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 _____	08/22/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 8/19/19 through 8/22/19. The facility was found in compliance with the requirement CFR 433.73, Emergency Preparedness. Event ID LD9R11	E 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to place a resident ' s call light (Resident #3) within reach to allow for the resident to request staff assistance if needed for 1 of 1 resident reviewed for accommodation of needs. The findings included: Resident #3 was admitted to the facility on 4/29/19 with diagnoses that included hemiparesis (weakness on one side of the body), chronic obstructive pulmonary disease, heart disease, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 8/5/19 indicated Resident #3 ' s cognition was moderately impaired. She had no behaviors and no rejection of care. She required the extensive assistance of 2 or more for bed mobility and was dependent on 2 or more for	F 558	Problem: Resident□s #3 call light was attached to her left side pillow in which resident was unable to reach call light. The Director of Nursing (DON) repositioned the call light to the center of the resident□s chest on top of sheet on 8-21-19 at 12pm. The DON, Registered Nursed (RN) supervisor and Staff Development Coordinator (SDC) performed a call light audit on 100% of residents on 8-21-19. This audit was to monitor if the resident was able to reach call bell. No other residents were found to be affected by this deficiency. The SDC educated 100% of all staff on ensuring that the resident is able to reach their call bells on 8-30-19. Any staff	8/30/19

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

Electronically Signed | 09/04/2019

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 _____	08/22/2019

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 558	Continued From page 1 transfers. She had functional limitations with range of motion on one side of her upper and lower extremities. Resident #3 was on oxygen therapy. Resident 3 ' s plan of care, last revised on 8/7/19, indicated she was at risk for falls. The interventions included placing her call light within reach at all times. An observation and interview was conducted with Resident #3 on 8/19/19 at 11:10 AM. Resident #3 was lying on her back in bed. Her call light cord was clipped to the left side of her pillow and the call light button was positioned underneath the pillow which was behind Resident #3 ' s head. Resident #3 reported she was dependent on staff for assistance with most tasks and that she pressed her call light when she needed assistance. She revealed that she had not known where her call light was currently positioned. Resident #3 was informed where her call light was positioned, and she demonstrated her inability to reach the call light. She indicated that if she was unable to reach her call light she would have to yell out to get someone to help her. Resident #3 stated that her call light was normally clipped onto her bed sheet/cover in the center of her chest, so she was able to reach it. An observation and interview were conducted of Resident #3 on 8/21/19 at 11:25 AM. She was observed in her room in bed. Resident #3 ' s call light cord was clipped to the left side of her pillow and the call light button was positioned underneath the pillow which was behind her head. She reported that she was unable to reach her call light to request assistance.	F 558	member on vacation, out on leave or on as needed (PRN) status will be educated prior to returning to their assignment. The RN supervisors and SDC will audit 50% of residents to ensure call bells are in reach of residents. This audit started on 8-26-19 and will be done daily for two weeks, weekly for one month and monthly for two months. All results will be brought to Quality Assurance Performance Improvement (QAPI) monthly by the SDC. All results will be reviewed by the QAPI team and the QAPI team will determine the need for further monitoring.	

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 _____	08/22/2019

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 558	Continued From page 2 An interview was conducted with NA #3 on 8/21/19 at 11:30 AM. He indicated that he was currently assigned to Resident #3. He reported that Resident #3 was able to use her call light to request staff assistance. NA #3 stated that Resident #3 ' s call light was supposed to clipped to her bed sheet around the center of her chest, so she was able to reach it. During this interview with NA #3 an observation was conducted of Resident #3 ' s call light positioning. NA #3 revealed that Resident #3 would not have been able to reach her call light in its current position (clipped to the left side of her pillow with the call light button beneath her pillow). He stated that he had not placed her call light in that position. NA #3 moved the call light and clipped it to Resident #3 ' s bed sheet in the center of her chest. A phone interview was attempted on 8/21/19 at 11:48 AM with the NA (NA #2) who was assigned to Resident #3 on 8/19/19 during the 1st shift. NA #2 was unable to be reached. An interview was conducted with the Director of Nursing (DON) on 8/22/19 at 11:30 AM regarding Resident #3 ' s call light not being placed within her reach. The DON indicated her expectations were for staff to place resident call lights within the residents ' reach at all times.	F 558		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		8/30/19

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 _____	08/22/2019

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 584	Continued From page 3 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to ensure a resident ' s wheelchair was clean, sanitary, and free of food debris (Resident #34)	F 584	Problem: Resident□s # 1 bathroom door was sticking to door frame. Resident□s #34 wheelchair had food particles on it.	

