STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	**300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278**

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E 000	Initial Comments An unannounced Recertification Survey and Complaint Investigation Survey was conducted on 1/27/2020 through 1/30/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 8CBK11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint investigation was conducted from 1/27/2020 through 1/30/2020. 1 of 1 complaint allegation was unsubstantiated.	F 000		
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	F 656		2/27/20

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

Electronically Signed | 02/14/2020

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F 656	Continued From page 1 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 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 review and staff interviews, the facility failed to develop a comprehensive individualized and person-centered care plan that addressed cognitive loss for 1 of 3 residents (Resident #45) reviewed for dementia care. Findings included: Resident #45 was admitted to the facility on 3-4-17 with multiple diagnosis that included Alzheimer's, protein calorie malnutrition. The annual Minimum Data Set (MDS) dated 1-8-20 revealed Resident #45 was severely cognitively impaired and had rejected care 4-6 days. Resident #45's care plan dated 1-13-20 revealed	F 656	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. F656 1- How will the corrective Action be accomplished for resident #45. For Resident #45, a care plan to address cognitive loss(Dementia) was put in place. This was done on January 29, 2020 by Minimum Data Set (MDS) Nurse #1. The resident did not suffer any adverse effects from the alleged deficient practice.	

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F 656	Continued From page 2 no goals or interventions related to her cognitive loss. During an interview with the MDS nurse on 1-29-20 at 10:29am, the nurse said there was not a care plan for Resident #45's diagnosis of Alzheimer's "but there should be." She also stated when the facility changed companies the care plans had to be entered into the computer manually and "the goals and interventions for her Alzheimer's must have just got missed." An observation of ADL care for Resident #45 occurred on 1-29-20 at 11:05am. Upon entering Resident #45's room with nursing assistant (NA) #2, the resident was noted to be pulling at her sheets and yelling incoherently. NA #2 was noted to ask the resident what was wrong. NA #2 was interviewed on 1-29-20 at 11:15am and stated she was not aware of any specific interventions for Resident #45's diagnosis of Alzheimer's "I just try to ask her what is wrong and calm her down by talking with her." NA #1 was interviewed on 1-29-20 at 1:35pm. NA #1 stated she did not know specific interventions for Resident #45 related to the resident's cognitive loss "there aren't any interventions on the care guide for that." She did say if Resident #45 became agitated during a task she would walk away for a few minutes then return to try and complete the task which she stated worked "sometimes." During an interview with Nurse #4 on 1-29-20 at 1:45pm, the nurse said Resident #45 would become agitated during tasks and often refuse her medication. She also stated she did not know	F 656	2- How will the facility identify other residents having the potential to be affected. 100% audit was conducted on January 31, 2020 where care plans were reviewed to ensure accuracy and completion of care plan related to cognitive loss. This was completed on January 31, 2020 by the DON. No other resident was affected by the alleged deficient practice. 3- What changes are being made to prevent recurrence. MDS Nurse #1 and MDS Nurse #2 and the IDT (Interdisciplinary Team), which consists of the Social Worker, Activity Director, Dietary manager, RN Supervisors, DON, SDC, and Treatment Nurse were educated by the facility□s Regional Care Manager in regards to accuracy and completion of care plans related to cognitive loss. This education also included that individualized interventions were to be put in place and added to the resident□s profile so that all staff would be aware of these interventions. This was completed on 02/07/2020. All admissions will be reviewed within 72 hours of admission by the IDT Team and assessed for the need of a Dementia care plan. Furthermore, new orders will be reviewed daily in clinical meeting by the clinical team and the care plans and resident profiles will be updated and/or implemented as necessary. In addition, care plans and resident profiles will be reviewed with	

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F 656	Continued From page 3 of any interventions specifically for the resident's diagnosis of Alzheimer's, but she was familiar enough with the resident to know certain interventions that worked to calm her down such as Resident #45's stuffed animals and giving her a hug. The Director of Nursing (DON) and the Administrator were interviewed on 1-30-20 at 1:00pm. The DON stated the facility had a clinical risk meeting weekly where the clinical risk committee examines 1 hall per week and reviewed each residents care plan that lived on that hall and was not sure how Resident #45's care plan for Alzheimer's got missed but planned on completing a 100% audit on all long term care, care plans with the MDS nurse.	F 656	each comprehensive and quarterly assessment and updated by the MDS nurses, as appropriate. CNA staff and licensed nursing staff will be educated on the resident profile within the EHR software. This will be done by the Staff Development Coordinator (SDC) nurse on Multiple Inservice Dates and completed by February 21, 2020. Any staff out on leave or on PRN status will be educated prior to returning to duty. Any new staff hire will be educated upon hire during orientation. 4- How will the facility monitor its performance. An audit tool was developed which includes monitoring to make sure the comprehensive care plan is put in place to address resident□s needs to attain or maintain the highest level of function and to ensure that the resident□s profile has the individualized approaches. MDS Nurse #1 will audit 10% of MDS Nurse #2 residents□ comprehensive care plans and resident profiles with cognitive loss/dementia diagnoses weekly for 4 weeks, then 10% every other week for 4 weeks and then monthly for 2 months. MDS Nurse #2 will audit 10% of MDS Nurse #1 residents□ comprehensive care plans and resident profiles with cognitive loss/dementia diagnoses weekly for 4 weeks, then 10% every other week for 4 weeks and then monthly for 2 months. All audit results will be reported to the Administrator. All audit information will be reported	

