear to left elbow. On 5/17/18, MDS coordinator completed 100% in house audit of CNA care plans (resident profiles). All CNA care plans (resident profiles) that need 2+ assistance with bed mobility have been added. No other residents were adversely affected by CNA not following CNA care plans. DON educated CNA #1 regarding reviewing CNA care plan (resident profile) prior to ADL care on 5/2/2018. DON or designee will educate all nursing staff to follow CNA care plan (resident profile) when providing care for a resident. Licensed nursing staff will be educated to update CNA care plan with any changes in ADL assistance required. All education will be completed by 5/21/18 by the DON/designee. CNA care plans are reviewed by MDS Coordinator at admission and then quarterly by Interdisciplinary team to ensure accuracy. Root cause analysis: CNA #1 not following CNA care plan (resident profile). A monitoring tool was developed to monitor nursing staff to ensure that they are following the CNA care plan (resident profile) during ADL care. DON/designee will utilize monitoring tool to randomly	

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F 689	Continued From page 7 Resident #278 had a skin tear to her left lateral elbow and Resident #278 stated she did not hurt anywhere. Review of an incident reported dated 4/12/18 revealed Resident #278 had sustained a witnessed fall on 4/1/18. Nurse Aide #1 was documented to have been providing incontinence care and the resident rolled out of bed and fell to the floor. No major injuries were noted. Resident #278 did sustain a bruise to her left arm. The intervention was to replace Resident #278's bed with a geriatric bed. During an interview on 5/2/18 at 3:07 PM Nurse #1 stated Resident #278 had been assessed for the use of side rails prior to her fall and they had been removed. She stated because of this, Resident #278 required two person assistance with bed mobility. She further stated this was on the resident's care guide. The nurse stated if the resident needed to be turned to one side for wound care or incontinent care, two staff members needed to be present. During an interview on 5/2/18 at 3:27 PM Nurse #2 stated Resident #278 was able to move in bed because when she provided wound care, Resident #278 could turn and hold the side rails when the side rails were on the bed. She further stated when the new federal regulations came out and side rails were assessed by the facility, Resident #278's side rails were removed for safety concerns because of her ability to move in bed and impaired cognition. The nurse stated because of this there were always two staff members present to provide wound care since she could move and fall out of bed.	F 689	audit ADL care on all 3 shifts to ensure that nursing staff is following CNA care plan. Audits will be conducted on 10 residents weekly x 4 weeks, then monthly x 3 months. The results of these audits will determine the need for further monitoring. Audit results will be brought to QAPI meeting by the DON monthly x 4 months and will be reviewed and analyzed by the QAPI team.	

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During an interview on 5/3/18 at 8:03 AM Nurse Aide #1 stated she was in the middle of doing incontinence care for Resident #278 when the fall occurred. She stated she was standing beside the bed on Resident #278's left side and turned Resident #278 to face the right side. She stated she was cleaning Resident #278 up and when she turned and reached to get more wipes, Resident #278 slipped out of her hand and fell off the bed on the right side of the bed. She further stated she was by herself when the fall occurred while she provided incontinence care. She stated she did not get another staff member because she did not believe she was coded as a needing two person assistance for bed mobility at that time. She stated that she would use the care guide to know how many staff members needed to be present and she did not remember if she consulted the care guide prior to providing care that day.

During an interview on 5/3/18 at 8:53 AM the Director of Nursing stated that it was her expectation the plan of care be followed and it was not. She stated Resident #278's plan of care, which was made available to nurse aides, was to have two staff members present for care and it was not done.