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 _____	08/22/2019

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 584	Continued From page 4 and also failed to ensure a resident ' s bathroom door was in proper working condition (Resident #1) for 2 of 2 residents reviewed for environmental concerns. The findings included: 1. Resident #34 was admitted to the facility on 11/16/14 with diagnoses that included traumatic brain injury and hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebrovascular disease. The quarterly Minimum Data Set (MDS) assessment dated 6/26/19 indicated Resident #34 ' s cognition was severely impaired. She required the limited assistance of 1 for eating, had impairment on one side of her upper and lower extremities, and utilized a wheelchair. An observation was conducted of Resident #34 on 8/19/19 at 11:15 AM. Resident #34 was seated in her wheelchair in a common area of the facility. Her wheelchair was observed with what appeared to be dried food debris in multiple areas of the wheelchair. An interview was conducted with Nursing Assistant (NA) #4 on 8/21/19 at 8:10 AM. She reported that Resident #34 ' s wheelchair tended to become dirty quickly. She explained that Resident #34 preferred to eat without assistance and that she regularly spilled and/or dropped food particles on herself and onto her wheelchair. NA #4 stated that she believed Resident #34 ' s wheelchair was cleaned once or twice a week. An observation was conducted of Resident #34	F 584	The Maintenance Director and the Administrator adjusted the door frame for Resident #1 bathroom door on 8-21-19. Door is in proper working order. The Administrator cleaned resident□s #34 wheelchair on 8-21-19. Wheelchair is cleaned and sanitized. The Maintenance Director audited 100% of resident doors on 8-22-19. One door was found to be sticking and that was fixed on 8-22-19. The Housekeeping Supervisor cleaned 100% of all wheelchairs on 8-23-19. One other wheelchair was found to be dirty with food particles. That wheelchair was cleaned on 8-23-19. The Staff Development Coordinator (SDC) educated 100% of all floor staff to ensure that any door that is malfunctioning should be reported to the Maintenance Director immediately and that any wheelchair that is not clean should be taken out of service and cleaned and sanitized. This was completed on 8-30-19. Any staff member on vacation, out on leave or PRN status will be educated prior to returning to their work assignment. The Maintenance Director will be auditing all doors in the facility weekly for four weeks and monthly for three months. This audit will ensure that doors are latching and not sticking to the door frame and are in good working order. The Housekeeping Supervisor has updated the wheelchair cleaning schedule to include a cleaning of 3x/week for	

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 _____	08/22/2019

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 584	Continued From page 5 on 8/21/19 at 8:15 AM. Resident #34 was seated in her wheelchair in the restorative dining area. She was eating independently with staff encouragement. Resident #34 had food debris on her clothing protector, clothing, and on multiple areas of her wheelchair. An interview was conducted with the Administrator on 8/21/19 at 9:00 AM. He revealed that he had observed Resident #34 ' s wheelchair and confirmed there was food debris in multiple areas on the wheelchair. He reported that at present, the wheelchair was cleaned twice per week. The Administrator stated he was going to increase the frequency of cleanings for Resident #34 ' s wheelchair. He indicated his expectation was for wheelchairs to be clean, sanitary, and free of food debris. #1.Failed to ensure Resident #34's wheelchair was in clean and sanitary condition for 2 of 2 residents evaluated for environment. #2 Failed to ensure bathroom door was in proper working order for 2 of 2 residents evaluated for environment FACILITY Environment Findings included: Resident #1 was admitted to the facility on 01/28/2019 with diagnoses that included cardiovascular accident (CVA), Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, essential hypertension, type two diabetes, and chronic kidney disease.	F 584	wheelchairs that are usually heavily soiled and monthly for all other wheelchairs. The Housekeeping Supervisor will be auditing 100% of wheelchairs weekly for four weeks and monthly for three months. This audit will ensure that wheelchairs are clean and sanitized. During the weekly audits if wheelchairs need to be cleaned more often, they will be placed on the 3x/week cleaning schedule. All results will be brought to Quality Assurance Performance Improvement (QAPI) monthly by the Maintenance Director and the Housekeeping supervisor. All results will be reviewed by the QAPI team and the QAPI team will determine the need for further monitoring.	

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 _____	08/22/2019

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 584	Continued From page 6	F 584		

Resident #1's most recent quarterly minimum data set (MDS) dated 5/7/2019 documented the resident was cognitively intact with a BIMS of 15. He was documented to have functional limitation of movement on one side and required limited assistance with toileting.

