STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

(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 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to have a medical symptom that warrant the use of a physical restraint for 1 of 1 sampled resident reviewed for restraints. (Resident #16). Findings included:	F 604	Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to	8/10/18

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

Electronically Signed | 08/06/2018

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F 604	Continued From page 1 Resident #16 was originally admitted on 10/20/15. She was discharged to the hospital on 4/19/18 and was readmitted on 4/24/18 with multiple diagnoses including Alzheimer's disease and cervical fracture (2013). The significant change in status Minimum Data Set (MDS) assessment dated 5/4/18 indicated that Resident #16 had severe cognitive impairment and she was not using any physical restraints. Resident #16's physician's orders were reviewed. On 12/19/17 and 5/23/18, there was an order for activity tray to broda chair, check resident every 30 minutes and release every 2 hours for repositioning. The diagnosis for the use of the activity tray was dementia with behavioral disturbances. Resident #16's care plan dated 5/25/18 was reviewed. One of the care plan problems was physical restraint - activity tray in place to broda chair while out of bed secondary to dementia with behavioral disturbance. The goal was "the activity tray will be used when resident is in broda chair and resident will remain free from injury". The approaches included to assure the medical record contained documentation of the medical condition justifying the use of restraint, explain how the restraint would treat the medical symptoms and maintain resident's highest level of function and to complete a restraint assessment before applying the restraint and quarterly thereafter as long as restraint was used. On 7/23/18 at 2:08 PM, Resident #16 was observed up in a broda chair in the television (TV) room. There was a lap tray in front of her and the tray was attached to the broda chair. At 3:50 PM,	F 604	continue to provide high quality of care. F604: Root Cause Analysis: The facility failed to have an active medical symptom/diagnosis to warrant the use of a physical restraint. Resident had a history of a C2 cervical fracture, falls, dementia, and decreased safety awareness. After an evaluation by the consulting physician and the Interdisciplinary Team, it was determined that the restraint was no longer required. Facility staff and the Interdisciplinary Team did not adequately reevaluate the continued need for the restraint per facility policy. Resident did not have any adverse effects from this practice. Immediate Assessment and Plan: Resident # 16 was sent on a neurology appointment per Dr. Mitchell to ascertain whether there was still an active diagnosis that warranted the use of the lap tray on 8/2/2018. At the appointment Dr. Michael Fromke reviewed this resident's chart as well as spoke with POA daughter Lisa Ledford. It was determined that the resident did not have an active medical symptom that warranted the use of the lap tray. The current care plan and assessment for this resident post appointment is to remove lap tray. Orders obtained to continue use of soft collar at all times related to comfort. Rajan Mitchell, MD, the facility medical director agrees with current plan. Lap tray removed at this time. Long term assessment and Plan: The	

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F 604	Continued From page 2 she was observed up in a broda chair in her room with a lap tray in front of her and the tray was attached to the broda chair. On 7/24/18 at 1:15 PM and 3:10 PM and on 7/25/18 at 10:54 AM and 1:20 PM, Resident #16 was observed up in a broda chair with a lap tray in front of her. On 7/25/18 at 10:05 AM, Nurse Aide (NA) #1 was interviewed. She stated that she was assigned to Resident #16. NA #1 further stated that the lap tray was used when the resident was up in a broda chair. She revealed that the resident was unable to release the lap tray. On 7/25/18 at 10:15 AM, Nurse #1 was interviewed. She stated that she was assigned to Resident #16. She stated that she didn't know why the resident was using a lap tray. On 7/24/18 at 4:45 PM, MDS Nurse #1 was interviewed. She stated that Resident #16 had the lap tray for years and was discontinued when she was discharged to the hospital in April, 2018. She was readmitted in May 2018 and the lap tray was restarted sometime in May 2018 per family request and for safety reasons. The MDS Nurse further indicated that a restraint assessment should have been completed before the restraint (lap tray) was reapplied but it was not. On 7/26/18 at 8"125 AM, the Physician was interviewed. The Physician stated that the restraint (lap tray) was more of family driven, they requested it for the resident. On 7/25/18 at 11:18 AM, the Director of Nursing (DON) was interviewed. The DON stated that	F 604	facility will not use restraints without an active medical symptom. The facility will reevaluate the continued need for restraints based on an assessment, physician orders, and medical symptoms. No other residents in facility have restraints. Education: SDC will educate 100 % of Full Time (FT), Part Time(PT) and as needed (PRN) staff that provide patient care, to include licensed nurses and certified nursing assistants, about what is considered a restraint and that they are not allowed in the facility unless there is a medical diagnosis to warrant such restraint. Education also provided to licensed staff that along with an active diagnosis to warrant the use of restraint, a physician's order must be obtained as well as continued ongoing re-evaluation of the need for the restraint and documentation of the consent and assessment. This will be completed by Friday 08/10/2018. Any licensed staff member not present will be educated by SDC prior to returning to work or during orientation for new employees. The Director of Nursing will educate the Interdisciplinary team which includes the Administrator, Staff Development Coordinator (SDC), Minimum Data Set(MDS) nurses, Nurse Supervisor and the Social Worker regarding the restraint policy to include a review of all residents with restraints at the weekly clinical at risk meeting to ensure that all aspects of the restraint policy are in place. This will	

