STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. BUILDING _____ B. WING _____	C 10/10/2019

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PEAK RESOURCES - SHELBY	**1101 NORTH MORGAN STREET SHELBY, NC 28150**

(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 and Complaint Investigation Survey was conducted on 10/07/19 through 10/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency preparedness. Event ID #7ZV911.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint Investigation Survey was conducted 10/07/19 through 10/10/19. A total of two allegations were investigated and one was substantiated.	F 000		
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 reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) reviewed for the areas of Hospice to reflect prognosis (Resident #3), Skin Condition to reflect a pressure ulcer (Resident #340) and Medication to reflect accurate gradual dose reduction (GDR) contraindication date (Resident #49) for 3 of 9 sampled residents reviewed for MDS accuracy. Findings included: 1. Resident #3 was admitted to the facility on 12/28/18 with diagnoses which included protein calorie malnutrition and dementia. A Hospice contract dated 12/18/18 certified Resident #3 was admitted under the care and	F 641	F641 Accuracy of Assessment Resident Effected: Residents # 3; 340 & #49 did not experience any adverse effects related to coding inaccuracy. Resident #340 was admitted on 8/9/19 a Stage 2 Pressure Injury and was discharged to the hospital on 8/22/19 Resident #3 was admitted under the care and services of Hospice for end of life on 12/18/18. The MDS was corrected and re-submitted on 10/10/19 Resident # 49 Gradual Dose Reduction (GDR) was initiated on 1/9/19, the MDS was modified by the MDS nurse on 10/10/19 to reflect gradual dose reduction	11/6/19

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

Electronically Signed | 10/30/2019

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F 641	Continued From page 1 services of Hospice for end of life. Review of the quarterly Minimum Data Set (MDS) dated 07/01/19 revealed Resident #3 was severely cognitively impaired for daily decision making. Review of Section J1400 (Prognosis - Does the resident have a condition or chronic disease that may result in life expectancy of less than 6 months?) was coded as Resident #3 not having less than 6 months to live. An interview was completed with the long term MDS Nurse on 10/09/19 at 12:07 PM. The MDS Nurse indicated Section J1400 (Prognosis) should have been coded on the MDS assessment to reflect a life expectancy of less than 6 months. The MDS Nurse revealed a modification assessment would be completed to accurately reflect prognosis of life expectancy of less than 6 months for Resident #3. The MDS Nurse revealed she made a typographical error trying to complete the assessment timely and stated she would pay closer attention to ensure accurate coding in the future for Section J1400 (Prognosis). An interview was completed with the Director of Nursing (DON) on 10/10/19 at 2:10 PM. The DON stated her expectation was for the quarterly MDS assessment to be accurately coded. The DON indicated it may have been a typographical error in the coding of Section J1400 (Prognosis) and stated the MDS Nurse should check her assessment prior to it being submitted. An interview was completed with the Administrator on 10/10/19 at 2:10 PM. The Administrator stated her expectation was for the MDS assessment to be accurately coded. The	F 641	(GDR). Others potentially effected: The MDS nurses #1 & #2 audited all annual MDS assessments in the 3rd quarter of 2019 on 10/29/19 & ending on 10/30/19 to ensure coding accuracy of pressure injuries, Hospice service and gradual dose reduction (GDR) on the MDS. There were three additional modifications required, this was done on 10/29/19 & 10/30/19. Measures in Place: Education was provided to the MDS nurses by the regional care manager on 10/18/19. The education included the importance of coding the MDS accurately including gradual dose reduction (GDR), pressure injuries and Hospice services. An MDS audit tool was developed by the regional care manager to include of review of assessments to determine accuracy of coding, Hospice services, gradual dose reduction and pressure injuries. Monitoring performance: The MDS nurses/designee (RN) will utilize the audit tool effective 10/29/19 and will audit 10% of MDS assessments for coding accuracy related to Hospice Services, gradual dose reduction (GDR) and pressure injuries, weekly for 4 weeks and then monthly for 3 months. Ongoing auditing will be determined by the prior 4	