On 08/21/19 12:02 PM Surveyor observed bathroom door in room 102 did not open or close properly. The door would stick making it difficult to open if closed. For this reason, Resident #1 stated he would ask staff not to force the door closed or he could not open the door. The bathroom was shared with another resident in the next room. Resident #1 had right arm paralysis due to CVA. Resident #1 stated he had reported the issue with the door to the building maintenance supervisor on multiple occasions, but it had not been fixed. Resident #1 stated the door had been in poor working condition since his admission, seven months ago.

Interview with NA#7 on 08/21/19 01:55 PM she stated she regularly works the100 hall, was familiar with Resident #1, and she had not heard any complaints regarding the door to his bathroom. NA#7 further stated the door was always open when she went into the room to provide care.

On 08/21/19 at 02:21 PM In an interview with the maintenance supervisor, he stated he was not aware the door to the bathroom in 102 was not working properly. He further stated he would get the door fixed.

On 8/22/2019 at 11:22am, an interview with the facility administrator was conducted, he stated doors in resident's rooms should be working

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 _____	08/22/2019

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 584	Continued From page 7 properly.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		9/6/19

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 _____	08/22/2019

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 656	Continued From page 8 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to develop comprehensive, individualized, and person-centered care plans in the areas of tracheostomy (Resident #65) and tobacco use (Resident #26). The facility also failed to implement care plan interventions in the areas of oxygen therapy and the risk for falling (Resident #3). This was for 3 of 23 sampled residents. The findings included: 1. Resident #26 was admitted to the facility on 1/27/16 with diagnoses that included heart failure. The quarterly Minimum Data Set (MDS) assessment dated 6/11/19 indicated Resident #26 ' s cognition was severely impaired. Resident #26 ' s care plan, last revised 6/25/19, indicated the problem area of tobacco use. The long-term goal indicated Resident #26 would safely use chewing tobacco. The interventions included, "observe clothing/skin for any burns, holes ...". This intervention was created by MDS Nurse #2. An interview was conducted with MDS Nurse #2 on 8/21/19 at 11:20 AM. The care plan related to tobacco use for Resident #26 was reviewed with MDS Nurse #2. MDS Nurse #2 confirmed that	F 656	Problem: Resident□s #3 call light was attached to her left side pillow in which resident was unable to reach call light and her Oxygen was not on resident. Resident #26 tobacco care plan was addressing smoked tobacco and not smokeless tobacco. Resident #65 did not have a tracheostomy care plan. The floor nurse repositioned call light to the center of the resident□s chest on top of sheet and placed Oxygen back on resident on 8-21-19 at 12pm. Resident #26 care plan was updated on 8-21-19 to address chewing tobacco by the Minimum Data Set (MDS) Coordinator. The care plan for Resident #65 was revised to include tracheostomy care by the MDS Coordinator on 8-21-19. The regional care manager inserviced MDS nurse 1 and MDS nurse 2 that all residents should have a comprehensive and accurate careplans on 8-30-19. This careplans should include the needs of the resident. MDS nurse 1 will audit 100% of MDS nurse 2 care plans and MDS nurse 2 will audit 100% of MDS nurse 1 care plans on tracheostomy residents and residents that use tobacco to ensure they	

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 _____	08/22/2019

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 656	Continued From page 9 Resident #26 used chewing tobacco. She revealed that there was no risk for burns to Resident #26 or holes to her clothing from the use of chewing tobacco. She indicated that this was not an individualized and person-centered intervention for Resident #26. MDS Nurse #2 reported that the intervention of observing resident ' s clothing or belongings for stains caused by the chewing tobacco would have been a more individualized intervention. She stated that she was going to revise the care plan interventions. On 8/21/19 at 11:30 AM MDS Nurse #2 provided the revised care plan related to tobacco use for Resident #26. The interventions were revised to indicate the observation of clothing/skin/wheelchair for any stains. An interview was conducted with the Director of Nursing on 8/22/19 at 11:30 AM. She indicated she expected care plans to be individualized and person-centered. 2. Resident #3 was admitted to the facility on 4/29/19 with diagnoses that included hemiparesis (weakness on one side of the body), chronic obstructive pulmonary disease, heart disease, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 8/5/19 indicated Resident #3 ' s cognition was moderately impaired. She had no behaviors and no rejection of care. She required the extensive assistance of 2 or more for bed mobility and was dependent on 2 or more for transfers. She had functional limitations with range of motion on one side of her upper and	F 656	had a comprehensive and accurate care plan, which was completed on 9-6-19. No other residents were identified with this deficiency. The Staff Development Coordinator (SDC) nurse educated all floor staff on the importance of following the care plan for each resident on 8-30-19. Any staff member who is on vacation, out on leave or as needed (PRN) status will be educated upon return to their assignment. An audit tool was created to monitor the accuracy tobacco use and tracheostomy careplans and to monitor that careplan interventions are being followed. MDS nurse 1 will audit 25% of MDS nurse 2 careplans and MDS nurse 2 will audit 25% of MDS nurse 1 careplans, including tobacco use and tracheostomy to ensure that these careplans are comprehensive, accurate and person centered weekly x 4 weeks, then monthly x 3 months. The Registered Nurse (RN) supervisors and SDC will be auditing residents to ensure that careplan interventions are being followed with call bell & Oxygen audits. They will complete audits on 50% of residents daily for two weeks, weekly for one month and monthly for two months. The RN supervisors and SDC will be auditing 100% of all residents that have schedule oxygen orders to ensure that those residents have oxygen in place. This audit started on 8-26-19 and will be weekly for two weeks, then monthly for three months. All results will be brought to Quality	