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F 656	Continued From page 4	F 656	monthly in QAPI for further review and recommendations. 5- This Plan of Correction will be completed by 02/27/2020	
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, staff interviews and family interview, the facility failed to provide incontinence care at a frequency to minimize the resident exposure to being wet and soiled for 1 of 3 dependent residents (Resident #45) reviewed for activities of daily living. Findings included: Resident #45 was admitted to the facility on 3-4-17 with multiple diagnoses that included Alzheimer's disease. The annual Minimum Data Set (MDS) dated 1-8-20 revealed Resident #45 was severely cognitively impaired and needed extensive assistance with one person for bed mobility, dressing and personal hygiene. The resident needed extensive assistance with 2 people for toileting. The MDS also had Resident #45 coded as always incontinent of urine and always incontinent of bowel. Resident #45's care plan dated 1-13-20 revealed	F 677	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. F677 1- How will the corrective Action be accomplished for resident #45. ADL care, including incontinent care and linen change was completed by NA#2 on 1-29-20 for resident #45. The resident□s skin was dry and intact. 2- How will the facility identify other residents having the potential to be affected. All residents requiring incontinence care were checked to ensure that timely care was provided by facility staff. This was completed by RN Supervisor #1, RN	2/27/20

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F 677	Continued From page 5 a goal that the resident's needs would be anticipated and provided by staff. The interventions for that goal in part were; assist with incontinence care routinely and as needed and monitor resident routinely to anticipate needs and assist resident as needed with all activities of daily living (ADL). During a family interview for Resident #45 on 1-28-20 at 9:09am, the family member stated he had visited the resident "several times" around 10:00am during the week and Resident #45 would not be clean and had a soiled brief. Resident #45 was observed on 1-28-20 at 10:15am laying in her bed with crumbs on her sheet and face as well as a dried yellow substance on her face. No odors were noted, and the resident was unable to clarify if she had received any personal care. An observation of ADL care for Resident #45 occurred on 1-29-20 at 11:05am. The nursing assistant (NA) #2 was noted to explain to the resident what she was doing and allowed the resident to help in her care. When NA #2 repositioned Resident #45 on her left side, the bottom sheet was noted to be wet with a brown substance. The NA removed Resident #45's brief and it was noted to be wet and have feces present. The feces were noted to also be on Resident #45's buttocks and the feces was dried around the edges. The resident's skin was noted to be intact but slightly red and blanchable. NA #2 was interviewed on 1-29-20 at 11:15am. NA #2 said she had not checked the resident for incontinence when she started her shift "the night shift said they had just changed her at 6:30am."	F 677	Supervisor #2 and was completed on 1-29-20. No other resident suffered any adverse effect from the alleged deficient practice. 3- What changes are being made to prevent recurrence. The Staff Development Coordinator, Director of Nursing and RN Supervisors will provide education to all licensed nursing staff and certified nursing assistants regarding the policy of providing ADL care and incontinence care every 2 hours, as indicated. This will be completed by February 21, 2020. Any staff out on leave or on PRN status will be educated prior to returning to duty. Any newly hired staff will be educated upon hire, during orientation. 4- How will the facility monitor its performance. In order to monitor compliance, the DON, SDC, and RN Supervisors will conduct random ADL care audits to determine if ADL and incontinence care has been provided per policy. 10 percent of residents will be done weekly for 4 weeks, 10 percent will be done every other week for 4 weeks, and 10 percent will be done monthly for an additional two months. The results will be recorded on the ADL audit tool. All audit results will be reported to the Administrator. All audit information will be reported monthly in QAPI for further review and	

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F 677	Continued From page 6 The NA #2 also stated she had not provided incontinence care to the resident until "just now" (1-29-20 11:05am) "the trays came for breakfast then I got busy with giving showers and getting other residents up and just did not have time to go back and check on the resident for incontinence." NA #2 said she should be checking her residents every 2 hours for incontinence but "sometimes it is too busy, and it takes longer." During an interview with NA #3 on 1-29-20 at 6:50pm, the NA said she had provided incontinence care to Resident #45 at 6:30am on 1-29-20 and she had informed the on coming NA that incontinence care had already been provided to Resident #45. NA #3 also stated she checked her residents every 2 hours or sooner "I usually check Resident #45 more often because she urinates a lot." The Director of Nursing (DON) and the Administrator were interviewed on 1-30-20 at 1:00pm. The DON stated the on coming shift was supposed to round with the off going shift "that way if someone needs changing there are 2 of them to get it done." She also said she expected within an hour of the on coming staff starting, the staff would make sure incontinence care was provided before the breakfast trays arrived on the unit. The DON revealed the facility was conducting education with the NA's on incontinence care and skin break down and that the education would continue.	F 677	recommendations. 5- This plan of correction will be complete by 02/27/2020.	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the	F 809		2/27/20