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F 641	Continued From page 2 Administrator stated she felt the inaccurate coding of Section J1400 (Prognosis) was a typographical error and she too expected the MDS Nurse to check her assessment prior to it being submitted. 2. Resident #340 was admitted to the facility on 08/09/19 with diagnosis which included coronary artery disease and end stage renal disease. Review of Resident #340's "Resident Skin Integrity Review" assessment dated 08/09/19 and completed by Nurse #1 indicated, a stage II pressure ulcer to coccyx was present on admission. Review of Resident #340's Progress Note written by the Wound Nurse on 08/13/19 at 2:49 PM revealed, a "2.5 x 5.0 centimeter (cm) open area noted to sacrum". Review of Resident #340's admission Minimum Data Set (MDS) assessment dated 08/16/19 revealed, under Section M for Skin Conditions specifically MO300, there were no areas coded for a pressure ulcer of any stage. On 10/10/19 at 4:27 PM an interview was conducted with MDS Nurse #2 who explained, she had already reviewed Resident #340's admission MDS assessment dated 08/09/19 and realized she had not coded it for a pressure ulcer. The MDS Nurse stated, she could not explain how she missed the inaccurate coding and stated, "I just did". During an interview with the Administrator on 10/10/19 at 7:45 PM she stated, her expectation was that the MDS be coded accurately.	F 641	months of audits. The results of the audits will be reviewed and presented by the Director of Nursing each month at the scheduled Quality Assurance Performance Improvement (QAPI) meeting.	

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F 641	Continued From page 3	F 641		

3. Resident #49 was admitted to the facility on 10/07/2016 with diagnoses which included non-Alzheimer's dementia, depression, and insomnia.

A review of the annual MDS dated 08/13/2019 indicated that Resident #49 was marked for cognitive impairment and had been on an antipsychotic medication (Seroquel).

The MDS assessment revealed a gradual dose reduction (GDR) of Seroquel had last been attempted on 01/09/2019. The date entered on the MDS assessment as GDR was clinically contraindicated by the physician had been entered as 01/09/2018.

On 10/09/19 at 12:07 PM an interview was conducted with the MDS Nurse. The MDS Nurse indicated the GDR contraindication date of 01/09/2018 was incorrect and should have been entered as 01/09/2019. The MDS Nurse revealed a modification assessment would be completed to accurately reflect the correct GDR contraindication date. According to the MDS Nurse, she made a typographical error trying to complete the assessment timely and stated she would pay closer attention to ensure accurate coding in the future.

An interview was completed with the Director of Nursing (DON) on 10/10/19 at 2:10 PM. The DON stated her expectation was for the annual MDS assessment to be accurately coded. According to the DON, it may have been a typographical error in the coding of the GDR date and stated the MDS Nurse should check her assessment prior to submitting.

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F 641	Continued From page 4 An interview was completed with the Administrator on 10/10/19 at 2:10 PM. The Administrator stated her expectation was for the MDS assessment to be accurately coded. According to the Administrator, she felt the inaccurate coding of the GDR contraindication date was a typographical error and she too expected the MDS Nurse to check her assessment prior to submitting.	F 641		
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	F 656		11/6/19