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 _____	08/22/2019

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 656	Continued From page 10 lower extremities. Resident #3 was on oxygen therapy. 2a. Resident 3 ' s plan of care, last revised on 8/7/19, indicated she was at risk for falls. The interventions included placing her call light within reach at all times. An observation and interview were conducted with Resident #3 on 8/19/19 at 11:10 AM. Resident #3 was lying on her back in bed. Her call light cord was clipped to the left side of her pillow and the call light button was positioned underneath the pillow which was behind Resident #3 ' s head. Resident #3 indicated she was unable to reach her call light to request assistance in its current position. She stated that her call light was normally clipped onto her bed sheet/cover in the center of her chest, so she was able to reach it. An observation and interview were conducted with Resident #3 on 8/21/19 at 11:25 AM. She was observed in her room in bed. Resident #3 ' s call light cord was clipped to the left side of her pillow and the call light button was positioned underneath the pillow which was behind her head. She reported that she was unable to reach her call light to request assistance. An interview was conducted with NA #3 on 8/21/19 at 11:30 AM. He indicated that he was currently assigned to Resident #3. He reported that Resident #3 ' s call light was supposed to clipped to her bed sheet around the center of her chest, so she was able to reach it. During this interview with NA #3 an observation was conducted of Resident #3 ' s call light positioning. NA #3 revealed that Resident #3 would not have	F 656	Assurance Performance Improvement (QAPI) monthly by the SDC and MDS nurse 1&2. All results will be reviewed by the QAPI team and the QAPI team will determine if further monitoring is required.	

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 _____	08/22/2019

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 656	Continued From page 11	F 656		

been able to reach her call light in its current position (clipped to the left side of her pillow with the call light button beneath her pillow).

An interview was conducted with the Director of Nursing on 8/22/19 at 11:30 AM. She indicated she expected care plan interventions related to the risk for falls to be implemented and for call lights to be placed within reach of the residents at all times.

2b. Resident 3 ' s plan of care, last revised on 8/7/19, indicated she required oxygen (O2) therapy. The interventions included the administration of O2 at 5 liters per minute via nasal canula.

A review of Resident #3 ' s active physician ' s orders indicated O2 at 5 liters per minute continuously.

An observation and interview were conducted with Resident #3 on 8/19/19 at 11:10 AM. Resident #3 was lying on her back in bed. Her O2 via nasal canula was observed not to be in place. Resident #3 revealed that she required continuous O2 but that her Nursing Assistant (NA) had removed her O2 during morning care and she must have forgotten to put it back on her before she left the room. She was unable to recall the name of the NA who provided her with morning care. Resident #3 reported she was unable to reach her O2 tubing to put it on herself.

A phone interview was attempted on 8/21/19 at 11:48 AM with the NA (NA #2) who provided morning care to Resident #3 on 8/19/19 during

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 _____	08/22/2019

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 656	Continued From page 12	F 656		

the 1st shift. NA #2 was unable to be reached.

An interview was conducted with the Director of Nursing on 8/22/19 at 11:30 AM. She indicated she expected care plan interventions related to oxygen therapy to be implemented and for continuous O2 to be administered as ordered.

3. Resident # 65 was admitted to the facility on 4/16/19 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 7/24/19 indicated that Resident #65 had moderate cognitive impairment and she required tracheostomy care and suctioning.

Resident #65's care plan with the revised date of 8/4/19 was reviewed. There was no care plan developed for tracheostomy care.