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F 604	Continued From page 3 Resident #16 was using the restraint (lap tray) due to high risk for falls, family request, and dementia and to aide in activity and nutrition. She also indicated that a restraint assessment should have been completed before applying the lap tray in May 2018. On 7/26/18 at 9:10 AM, the DON was again interviewed. She stated that she expected that the resident had a medical symptom for the use of a restraint.	F 604	include a restraint assessment and consent, an active medical symptom/diagnosis, a physician's order for the restraint, orders to release restraint and assess resident every 2 hours, and a care plan for the use of the restraint. MDS will reassess any person with a restraint quarterly to ensure there that all components of the restraint policy are followed. This education will be completed by 8-10-18. QAPI: An audit tool was developed, which included the following questions: Is there an order for the restraint? Is there an active medical symptom/diagnosis for the restraint? Is there consent for the restraint? Is there an evaluation of the need for the restraint? DON will complete audits on residents with restraints weekly x 8 weeks and quarterly for 4 months thereafter. The results of these audits will determine the need for further monitoring. The Director of Nursing will review the results at the monthly QAPI meeting for any necessary revisions to the plan of correction.	
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 code the Minimum Data Set	F 641	Filing the plan of correction does not constitute that the alleged deficiencies did	8/10/18

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F 641	Continued From page 4 (MDS) assessment accurately in the area of medications for 2 of 5 residents (Residents #14 and #60) reviewed for unnecessary medications. The findings included: 1. Resident #14 was admitted to the facility on 2/2/18 and most recently readmitted on 7/9/18 with diagnoses that included dementia with behavioral disturbance. The quarterly Minimum Data Set (MDS) assessment dated 5/3/18 indicated Resident #14 ' s cognition was moderately impaired. Section N, the Medication Section, indicated Resident #14 was administered antipsychotic medications on 7 of 7 days. The Antipsychotic Medication Review indicated Resident #14 had received routine antipsychotic medication and that a Gradual Dose Reduction (GDR) had not been attempted. Question N040D indicated the physician had not documented a GDR as clinically contraindicated for Resident #14. This section of the 5/3/18 MDS for Resident #14 was completed by MDS Nurse #2. A review of Resident #14 ' s Pharmacy Consultant recommendations indicated a recommendation was made for a GDR of Resident #14 ' s Risperdal (antipsychotic medication) on 4/2/18. The physician signed this form on 4/23/18 declining a GDR of Resident #14 ' s Risperdal with documentation of clinical contraindication. An interview was conducted with MDS Nurse #2 on 7/26/18 at 8:40 AM. The 5/3/18 MDS for Resident #14 that indicated the physician had not documented a GDR as clinically contraindicated was reviewed with MDS Nurse #2. The	F 641	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. F641 Root Cause Analysis. It was determined that the Minimum Data Set (MDS) Coordinators failed to review all documentation in the medical record regarding Gradual Dose Reductions (GDR). There are several documents in the medical record that address GDR. One of those documents is the psychiatrist notes. At the top of both resident notes there was a comment that GDR was not recommended on these residents, however, the psychiatrist actually did a GDR for both residents. It was determined that although the MDS Coordinators had conflicting information regarding GDR, they did not completely review the psychiatrists documentation or physician's orders GDR. Section N of the Minimum Data Sets (MDS) was coded inaccurately on Resident #14 MDS assessment dated 5-3-18 & Resident #60 MDS assessment date 3-26-18 and 6-26-18. All MDS assessments were modified and transmitted by the MDS Coordinator on 7-27-18. The resident's did not have any adverse effect from the coding inaccuracies. An audit was completed for coding accuracy of Section N by the MDS	