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F 656	Continued From page 5 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 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 record reviews and interviews the facility failed to develop a comprehensive care plans that addressed an actual stage II pressure ulcer for Resident #340 and an indwelling urinary catheter for Resident #11 for 2 of 9 residents sampled for comprehensive care plans. The finding included: 1. Resident #340 was admitted on 08/09/19 with diagnoses which included status post hip fracture, coronary artery disease and end stage renal disease. Review of Resident #340's "Resident Skin Integrity Review" assessment dated 08/09/19 and completed by Nurse #1 indicated, a stage II pressure ulcer to coccyx was present on admission. Review of Resident #340's Progress Note (PN) written by the Wound Nurse (WN) on 08/13/19 at	F 656	F656 Develop & Implement Care Plan Resident Effected: Resident #340 was admitted on 8/9/19 with a Stage 2 Pressure Injury and was discharged to the hospital on 8/22/19 with a stage 2 pressure injury. Resident #11 had an indwelling urinary catheter placed on 3/8/19. A comprehensive care plan was initiated on 10/8/19. Others potentially effected: All residents in the facility with Pressure injuries have had their care plans reviewed by the MDS nurses on 10/10/19 to ensure care plans include the specific pressure injury noted and to validate the comprehensive plan of care is measurable, objective and has	

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F 656	Continued From page 6 2:49 PM revealed, a "2.5 x 5.0 centimeter (cm) open area noted to sacrum". The PN also indicated, a treatment of an ointment which contained 40% (percent) zinc was initiated for the open area. Review of a Weekly Pressure Ulcer/Wound QI Log provided by the Wound Nurse on 10/09/19 revealed, on 08/19/19 Resident #340 had a stage II pressure ulcer on his sacrum which measured 3.2 cm x 4.6 cm. Review of Resident #340's admission Minimum Data Set (MDS) assessment dated 08/16/19 revealed, he had intact cognition and required extensive assistance with turning and positioning. The MDS also indicated, he was frequently incontinent of bladder and bowel. Review of Resident #340's Comprehensive Care Plan dated (up to and including) 08/23/19 revealed, there was no care plan initiated to address an actual pressure ulcer of any stage. An interview was conducted with MDS Nurse #2 on 10/10/19 at 9:35 AM. During the interview the MDS Nurse stated she could not offer an explanation as to why she did not develop a care plan for actual skin breakdown but stated she should have written a care plan for Resident #340's pressure ulcer. During an interview with the Administrator on 10/10/19 at 7:45 PM she stated, her expectation was that care plans be developed to accurately reflect the condition of the residents. 2. Resident #11 was admitted to the facility 05/03/01 with diagnoses including hemiplegia	F 656	appropriate time frames indicated. No other resident was identified as not having a comprehensive care plan for an identified pressure injury. All residents with indwelling catheters have had their care plans reviewed by the MDS nurses on 10/10/19 to validate the comprehensive plan of care includes the indwelling catheter and that the plan of care is measurable, objective and has appropriate time frames indicated. No other residents were identified as not having a comprehensive care plan for their indwelling catheter. Measures in Place: The regional care manager in-service MDS nurse #1 and MDS nurse #2 on 10/18/19 The in-service included i.e.: All resident should have a comprehensive and accurate care plan. The care plans should include the needs and strengths of the resident and must be person centered. An audit tool was developed by the regional clinical manager to ensure initiation of a care plans for residents with both indwelling urinary catheters and for residents with identified pressure injuries. The audit tool includes i.e.: if the resident has an indwelling catheter or a pressure ulcer is there a comprehensive care plan in place, is the plan person centered, are there specific to the resident and include appropriate interventions, are the goals and time frames realistic. Monitoring performance:	