On 8/20/19 at 4:05 PM, Resident #65 was observed in her room with a tracheostomy. When interviewed, Resident #65 stated that she was using a humidifier at night and she needed to be suctioned at times.

On 8/21/19 at 4:05 PM, MDS Nurse #2 was interviewed. She reported that residents with a tracheostomy should have a care plan developed. The MDS Nurse reviewed the resident's care plan and stated that she could not find a care plan for the tracheostomy care, she missed it.

On 8/22/19 at 11:30 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected a care plan developed for residents with tracheostomy.

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 _____	08/22/2019

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 657	Continued From page 13	F 657		
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 and staff interview, the facility failed to review and revise care plans in the area of psychotropic medications (Resident #36) for 1 of 5 residents reviewed for unnecessary medications. The findings included:	F 657	Problem: Resident #36 had a psychotropic medication that was discontinued and the care plan was not updated to reflect the discontinued psychotropic medication. Minimal Data Set (MDS) nurse 1	9/6/19

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 _____	08/22/2019

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 657	Continued From page 14 Resident #36 was admitted to the facility on 5/31/19 with diagnoses that included dementia. The admission Minimum Data Set (MDS) assessment dated 6/7/19 indicated Resident #36 ' s cognition was severely impaired. She was administered routine antipsychotic medication on 7 of 7 days. A physician ' s order for Resident #36 dated 6/28/19 indicated the discontinuation of routine Seroquel (antipsychotic medication) 50 milligrams (mg) at bed. A physician ' s order for Resident #36 dated 7/12/19 indicated the discontinuation of as needed (PRN) Ativan/Benadryl/Haldol (ABH) cream (topical cream made up of antianxiety, antihistamine, and antipsychotic medication). A review of Resident #36 ' s active physician ' s orders on 8/21/19 indicated she was not on any antianxiety or antipsychotic medications. Resident #36 ' s active care plan was reviewed on 8/21/19. The active care plan included, in part, the problem areas of the use of psychotropic medications related to antianxiety medication (last revised 7/10/19) and the use of psychotropic medications related to antipsychotic medication (last revised 7/8/19). An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 8/21/19 at 4:10 PM. The care plans for Resident #36 related to antianxiety medication and antipsychotic medication were reviewed with the MDS Nurses. The active physician ' s orders for Resident #36 that included	F 657	corrected the resident□s #36 care plan to reflect the discontinued psychotropic medication on 8-21-19. The regional care manager inserviced MDS nurse 1 and MDS nurse 2 that all residents care plans should be updated and accurate on 8-30-19. MDS nurse audited 100% of MDS nurse 2 careplans and MDS nurse 2 audited 100% of MDS nurse 1 careplans for all psychotropic medication to ensure they were accurate and up to date on 9-6-19. No other residents were found to be affected by this deficiency. MDS nurse will audit 25% of MDS nurse 2 careplans and MDS nurse 2 will audit 25% of MDS nurse 1 careplans on all psychotropic medication to ensure they are accurate and up to date weekly for four weeks and then monthly for three months. All results will be brought to Quality Assurance Performance Improvement (QAPI) monthly by the MDS nurse 1&2. All results will be reviewed by the QAPI team and the QAPI team will determine if further monitoring is required.	

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 _____	08/22/2019

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 657	Continued From page 15 no antianxiety or antipsychotic medications were reviewed with the MDS Nurses. The MDS Nurses indicated that about a month ago the facility changed its morning meeting agenda to include a review of all new/revised/discontinued orders. They indicated this change was made as they had identified that they were not being informed of all changes which caused some care plans not to be revised. They revealed this was an instance in which they had not been aware of the change. MDS Nurse #1 and MDS Nurse #2 reported that these medications were discontinued prior to the initiation of the new morning meeting process. They stated that moving forward, they believed this problem would be resolved as a result of the new process. Both MDS Nurses agreed that these care plans should have been revised for Resident #36 as she was no longer on any psychotropic medication. An interview was conducted with the Director of Nursing on 8/22/19 at 11:30 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the residents.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(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 record review, observation and staff and resident interview, the facility failed to provide nail care for 2 of 2 sampled residents reviewed for activity of daily living (ADL) (Residents #38 &	F 677	Problem: Resident's # 38 & #70 had dirty finger nails.	8/30/19