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F 641	Continued From page 5 Pharmacy Consultant ' s recommendation for a GDR of Resident #14 ' s Risperdal dated 4/2/18 and signed by the physician on 4/23/18 noting a decline of the GDR due to clinical contraindication was reviewed with MDS Nurse #2. MDS Nurse #2 revealed she had not reviewed the scanned pharmacy recommendations in the electronic medical record when she completed the Antipsychotic Medication Review on the MDS assessments. She stated she had coded the MDS incorrectly for Resident #14. She reported Resident #14 ' s 5/3/18 MDS should have been coded to indicate a GDR was documented as clinically contraindicated on 4/23/18. An interview was conducted with the Director of Nursing (DON) on 7/26/18 at 8:20 AM. The DON indicated she expected the MDS to be coded accurately. 2a. Resident #60 was admitted to the facility on 11/8/15 and most recently readmitted on 2/19/17 with diagnoses that included vascular dementia with behavioral disturbance. The quarterly Minimum Data Set (MDS) assessment dated 3/26/18 indicated Resident #60 ' s cognition was severely impaired. Section N, the Medication Section, indicated Resident #60 was administered antipsychotic medications on 7 of 7 days. The Antipsychotic Medication Review indicated Resident #60 had received routine antipsychotic medication. Question N0450B indicated a Gradual Dose Reduction (GDR) had not been attempted for Resident #60. This section of the 3/26/18 MDS for Resident #60 was completed by MDS Nurse #1. A review of the physician ' s orders and the	F 641	Coordinators for 100% of all MDS assessments transmitted for June and July of 2018. Section N was audited for coding accuracy by reviewing all physician's notes, physician's orders and psychiatrist notes. There were no additional coding inaccuracies identified. This was completed on 8-2-18. Education will be provided to the MDS Coordinators by 8-10-18 by the Regional MDS Consultant regarding the Resident Assessment Instrument (RAI) assessment process and the importance of coding the MDS accurately. MDS Coordinators were also educated by the Director of Nursing on the RAI Manual Rules of Coding Section N. In addition, MDS Coordinators completed a course on Health Care Academy on MDS assessments Section N on 8-2-18. An audit tool was developed to monitor MDS assessments for proper coding of section N on MDS assessment. Audits will be completed by the RN Supervisor/DON for 50% of all MDS assessments weekly for 4 weeks, then 20% monthly for 3 months. The results of these audits will determine the need for further monitoring. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting.	

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F 641	Continued From page 6	F 641		

Medication Administration Record (MAR) for March 2018 revealed a GDR of Resident #60 ' s Seroquel (antipsychotic medication) was attempted on 3/12/18. The Seroquel dosage was decreased from 50 milligrams (mg) twice daily to 25 mg twice daily.

An interview was conducted with MDS Nurse #1 on 7/26/18 at 8:52 AM. The 3/26/18 MDS for Resident #60 that indicated a GDR was not attempted was reviewed with MDS Nurse #1. The March 2018 physician ' s orders and MAR for Resident #60 that indicated a GDR was attempted for Resident #60 ' s Seroquel beginning on 3/12/18 were reviewed with MDS Nurse #1. MDS Nurse #1 revealed she had coded the MDS incorrectly. She stated that she reviewed physician ' s orders, MARs, physician progress notes, psychiatric progress notes, and pharmacy notes to code this section of the MDS. She reported she made an error and that the 3/26/18 MDS should have been coded to indicate a GDR was attempted for Resident #60 on 3/12/18.

An interview was conducted with the Director of Nursing (DON) on 7/26/18 at 8:20 AM. The DON indicated she expected the MDS to be coded accurately.

2b. Resident #60 was admitted to the facility on 11/8/15 and most recently readmitted on 2/19/17 with diagnoses that included vascular dementia with behavioral disturbance.

The quarterly Minimum Data Set (MDS) assessment dated 6/26/18 indicated Resident #60 ' s cognition was severely impaired. Section N, the Medication Section, indicated Resident #60

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F 641	Continued From page 7	F 641		

was administered antipsychotic medications on 7 of 7 days. The Antipsychotic Medication Review indicated Resident #60 had received routine antipsychotic medication. Question N0450B indicated a Gradual Dose Reduction (GDR) had not been attempted for Resident #60. This section of the 6/26/18 MDS for Resident #60 was completed by MDS Nurse #1.

A review of the physician ' s orders and the Medication Administration Record (MAR) for March 2018 revealed a GDR of Resident #60 ' s Seroquel (antipsychotic medication) was attempted on 3/12/18. The Seroquel dosage was decreased from 50 milligrams (mg) twice daily to 25 mg twice daily.

An interview was conducted with MDS Nurse #1 on 7/26/18 at 8:52 AM. The 6/26/18 MDS for Resident #60 that indicated a GDR was not attempted was reviewed with MDS Nurse #1. The March 2018 physician ' s orders and MAR for Resident #60 that indicated a GDR was attempted for Resident #60 ' s Seroquel beginning on 3/12/18 were reviewed with MDS Nurse #1. MDS Nurse #1 revealed she had coded the MDS incorrectly. She stated that she reviewed physician ' s orders, MARs, physician progress notes, psychiatric progress notes, and pharmacy notes to code this section of the MDS. She reported she made an error and that the 6/26/18 MDS should have been coded to indicate a GDR was attempted for Resident #60 on 3/12/18.

An interview was conducted with the Director of Nursing (DON) on 7/26/18 at 8:20 AM. The DON indicated she expected the MDS to be coded accurately.