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F 809	Continued From page 7 facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews the facility failed to offer bedtime snacks to 4 of 4 residents (Resident #3, Resident #44, Resident #54, and Resident #55). Findings included: During the resident council meeting that was held on 1/28/20 at 11:00 am, Resident #3 and Resident #44 revealed that bedtime snacks were not being offered. During an observation on 1/29/20 from 7:00 pm until 9:00 pm no one was observed offering snacks to the residents on the 200, 300 and 600 halls. During a second interview on 1/29/20 at 8:45 pm Resident #3 stated that she was not offered a	F 809	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. F809 1- How will the corrective Action be accomplished for resident 3,44,54, and 55. On 1-30-2020, the Administrator informed Residents #3, #44, #54, and #55 that snacks were available and the time frames in which they were supposed to be offered. They were also informed that they can request snacks at any other time during the day or night as well. Each	

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F 809	Continued From page 8 snack tonight. Resident #3 was alert and oriented with a brief interview mental status (BIMS) of 15 During a second interview on 1/29/20 at 9:10 pm Resident #44, who resided on the 300 hall, stated she was not offered a snack tonight, but staff did ask her if she wanted some ice water. Resident #44 was alert and oriented with a BIMS score of 14. During an interview on 1/29/20 at 9:14 pm with Resident #54 who resided on the 300 hall, indicated she had never been offered a snack before. The resident asked if this was something new and she would love to have a good snack. The resident was alert and oriented with a BIMS score of 15 During an interview on 1/29/20 at 9:20 pm with Resident #55 who resided on the 600 hall indicated he had been at the facility since 12/31/19 and no one had ever asked him if he wanted a snack at night. He stated he would like to have a snack. The resident was alert and oriented with a BIMS score of 13 During an interview with the NA #6 on 1/29/20 at 9:30 pm he revealed he passed out snacks nightly around 8:30 pm, however he was running behind tonight and he would get "Resident #55 a snack right now". On 1/29/20 at 8:50 pm an interview was conducted with NA#2 and she stated NAs passed snacks on their assignments and they tried to do this between 8:00 pm and 9:00 pm. She stated they were running behind tonight because they were getting people in bed and giving showers	F 809	resident voiced understanding. These residents did not suffer any adverse effects from the alleged deficient practice. 2- How will the facility identify other residents having the potential to be affected? All residents in the facility were identified as having the potential to be impacted when evening snacks are not offered or passed out. 3- What changes are being made to prevent recurrence. All certified nursing assistants and licensed nursing staff will be educated by the Staff Development Coordinator, Director of Nursing and/or Nursing Supervisor on the process for offering/delivering bedtime snacks to residents. This education will be completed by 2-27-2020. Any certified nursing assistants or licensed nursing staff out on leave or on PRN status will be educated prior to returning to duty. Any newly hired staff will be educated upon hire during orientation. 4- How will the facility monitor its performance. Each Day a random selection of residents will be interviewed to ensure that they are receiving evening/bedtime snacks. The selection of residents and responses will be recorded on the Between Meal Snack form. This will be done by the facility department heads and results reported to	

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F 809	Continued From page 9 and some residents wanted to go to bed early. She stated they offered everyone on their assignment a snack. During an interview with the Dietary Manager (DM) on 1/30/20 at 9:00 am revealed snacks were prepared daily for all residents at 10am, 2pm and 8pm. The DM indicated it was the responsibility of the nursing staff to pass out the snacks during the time frame set by the facility. An interview was conducted on 1/30/19 at 12:52 pm with Administrator and he stated snacks were being sent out by dietary at 10am, 2pm and 8pm. He stated the process was the staff distributed snacks after dietary brought them out to each hall. He added the staff should ask the residents for their snack preferences.	F 809	the administrator and DON each day in the morning meeting. Nurse Managers will also run the snack consumption report for 25 percent of the residents to monitor snack delivery and consumption. This will be done for Monday through Friday each week for 4 weeks, then Monday, Wednesday, Friday for 4 weeks, then Once a week for four weeks. Result from both the Between Meal Snack form and the snack consumption reports will be reported monthly to the QAPI committee and the Resident Council for review and further recommendations. 5- This POC will be completed by February 27, 2020.	