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 _____	08/22/2019

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 677	Continued From page 16 #70). Findings included: 1. Resident #38 was admitted to the facility on 3/8/16 with multiple diagnoses including vascular dementia. The quarterly Minimum Data Set (MDS) assessment dated 6/25/19 indicated that Resident #38 had moderate cognitive impairment and she needed extensive assistance with personal hygiene. The assessment further indicated that Resident #38 did not refuse care. Resident #38's care plan dated 7/8/19 was reviewed. One of the care plan problems was resident was at risk for poor hygiene due to hemiplegia. The goal was resident would maintain proper hygiene and the approaches included for the staff to provide extensive assistance with ADL. On 8/19/19 at 12:07 PM and on 8/20/19 at 2:50 PM, Resident #38 was observed in bed with long and dirty fingernails. The fingernails on both hands were observed to extend approximately 1/4-1/2 of an inch beyond the tip of the nail bed and the fingernails had debris caked under each nail. Resident #38 stated that she didn't remember the last time her fingernails were trimmed and cleaned. On 8/20/19 at 2:52 PM, the Clinical Coordinator was interviewed. She looked at Resident #38's fingernails and verified that the nails needed to be trimmed and cleaned. She stated that the Nurse Aides (NAs) were responsible for providing nail care to residents. At 2:55 PM, the Clinical Coordinator was observed trimming and cleaning the resident's fingernails.	F 677	The Director of Nursing (DON) & RN Supervisor cleaned resident #38 &#70 fingernails on 8-21-19. The RN supervisor and Staff Development Coordinator (SDC) performed a nail care audit of 100% of all residents in the facility on 8-21-19. This audit looked to see if nails were clean and well kept. No other residents were found to be affected by this deficiency. The SDC educated 100% of all floor staff on ensuring that residents fingernails were well kept and clean. Any staff member who is on vacation, out on leave or PRN status will be educated prior to returning to their assignment. The RN supervisors and SDC will audit 25% of all residents weekly x 4 weeks, then monthly x 3 months to ensure that their nails are well kept and clean. All results will be brought to Quality Assurance Performance Improvement (QAPI) monthly by the SDC. All results will be reviewed by the QAPI team and the QAPI team will determine if further monitoring is required.	

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 _____	08/22/2019

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 677	Continued From page 17	F 677		

On 8/20/19 at 2:58 PM, NA #5, assigned to Resident #38 was interviewed. The NA stated that the NAs were responsible for providing nail care to residents. She reported that she noticed Resident #38's fingernails to be long and dirty when she provided AM care, however, she did not trim/clean her nails at that time. The NA added that she planned to trim and to clean Resident #38's fingernails in the afternoon during her shower.

On 8/22/19 at 11:30 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the NAs to provide nail care to residents.

2. Resident #70 was admitted to the facility on 7/12/19 with diagnoses that included dementia.

The admission Minimum Data Set (MDS) assessment dated 7/19/19 indicated Resident #70 ' s cognition was severely impaired, and she required extensive assistance with personal hygiene.

Resident #70 ' s care plan, last revised on 7/24/19, included the problem area of the risk for poor hygiene due to impaired mobility. The goal was for Resident #70 to maintain proper hygiene and the interventions included staff to provide limited to extensive assistance with Activities of Daily Living (ADLs).

On 8/19/19 at 9:30 AM Resident #70 was observed seated in a common area of the facility. Her fingernails were observed to be varied in length up to approximately half an inch long. Multiple nails were jagged and appeared to have

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 _____	08/22/2019

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 677	Continued From page 18 a dark substance underneath them. On 8/20/19 at 2:20 PM Resident #70 was observed in bed. Her fingernails remained in the same condition as the observation on 8/19/19 at 9:30 AM. An interview was conducted with Nursing Assistant (NA) #6 on 8/20/19 at 2:26 PM. She reported that she was assigned to Resident #70 about 2 to 3 days per week during the 1st shift. She indicated that she currently was assigned to Resident #70 and that the resident was dependent on staff for personal hygiene care. NA #6 stated that the NAs were responsible for providing fingernail care to residents who needed assistance. She revealed that she had not recalled providing nail care to Resident #70. Resident #70 ' s fingernails were then observed by NA #6. She confirmed that Resident #70 ' s fingernails needed to be trimmed and cleaned. A second interview was conducted with NA #6 on 8/20/19 at 3:05 PM. NA #6 stated that she had completed fingernail care for Resident #70. She indicated that she trimmed the nails, smoothed out the edges, and cleaned out the area underneath the fingernails. She reported that Resident #70 had a couple of fingernails that were thick and were difficult to reduce the length, but that she smoothed out the edges of those fingernails and cleaned underneath them. An interview was conducted with the Director of Nursing on 8/22/19 at 11:30 AM. She indicated she expected the NAs to provide nail care to residents.	F 677		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		8/30/19