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to review and revise a plan of care in the area of fall risk interventions for 1 of 4 residents reviewed for accidents (Resident #69). The findings included: Resident #69 was most recently readmitted to the facility on 6/6/18 with diagnoses that included	F 657	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law.	8/10/18

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F 657	Continued From page 9 dementia, epilepsy, osteoporosis, fracture of left lower leg, and fracture of right tibia (shinbone). The significant change Minimum Data Set (MDS) assessment dated 6/13/18 indicated Resident #69 had severe cognitive impairment. She required the extensive assistance of 2 or more staff with bed mobility, transfers, toileting, and personal hygiene. Resident #69 had impaired range of motion in both lower extremities. The plan of care for Resident #69 included the problem area of the risk for falls. This area was initiated on 6/30/15 and last revised on 7/24/18. The interventions included a fall mat initiated on 6/6/18 and last revised on 6/18/18. This plan of care also included the intervention of fall mat for standards of care required for Resident #69. This intervention was initiated on 6/6/18 and had not been revised. An observation was conducted of Resident #69 on 7/25/18 at 10:00 AM. Resident #69 was in bed and a fall mat was not in place. An observation was conducted of Resident #69 on 7/25/18 at 1:15 PM. Resident #69 was in bed and a fall mat was not in place. An interview was conducted with the Director of Nursing (DON) on 7/25/18 at 2:00 PM. She revealed the fall mat for Resident #69 was discontinued related to her immobility when she was readmitted on 6/6/18. She stated the care plan that included the intervention of a fall mat should have been revised. An interview was conducted with MDS Nurse #1 on 7/26/18 at 8:52 AM. The care plan that	F 657	F-657 Root cause analysis: The facility practice is to update and revise care plans timely with any changes in resident condition, interventions, and/or goals of care. In addition, the Interdisciplinary Team meets weekly to ensure that all care plans have been revised appropriately, and the MDS Coordinators also review all care plans quarterly to ensure that the care plans are current and reflect the actual condition of the resident. The facility failed to follow this process for review of care plans. Director of Nursing revised the care plans for resident # 69 on 7-25-18 to include discontinuation of landing strip. Resident #69 had no adverse effects from the facility's failure to revise/update care plans timely. The Director of Nursing (DON), RN Supervisor, Staff Development Coordinator (SDC) and Minimum Data Set (MDS) nurses reviewed 100% of all fall care plans on 7-31-18. It was found that there were 11 care plans that required revision. The DON, SDC, and MDS nurses revised all care plans at that time. The Staff Development Coordinator (SDC) to educate all interdisciplinary team (IDT) members that included DON, SDC, MDS nurses, Social Worker, Treatment nurse and Clinical Supervisor and all full time (FT), part time (PT) and as needed (PRN) licensed staff on how to review care plans for accuracy and to ensure that all fall care plans are updated timely by the RN by 8-10-18. Any staff not present	

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PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

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F 657	Continued From page 10 indicated Resident #69 had an intervention that included a fall mat was reviewed with MDS Nurse #1. She confirmed the DON ' s interview that the fall mat was discontinued related to Resident #69 ' s immobility when she was readmitted on 6/6/18. She stated the care plan that included the intervention of a fall mat should have been revised. A follow up interview was conducted with the DON on 7/26/18 at 9:04 AM. She stated her expectation was for care plans to be reviewed and revised to reflect the current status of the residents.	F 657	or new licensed staff will be educated prior to returning to the floor or during orientation by the Staff Development Coordinator. The Interdisciplinary team will be reviewing/revising all fall care plans daily at clinical meeting. The weekend RN Supervisor will be making updates to the fall care plan on Saturday and Sunday, if required. In addition, fall care plans will be reviewed weekly by the Director of Nursing at IDT Clinical at Risk Meeting to ensure care plans are appropriate and reflect the actual condition of the resident. Any necessary revisions will be made to the care plan by the RN/clinical team. MDS Coordinators will continue to review all care plans quarterly for accuracy. An audit tool was developed to monitor the effectiveness of the plan of correction. This audit includes the following questions: Does the resident have a fall care plan, Does the resident still need all interventions on the fall care plan and if no, was the fall care plan updated. The DON or SDC nurse will audit 25% of all fall care plans weekly for 4 weeks, then monthly for 3 months. The results of these audits will determine the need for further monitoring. The DON will bring results of the audits to the monthly Quality Assurance and Performance Improvement Committee (QAPI) meeting and the QAPI team will make recommendations based on the results of theses .	
F 757	Drug Regimen is Free from Unnecessary Drugs	F 757		8/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 757 SS=D	Continued From page 11 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview, the facility administered an antibiotic without the presence of an active infection and failed to discontinue the antibiotic as ordered for Resident #8. The facility also failed to monitor the Thyroid-Stimulating Hormone (TSH) level as ordered by the physician for Resident #18. This was for 2 of 5 residents reviewed. The findings included: 1. Resident #8 was admitted to the facility on 1/13/17 with diagnoses that included encounter	F 757	Filing the plan of correction does not constitute that the alleged deficiencies 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. F757 Root cause: An antibiotic order for Resident #8 was improperly transcribed into the electronic medication administration record by Nurse #2 and an	

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F 757	Continued From page 12	F 757		

for prophylactic measures. The quarterly Minimum Data Set (MDS) assessment dated 4/23/18 indicated Resident #8 ' s cognition was intact.

Discharge instructions dated 6/12/18 related to dental surgery for Resident #8 indicated an order for Clindamycin (antibiotic medication) 300 milligrams (mg) 4 times daily for 7 days (28 doses total).