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F 656	Continued From page 7 (paralysis of one side of the body) and urinary retention. Resident #11's medical record revealed an indwelling urinary catheter was placed 03/08/19 at the Urologist's office for urinary retention. A Physician's order was written 03/12/19 to change the indwelling urinary catheter as needed, perform catheter care every shift, and monitor the securement strap and privacy bag every shift. The quarterly Minimum Data Set (MDS) dated 04/03/19 revealed Resident #11 was coded has having an indwelling catheter. The annual MDS dated 07/01/19 revealed Resident #11 was coded as having an indwelling catheter. The quarterly MDS dated 09/17/19 revealed Resident #11 was coded as having an indwelling catheter. Resident #11's comprehensive plan of care most recently revised 10/03/19 revealed no plan of care for an indwelling urinary catheter. An observation of Resident #11 on 10/07/19 at 11:19 AM revealed an indwelling urinary catheter was in place. An interview with MDS Nurse #1 on 10/08/19 at 11:32 AM revealed she was responsible for updating Resident #11's care plan. MDS Nurse #1 stated she reviewed Resident #11's care plan when she completed the annual MDS on 07/01/19 and the quarterly MDS on 09/17/19 and overlooked the fact that there was no care plan for an indwelling urinary catheter. She stated she	F 656	The Treatment nurse and the MDS nurses were trained on how to utilize the audit tool on 10/14/19 by the regional clinical manager. They will utilize the audit tool on all new admissions starting October 10th for the next 3 months to validate a comprehensive care plan has been developed which addresses any identified pressure injuries and/or indwelling catheters as appropriate. These nurses will also audit a random sample of 25% of current resident's over the next 3 months ending 1/3/2020 to validate that the residents comprehensive care plans include current pressure injuries and/or indwelling urinary catheters if appropriate. Ongoing audits will be determined by the results of the prior 3 months of audits completed. The results of the audits will be presented by the Director of Nursing and will be reviewed each month at the scheduled Quality Assurance Performance Improvement (QAPI) meeting.	

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F 656	Continued From page 8 was not working as the MDS Nurse when the quarterly MDS dated 04/03/19 was completed. MDS Nurse #1 stated there should have been a care plan for an indwelling urinary catheter developed when the quarterly MDS was completed 04/03/19 but since it was not she should have developed the indwelling urinary catheter care plan when she completed the annual MDS dated 07/01/19 or the quarterly MDS dated 09/17/19. An interview with the Director of Nursing (DON) on 10/08/19 at 11:57 AM revealed she expected residents with an indwelling urinary catheter to have a care plan for an indwelling urinary catheter. She stated Resident #11 had an indwelling urinary catheter placed at the Urologist's office 03/08/19 and should have had a care plan developed on or near 03/08/19. A subsequent interview with the DON on 10/08/19 at 1:04 PM revealed she felt the reason the care plan for an indwelling urinary catheter was not developed for Resident #11 was most likely due to the fact it was overlooked. An interview with the Administrator on 10/10/19 at 2:06 PM revealed she expected residents with indwelling urinary catheters to have a care plan in place for an indwelling urinary catheter.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		11/6/19

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F 686	Continued From page 9 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to initiate a treatment for a stage II pressure ulcer for four days after admission for 1 of 3 residents sampled for pressure ulcers (Resident #340). The findings included: Resident #340 was admitted to the facility on 08/09/19 with diagnoses which included status post hip fracture, coronary artery disease and end stage renal disease. Review of Resident #340's Progress Notes (PN) dated 08/09/19 at 4:01 PM and written by Nurse #1 revealed, Nurse #1 received a telephone interview from hospital staff that reported Resident #340 had a stage II (pressure ulcer) on his coccyx. Review of a PN dated 08/09/19 at 4:35 PM and written by Nurse #1 indicated, during the assessment Resident #340 had area to coccyx that was covered with a dressing. Review of Resident #340's Resident Skin Integrity Review dated 08/09/19 and hand written by Nurse #1 revealed, a stage II (pressure ulcer) to	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcers Resident affected: Resident #340 was admitted to the facility with a stage 2 pressure injury and discharged to the hospital on 8/22/19 with a stage 2 pressure injury. The resident did not return to the facility. Other residents with the potential to be affected: All resident who currently reside in the facility who have a pressure injury were reviewed by the Treatment nurse for proper wound assessment/evaluation and timely treatment initiation on 10/29/19. All other residents had timely treatments initiated. All newly admitted residents from 10/10/19 were evaluated on admission for any pressure injuries as evidenced by a completed “Initial Skin Integrity Review” form, and for timely initiation of treatment(s). This process was accomplished by the Treatment Nurse	