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 _____	08/22/2019

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 695 SS=D	Continued From page 19 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to administer continuous oxygen as ordered (Resident #3) for 1 of 2 residents reviewed for respiratory care. The findings included: Resident #3 was admitted to the facility on 4/29/19 with diagnoses that included hemiparesis (weakness on one side of the body), chronic obstructive pulmonary disease, heart disease, and anxiety. A physician ' s order dated 4/29/19 indicated oxygen (O2) at 5 liters per minute continuously. The quarterly Minimum Data Set (MDS) assessment dated 8/5/19 indicated Resident #3 ' s cognition was moderately impaired. She had no behaviors and no rejection of care. She required the extensive assistance of 2 or more for bed mobility and was dependent on 2 or more for transfers. She had functional limitations with range of motion on one side of her upper and lower extremities. Resident #3 was on O2	F 695	Problem: Resident's #3 oxygen was left off resident after resident had bath. The Floor Nurse placed Oxygen back on resident on 8-21-19. The Director Of Nursing (DON), RN supervisor and Staff Development nurse (SDC) performed an oxygen audit on 100% of residents which had schedule oxygen orders on 8-21-19. This audit was to monitor if the resident had an oxygen order and if the resident had the oxygen in place per care plan & doctor's order. No other residents were found to be affected by this deficiency. The Staff Development Coordinator (SDC) educated all floor staff on the importance of following the care plan & doctor's orders for each resident 8-30-19. This included residents that have scheduled and PRN orders for oxygen treatment. Any staff member on vacation, out on leave or on PRN status will be	

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 _____	08/22/2019

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 695	Continued From page 20 therapy. Resident 3 ' s plan of care, last revised on 8/7/19, indicated she required O2 therapy. The interventions included the administration of O2 at 5 liters per minute via nasal canula. An observation and interview were conducted with Resident #3 on 8/19/19 at 11:10 AM. Resident #3 was lying on her back in bed. Her O2 via nasal canula was observed not to be in place. Resident #3 revealed that she required continuous O2 but that her Nursing Assistant (NA) had removed her O2 during morning care and she must have forgotten to put it back on her before she left the room. She was unable to recall the name of the NA who provided her with morning care. She also was not able to recall how long the O2 had been off as she had just realized it was not on. Resident #3 reported she was unable to reach her O2 tubing to put it on herself. A phone interview was attempted on 8/21/19 at 11:48 AM with the NA (NA #2) who provided morning care to Resident #3 on 8/19/19 during the 1st shift. NA #2 was unable to be reached. An interview was conducted with the Director of Nursing (DON) on 8/22/19 at 11:30 AM regarding Resident #3 ' s continuous O2 not being administered as ordered due to the O2 being removed by her NA during morning care and not being put back on the resident when care was completed. The DON indicated her expectations was for continuous O2 to be administered as ordered.	F 695	educated upon return to their assignment. The RN supervisors and SDC will be auditing 100% of all residents that have schedule oxygen orders to ensure that those residents have oxygen in place. This audit started on 8-26-19 and will be weekly for two weeks, then monthly for three months. All results will be brought to Quality Assurance Performance Improvement (QAPI) monthly by the SDC . All results will be reviewed by the QAPI team and the QAPI team will determine if further monitoring is required.	

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 _____	08/22/2019

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 759	Continued From page 21	F 759		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain a medication error rate of 5% or less as evidenced by the 2 errors of 28 opportunities for error resulting in a 7.14 % error rate for 1 of 3 sampled residents observed during the medication pass (Resident #33). Findings included: 1 a. Resident # 33 was admitted to the facility on 10/30/17 with multiple diagnoses including hypertension. On 6/10/19, Resident #33 had a doctor's order for isosorbide mononitrate ER (extended release) 30 milligrams (mgs) 1 tablet by mouth daily for hypertension. On 8/21/19 at 8:10 AM, the Medication Aide (Med Aide) was observed during the medication pass. The Med Aide was observed to prepare and to administer Resident #33's medications including isosorbide mononitrate ER 30 mg- 1 tablet. The Med Aide was observed to crush all the medications in tablet form including the isosorbide mononitrate ER tablet and she administered the crushed medications to the resident with apple sauce. The pharmacy supply	F 759	Problem: Medication error rate was over 5% The Director Of Nursing (DON) completed an observation on resident #33 to ensure there were no adverse side effects to these medication errors on 8-21-19. No adverse effects were noted. The Staff Development Coordinator (SDC) educated 100% of licensed nursing staff and medication aides on medication administration policy on 8-30-19. The SDC, DON and RN supervisor performed medication administration audits on 100% of all licensed staff and medication aides. This was completed on 8-30-19. Any licensed nursing staff or medication aide on vacation, out on leave or PRN status will be educated and audited prior to returning to their assignment. There were no additional medication errors identified. The DON, RN supervisors and SDC will be auditing 20% of all licensed staff weekly for four weeks and monthly for three months to ensure medication administration compliance.	8/30/19