A review of Resident #8 ' s June 2018 Medication Administration Record (MAR) indicated she received Clindamycin 300 mg related to a diagnosis of encounter for prophylactic (preventative) measures post dental procedure for a total of 36 doses from 6/12/18 through 6/21/18. This was 8 additional doses of the prophylactic antibiotic Clindamycin than that which was indicated on the dental surgery discharge instructions dated 6/12/18.

An interview was conducted with the Director of Nursing (DON) on 7/25/18 at 10:55 AM. The dental surgery discharge instructions for Resident #8 dated 6/12/18 that included an order for the prophylactic antibiotic Clindamycin 300 mg 4 times daily for 7 days (28 doses total) was reviewed with the DON. She confirmed the Clindamycin was prescribed as a prophylactic antibiotic related to Resident #8 ' s dental surgery. She stated Resident #8 had no active infection when the Clindamycin order was received and when the medication was administered. The order for the Clindamycin that was entered into the electronic medical record was reviewed with the DON. She stated the order was entered by Nurse #2 with a start date of 6/12/18 and an end date of 6/21/18. The June order for a TSH (thyroid stimulating hormone) level for resident #18 was not transcribed into the electronic medication administration record by Nurse #2. Nurse #2 failed to follow facility policy for physician order entry. The antibiotic medication had previously been discontinued and a TSH level was obtained immediately. No new orders received by physician. Neither resident had adverse effects from this practice.

The following Interventions were put in place for the residents that were affected by this deficiency.

1. Resident #8 antibiotic was discontinued on 6-21-18. Resident #8 was seen by her oral surgeon on 7-5-18 and by Physician Elder Care on 7-11-18. No adverse reactions noted in either consultation.

2. Resident #18 had a TSH stat lab ordered by Physician Elder Care on 7-25-18. The Medical Director reviewed the lab on 7-26-18 and no medication changes were needed. No adverse reactions were noted by the Medical Director.

3. Staff Development Coordinator (SDC) will educate Nurse #2 and all Full Time(FT), Part Time(PT) and as needed (PRN) licensed staff on how to properly transcribe physician orders into the electronic health record. The SDC will educate Nurse#2 and all FT, PT and PRN licensed staff on the use of antibiotics that have an adequate indication for use/active

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F 757	Continued From page 13 2018 MAR for Resident #8 that indicated she received 8 additional doses (36 doses total) of the prophylactic antibiotic Clindamycin was reviewed with the DON. The DON was unable to explain why Nurse #2 entered the order for a timeframe greater than 7 days as indicated on the discharge instructions dated 6/12/18. She confirmed Resident #8 had received 8 additional doses of the prophylactic Clindamycin than was indicated on the discharge instructions dated 6/12/18. An interview was conducted with Nurse #2 on 7/25/18 at 11:15 AM. The dental surgery discharge instructions for Resident #8 dated 6/12/18 that included an order for the prophylactic antibiotic Clindamycin 300 mg 4 times daily for 7 days (28 doses total) was reviewed with Nurse #2. The order for Clindamycin that was entered into the electronic medical record with a start date of 6/12/18 and an end date of 6/21/18 was reviewed with Nurse #2. The June 2018 MAR for Resident #8 that indicated she received 8 additional doses (36 doses total) of the prophylactic antibiotic Clindamycin was reviewed with Nurse #2. Nurse #2 revealed she had entered the order for Resident #8 ' s Clindamycin on 6/12/18. She was unable to explain why she had entered the order for a timeframe greater than 7 days. She indicated she normally would have entered the order for 28 doses rather than for a specific timeframe to allow the electronic medical record to discontinue the order when the specified doses were completed. Nurse #2 confirmed Resident #8 received 8 additional doses of the prophylactic antibiotic Clindamycin than was indicated on discharge instructions dated 6/12/18. She additionally stated she was aware the facility was not in the practice of using prophylactic antibiotics. Nurse #2 revealed she	F 757	diagnosis, to contact the Medical Director(MD) if a resident is on an antibiotic without an active diagnosis or an adequate indication for use and if one cannot be obtained, ask if the antibiotic can be discontinued (DC) . This will be completed by 8-10-18. Any licensed staff not present or any new staff will be educated prior to returning to work or during orientation by the SDC. To ensure that this deficiency did not affect other residents the following was completed. 1. The RN Supervisor audited 100% of all labs ordered for the past 90 days. All labs have been transcribed into the electronic medication administration record as ordered by the physician. This was completed on 8-3-18. 2. The Director of Nursing (DON) & RN Supervisor audited 100% of all current orders for antibiotics. The DON and RN Supervisor insured that all antibiotics had adequate indications for use, active diagnosis and that there were no prophylactic antibiotics in use in the facility. All antibiotic orders have been transcribed correctly into the electronic medication administration record and have adequate indication for use. This was completed on 8-3-18. To ensure that this deficiency does not reoccur the following auditing tools have been put in place.	