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F 686	Continued From page 10 his coccyx. Review of a PN dated 08/13/19 and written by the Wound Nurse (WN) revealed Resident #340 had an open area to sacrum that measured 2.5 x 5.0 centimeters (cm). The PN indicated, a treatment of 40% (percent) zinc (ointment) was processed to be applied every shift to the open area. Review of Resident #340's August 2019 Treatment Administration Record (TAR) revealed a treatment of zinc oxide 40% to sacrum every shift was initiated on 8/13/19. On 10/10/19 at 6:04 PM an interview was conducted with the Director of Nursing (DON) who explained, when a resident was admitted with a wound, it was the responsibility of the admitting Nurse to assess the wound and set up a treatment from the facility's Wound Care Management protocol. The DON continued to state, that for Resident #340, Nurse #1 should have assessed his wound during the admission assessment and set up the appropriate treatment for a stage II pressure ulcer. An interview was conducted with the admitting nurse, Nurse #1 on 10/10/19 at 6:34 PM. During the interview Nurse #1 explained, she was not accustomed to assessing wounds and setting up treatments for wounds. The Nurse stated, her normal routine was to leave that to the WN to assess the wounds and set up the appropriate treatments. During an interview with the WN on 10/10/19 at 7:18 PM she explained, when a resident was admitted to the facility with a wound while she was on duty, she tried to assess the wound and	F 686	and the Regional Clinical Nurse on 10/29/19. Measures to prevent reoccurrence of practice: Nurse # 1 is on LOA a one to one education will be provided prior to her returning to an assignment. This will be done by the SDC or other qualified RN. The education will include the documentation required for newly admitted residents i.e.: “Initial Skin Integrity Review” form completion and initiation of treatment(s) as necessary in a timely manner, post discovery of the pressure injury. All other nursing staff were educated starting 10/14/19 with regard to the “Initial Skin Integrity Review” form by the Director of Nursing and the Regional Clinical Nurse. This review is to be completed on day 1 of admission and if there are any pressure injuries noted, there must be a treatment initiated on day one. The education also included a review of treatment protocols that can be utilized. Any nurse who was on LOA or otherwise not available will be educated prior to being assigned on a unit. Monitoring Performance: An audit tool was developed by the regional clinical manager to validate any newly admitted resident will be evaluated on day 1 of admission for any pressure injury. This tool was initiated on 10/29/19 for residents with any pressure injuries a	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - SHELBY	1101 NORTH MORGAN STREET SHELBY, NC 28150

(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 686	Continued From page 11 set up the appropriate treatment according to the facility's Wound Care Management protocol. The WN continued to explain, that when residents with wounds were admitted while she was off duty, it was the admitting Nurse's responsibility to assess the wound and set up the appropriate treatment for that wound. The WN explained, that her normal routine for finding out if a resident was admitted with a wound while she was off duty was to retrieve a census and review their admitting assessments. The WN stated she discovered that Resident #340 had a wound on admission the following Monday morning (08/12/19) and she had to make rounds with the Wound Doctor and did not have time to assess Resident #340's wound before the rounds or after the rounds on Monday. The WN further stated, she was able to assess Resident #340's wound the first time on Tuesday the 13th and assessed it to be a stage II without drainage to his sacrum. The WN stated, the appropriate treatment for the stage II pressure ulcer was to apply zinc oxide 40% ointment every shift. An interview was conducted with the Administrator on 10/10/19 at 7:45 PM who stated, Resident #340 should have had a treatment set up for his pressure ulcer from the day of admission.	F 686	treatment has been initiated on day one of admission. The audit tool will be completed on 100% of new admissions over the next 90 days by the Treatment nurse, the Staff Development nurse or the Director of Nursing. Ongoing audits will be determined by the prior 90 days of audits. QA: The results of the audits will be analyzed and presented at the monthly QAPI meeting by the Director of Nursing.	