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 _____	08/22/2019

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 759	Continued From page 22 card for the Isosorbide mononitrate had a label "do not crush". On 8/21/19 at 9:05 AM, the Med Aide was interviewed. She verified that she had crushed the isosorbide mononitrate ER tablet. She reported that isosorbide ER should not be crushed, and she missed it. On 8/21/19 at 9:10 AM, the Staff Development Coordinator (SDC) was interviewed. She stated that the facility's policy included ER tablets on list of medications that should not be crushed. On 8/22/19 at 11:30 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nursing staff not to crush extended release tablets. 1 b. Resident # 33 was admitted to the facility on 10/30/17 with multiple diagnoses including hypertension. On 6/10/19, Resident #33 had a doctor's order for retaine eye drops - 2 drops to both eyes 4 times day for dry eyes. On 8/21/19 at 8:10 AM, the Medication Aide (Med Aide) was observed during the medication pass. The Med Aide was observed to prepare and to administer Resident #33's medications including the retaine eye drops. She was observed to administer 2 drops of retaine to the resident's left and right eyes. She was observed to wait less than 1 minute between drops. On 8/21/19 at 9:05 AM, the Med Aide was	F 759	All results will be brought to Quality Assurance Performance Improvement (QAPI) monthly by the SDC . All results will be reviewed by the QAPI team and the QAPI team determine if further monitoring is required.	

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 _____	08/22/2019

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 759	Continued From page 23 interviewed. She stated that she had to wait 1-2 minutes between drops for the same eye drops and 3-5 minutes for different eye drops. On 8/21/19 at 9:10 AM, the SDC was interviewed. The SDC stated that the facility's policy for eye drops administration was to wait 3-5 minutes between drops for same and different eye drops. On 8/22/19 at 11:30 AM, Director of Nursing (DON) was interviewed. The DON stated that she expected the nursing staff to wait 3-5 minutes between drops for same or different eye drops.	F 759		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff	F 812	Problem:	8/30/19

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 _____	08/22/2019

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 812	Continued From page 24 interview, the facility failed to allow the meal trays to air dry before stacking together and ready for use for 14 meal trays observed. Findings included: On 8/21/19 at 11:25 AM, observation of the tray line was conducted. The meal trays were observed stacked together and ready for use. The Dietary Aide (DA) was observed drying a meal tray with a paper towel while on the tray line. Observation of the stacked meal trays revealed 14 trays were wet. On 8/21/19 at 11:35 AM, the Dietary Manager (DM) was observed to remove the 14 wet trays and rewashed them in the dish machine. On 8/22/19 at 8:15 AM, the DM reported that he called the company that serviced the dish machine and the company had made adjustment to the drying agent. The DM added that the adjustment would make the kitchenware including the meal trays to dry faster. On 8/22/19 at 8:20 AM, the DA was interviewed. She stated that she normally washed the meal trays on the dish machine and air dry them. She reported that she didn't know why the meal trays were wet. She verified that some of the trays were wet and she had to dry them with paper towel before serving. On 8/22/19 at 11:34 AM, the Administrator was interviewed. He stated that he expected the dietary staff to air dry kitchenware and not to stack them together when wet.	F 812	Meal trays were not properly dried prior to storage. The Dietary Manager rewashed and dried 14 wet trays on 8-21-19. The Dietary Manager called Eco Lab to adjust the drying agent in the dish washing machine on 8-21-19. Eco Lab came to the facility on 8-21-19 and adjusted the drying agent. The Dietary Manager educated 100% of dietary employees on their policy on washing and drying dining trays on 8-30-19. The Dietary Manager pulled 100% stored trays on 8-21-19 and rewashed them and air dried them. Dining trays dried very quickly this time due to the adjustment to the dish machine. No other trays were found with moisture on them. The Dietary Manager or assistant manager will audit 100% of all trays daily for four weeks, weekly for four weeks and monthly for two months. The Dietary Manager and assistant manager will be auditing all meal trays to ensure they are stored dry. All results will be brought to Quality Assurance Performance Improvement (QAPI) monthly by the Dietary Manager. All results will be reviewed by the QAPI team and the QAPI team will determine if further monitoring is required.	