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F 757	Continued From page 14 needed to pay closer attention to antibiotics that were ordered without the presence of an active infection so she could discuss these orders with the new Infection Control Nurse and the DON. An interview was conducted with the physician on 7/26/18 at 8:32 AM. The dental surgery discharge instructions for Resident #8 dated 6/12/18 that included an order for the prophylactic antibiotic Clindamycin 300 mg 4 times daily for 7 days (28 doses total) was reviewed with the physician. The June 2018 MAR for Resident #8 that indicated she received 8 additional doses (36 doses total) of the prophylactic antibiotic Clindamycin was reviewed with the physician. He stated he believed the Clindamycin was prescribed as a prophylactic related to Resident #8 ' s dental surgery. The physician indicated he expected orders for antibiotics to have an adequate clinical indication for use, for physician orders to be entered into the electronic medical record as indicated by the prescribing physician, and for medications to be administered and discontinued as ordered. A follow up interview was conducted with the DON on 7/26/18 at 9:04 AM. She stated she expected medications to be administered and discontinued as ordered. She additionally stated she expected an active infection to be present prior to the administration of an antibiotic. 2. Resident #18 was admitted to the facility on 10/30/17 with multiple diagnoses including hypothyroidism. The quarterly Minimum Data Set (MDS) assessment dated 7/3/18 revealed that	F 757	1. An audit tool was developed to monitor physician's orders for labs. The audit tool consists of the following questions: does the resident have a physician's order to obtain a lab test? Has the physician order been transcribed correctly into the electronic medication administration record? was the lab test obtained according to the physicians' order? 2. The Director of Nursing/RN Supervisor and the weekend supervisor will audit 100% of all lab orders weekly for 4 weeks, then 50% monthly for 3 months. 3. An audit tool was developed to monitor antibiotic orders. The audit tool consists of the following questions: has the physicans order been transcribed correctly into the electronic medication administration record? Does the physician order for antibiotics have an appropriate medical diagnosis/adequate indication for use? If not, is there documentation explaining the continuation of the antibiotic? does the antibiotic order have a stop date? If not, is there documentation explaining the reason for the continuation of the antibiotic? 4. The Director of Nursing/RN Supervisor/designee, weekend supervisor or the Infection Control Nurse will audit 100% of all antibiotic orders weekly for 8 weeks and 50% monthly for 2 months. The results of these audits will determine the need for further monitoring.	

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F 757	Continued From page 15 Resident #18's cognition was intact. Resident #18's physician's orders were reviewed. She had an order for Synthroid (used to treat hypothyroidism) 112 microgram (mcg) by mouth daily for hypothyroidism. On 5/8/18, a thyroid stimulating hormone (TSH) level, a test used to evaluate thyroid function and symptoms of thyroid disorder, was drawn and the result was 39.51(normal value 0.45-5.33). On 5/9/18, the Physician had ordered to increase the Synthroid to 150 mcg from 112 mcg daily and to recheck the TSH level in 4 weeks. Resident #18's laboratory reports were reviewed on 7/25/18 and there was no TSH report found. On 7/25/18 at 2:52 PM, Nurse #2 was interviewed. She stated that she was the nurse who transcribed the order for Resident #18 on 5/9/18. She verified that she transcribed the order for the Synthroid but failed to transcribe the order for the TSH level. Nurse #2 indicated that she didn't remember exactly what happened but the order for the TSH level was not written in the laboratory (lab) book and therefore the sample was not drawn. On 7/26/18 at 8:30 AM, interview with the Physician was conducted. He stated that he expected the TSH level drawn as ordered. On 7/26/18 at 9:10 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurse who transcribed the order for the lab to write it in the lab book for the sample to	F 757	The DON will be responsible to bring results of audits to QAPI monthly. The QAPI team will make recommendation based on the results.	

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F 757	Continued From page 16 be drawn. She revealed that the order for the TSH level for Resident #18 was not written in the lab book and therefore it was not done.	F 757		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(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 review and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedure and to monitor these interventions that the committee put into place following the 7/20/17 recertification survey. This was for one recited deficiency (Minimum Data Set (MDS) accuracy) which was cited on 7/20/17 recertification survey and on the current recertification survey of 7/26/18. The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an	F 865	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F865 Root cause analysis: The Quality Assurance Performance Improvement	7/31/18

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F 865	Continued From page 17 effective QAA program. Findings included: This tag is cross referred to: F641 - Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications for 2 of 5 residents (Residents #14 and #60)) reviewed for unnecessary medications During the recertification survey of 7/20/17, the facility was cited F641 for failure to code the MDS assessments accurately in the areas of hospice and respite, behaviors, medications and Activities of daily Living (ADL). On 7/26/18 at 9:20 AM, the Administrator was interviewed regarding the facility's QAA program. The Administrator stated that the facility had a QAA program consisted of all the department heads including the Administrator, Director of Nursing and the Medical Director. He indicated that the committee had met monthly and quarterly. He revealed that the staff had been monitoring the MDS for accuracy but they were not concentrating in the section of antipsychotic gradual dose reduction. (GDR).	F 865	(QAPI) failed to identify a reoccurring issue in Minimum Data Set (MDS) accuracy. We have found that auditing small percentages of the whole MDS is not effective. Going forward we will focus our audits on the section N of the MDS in which seems to be the reoccurring problem. To correct this deficiency the following items were completed • The QAPI policy was reviewed by the Administrator by 7-31-18, the policy states 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 resolve identified problems. No changes to the policy were necessary. • Facility QAPI committee members were in-serviced by the Administrator and the Director of Nursing about the Quality Assurance Performance Improvement Committee, program and procedures on 7 -31-18. QAPI committee members include: Medical Director, Pharmacy Consultant, Administrator, Director of Nursing, Minimum Data Set (MDS) nurses, Admission Coordinator, Social Worker, Business Office Manager, Staff Development Coordinator, Nursing Supervisor, Medical Records Manager, Maintenance Director, Housekeeping Supervisor, Dietary Manager, Treatment Nurse and Activities Director.	

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F 865	Continued From page 18	F 865	• The in-service included: • Identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan, as necessary. • The Facility committee members will understand the purpose of the QA program i.e.: to provide a means for a resident(s) care and safety issues to be resolved. • Committee members will understand how the QAPI Committee monitors issues and follows up with unresolved issues that have been identified. • A tool was developed, titled, " Self-Evaluation". The tool included the following: o Does the QAPI committee have a current plan in place? o Does the committee identify who is responsible to oversee the plan/project? o Is the plan working? o If the plan is not working have changes been put in place to improve? o Is the outcome measurable? o Has the project been successful? o Can the plan be considered resolved? • This tool was developed for a QAPI sub-committee to establish the successfulness of the QAPI projects and make recommendations as necessary. The sub-committee is made up of 3 members of the QAPI general Committee which will included the Director of Nursing, Staff Development Coordinator and the Administrator.	

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F 865	Continued From page 19	F 865	• This tool will be used to focus on the MDS inaccurate coding in section N of the MDS. • Our new QAPI projects will include MDS accuracy and how to reduce falls and falls with fracture. Monitoring: • The Self-Evaluation tool will be completed by the sub-committee at scheduled meetings twice monthly prior to the next scheduled QAPI monthly meeting for 6 months. • Findings of the sub-committee will be addressed at the monthly QAPI meeting when all participants attend. • The Self-Evaluation tool will be utilized for 6 months; ongoing use of the tool will be determined by the prior 6 months of self-Evaluating the QAPI process. QAPI The results of the self-evaluation tool will be brought to the QAPI meeting monthly by the Administrator and reviewed by the QAPI team. The QAPI Team will make changes if necessary.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 881		8/10/18

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F 881	Continued From page 20 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview, the facility failed to follow its Antibiotic Stewardship Program as evidenced by the administration of an antibiotic without the presence of an active infection and failed to discontinue the antibiotic as ordered for 1 of 5 residents (Resident #8) reviewed. The findings included: A review of the facility ' s Antibiotic Stewardship Program ' s policy, dated 11/28/17, indicated appropriate indications for use of antibiotics included: "a. Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending)." Resident #8 was admitted to the facility on 1/13/17 with diagnoses that included encounter for prophylactic measures. The quarterly Minimum Data Set (MDS) assessment dated 4/23/18 indicated Resident #8 ' s cognition was intact. Discharge instructions dated 6/12/18 related to dental surgery for Resident #8 indicated an order for Clindamycin (antibiotic medication) 300 milligrams (mg) 4 times daily for 7 days (28 doses total). A review of Resident #8 ' s June 2018 Medication Administration Record (MAR) indicated she	F 881	Filing the plan of correction does not constitute that the alleged deficiencies 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. F881 Root Cause: Resident #8 had several teeth extracted on 6-12-18. Her oral surgeon orders antibiotics for seven days following the teeth extraction. The order was incorrectly transcribed for a total of nine days. In addition, there was no diagnosis for the antibiotic. Facility staff did not contact the oral surgeon to explain Peak Resources Pinelake's antibiotic stewardship program, request for a current diagnosis for the antibiotic or request that the antibiotic to be discontinued . How we corrected the deficiency for Resident #8. 1. Resident #8 antibiotic was discontinued on 6-21-18. Resident #8 was seen by her oral surgeon on 7-5-18 and by PA (Physicians Assistant) from Physician Elder Care on 7-11-18. No adverse reactions noted in either consultation. How we are insuring that no other	

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F 881	Continued From page 21 received Clindamycin 300 mg related to a diagnosis of encounter for prophylactic (preventative) measures post dental procedure for a total of 36 doses from 6/12/18 through 6/21/18. This was 8 additional doses of the prophylactic antibiotic Clindamycin than that which was indicated on the dental surgery discharge instructions dated 6/12/18. An interview was conducted with the Director of Nursing (DON) on 7/25/18 at 10:55 AM. She indicated the facility recently had hired a new Infection Control Nurse/Staff Development Coordinator (ICN/SDC) within the last month and that she was responsible for the Antibiotic Stewardship Program (ASP) at the facility. She stated prior to this hiring she herself was responsible for the ASP and she continued to assist the new ICN/SDC while she was training. The dental surgery discharge instructions for Resident #8 dated 6/12/18 that included an order for the prophylactic antibiotic Clindamycin 300 mg 4 times daily for 7 days (28 doses total) was reviewed with the DON. She confirmed the Clindamycin was prescribed as a prophylactic antibiotic related to Resident #8 ' s dental surgery. She stated Resident #8 had no active infection when the Clindamycin order was received and when the medication was administered. The DON revealed this administration of the prophylactic antibiotic Clindamycin was not in accordance with the facility ' s ASP. This interview with the DON continued. The order for Resident #8 ' s Clindamycin that was entered into the electronic medical record was reviewed with the DON. She stated the order was entered by Nurse #2 with a start date of	F 881	residents were affected by this deficiency 1.The Director of Nursing (DON) and SDC performed a 100% audit of all antibiotic orders in the facility on 7-31-18. They asked the following questions for anyone that was on an antibiotic, was the order transcribed correctly, was there a diagnosis for the antibiotic, was there a stop date for the antibiotic. There were no additional antibiotics ordered inappropriately. 2.The SDC educated all Full Time (FT), Part Time (PT)and As Needed (PRN)licensed staff and facility practitioners on the Antibiotic Stewardship program by 8-10-18. Any staff not present or new FT, PT or PRN licensed staff and facility practitioners will be educated prior to returning to work or during orientation. This training will include the facility policy on Antibiotic Stewardship, indications for antibiotic use, judicious use of antibiotics and staff's responsibility in ensuring antibiotic stewardship program is followed. This training will be completed on 8-10-18 and ongoing with new staff. Education will be given annually to existing staff. How we are ensuring this this deficiency does not reoccur. 1.An audit was developed to monitor antibiotic use in the facility. The audit includes the following: is the order transcribed correctly; is there an appropriate diagnosis for the antibiotic; is	

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	345429	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 881	Continued From page 22 6/12/18 and an end date of 6/21/18. The June 2018 MAR for Resident #8 that indicated she received 8 additional doses (36 doses total) of the prophylactic antibiotic Clindamycin was reviewed with the DON. The DON was unable to explain why Nurse #2 entered the order for a timeframe greater than 7 days as indicated on the discharge instructions dated 6/12/18. She confirmed Resident #8 had received 8 additional doses of the prophylactic Clindamycin than was indicated on the discharge instructions dated 6/12/18. An interview was conducted with Nurse #2 on 7/25/18 at 11:15 AM. The dental surgery discharge instructions for Resident #8 dated 6/12/18 that included an order for the prophylactic antibiotic Clindamycin 300 mg 4 times daily for 7 days (28 doses total) was reviewed with Nurse #2. The order for Clindamycin that was entered into the electronic medical record with a start date of 6/12/18 and an end date of 6/21/18 was reviewed with Nurse #2. The June 2018 MAR for Resident #8 that indicated she received 8 additional doses (36 doses total) of the prophylactic antibiotic Clindamycin was reviewed with Nurse #2. Nurse #2 revealed she had entered the order for Resident #8 ' s Clindamycin on 6/12/18. She was unable to explain why she had entered the order for a timeframe greater than 7 days. She indicated she normally would have entered the order for 28 doses rather than for a specific timeframe to allow the electronic medical record to discontinue the order when the specified doses were completed. Nurse #2 confirmed Resident #8 received 8 additional doses of the prophylactic antibiotic Clindamycin than was indicated on discharge instructions dated 6/12/18. She additionally stated she was aware the facility was not in the practice of using	F 881	there a stop date for the antibiotic. The SDC and DON will be auditing a 100% of all new antibiotic orders weekly for 8 weeks and 50% of all new antibiotic orders monthly for 3 months. The results of these audits will determine the need for further monitoring. All results will be brought to QAPI by the DON. The QAPI team will review the results and determine if the POC is effective.	

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F 881	Continued From page 23	F 881		

prophylactic antibiotics. Nurse #2 revealed she needed to pay closer attention to antibiotics that were ordered without the presence of an active infection so she could discuss these orders with the new ICN/SDC, the DON, and the physician.

An interview was conducted with the physician on 7/26/18 at 8:32 AM. The dental surgery discharge instructions for Resident #8 dated 6/12/18 that included an order for the prophylactic antibiotic Clindamycin 300 mg 4 times daily for 7 days (28 doses total) was reviewed with the physician. The June 2018 MAR for Resident #8 that indicated she received 8 additional doses (36 doses total) of the prophylactic antibiotic Clindamycin was reviewed with the physician. He stated he believed the Clindamycin was prescribed as a prophylactic related to Resident #8 ' s dental surgery. The physician indicated he expected orders for antibiotics to have an adequate clinical indication for use as described in the Antibiotic Stewardship Program, for physician orders to be entered into the electronic medical record as indicated by the prescribing physician, and for medications to be administered and discontinued as ordered.

A follow up interview was conducted with the DON on 7/26/18 at 9:04 AM. She stated she expected medications to be administered and discontinued as ordered. She additionally stated she expected the facility ' s Antibiotic Stewardship Program to be followed and for antibiotics to be administered only when the criteria for an active infection was met.