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 10/05/2022

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/26/22 through 10/5/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #YH7211.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/26/22 through 10/5/22. Event ID# YH7211. The following intakes were investigated NC001908771, NC00191259, NC00192358, NC00192959, and NC192960. Two of the eight complaint allegations were substantiated resulting in deficiencies. Immediate Jeopardy was identified at CFR 483.25 at tag F689 at a scope and severity (J). Tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 8/15/22 and was removed on 10/1/22. An extended survey was conducted. The posting of this statement of deficiencies was delayed due to IT issues. Due to IT issues the statement of deficiencies was not reviewed through our Quality Assurance process before posting. Revisions were made to the statement of deficiencies on 11/09/22 and the survey was reposted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		11/7/22

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

Electronically Signed | 11/02/2022

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 10/05/2022

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 550	Continued From page 1	F 550		

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this

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 10/05/2022

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 550	Continued From page 2 subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and resident and staff interviews, the facility failed to treat residents in a dignified manner when staff did not provide incontinence care when requested and left a clean brief in the resident's visitor chair. The resident expressed feelings of being upset and mad. This affected 1 of 3 residents reviewed for dignity and respect (Resident #58). The findings included: Resident #58 was admitted to the facility on 09/02/22 with diagnoses including depression. A review of the admission Minimum Data Set (MDS) dated 09/06/22 indicated Resident #58 was cognitively intact and required extensive assistance with activities of daily living (ADL). The MDS further revealed Resident #58 was always incontinent of urine and frequently incontinent with bowels. a. An interview conducted with Resident #58 on 09/26/21 at 12:20 PM stated she was "upset and mad as fire" because staff had not answered her call light timely yesterday on 09/25/22 and she had wet all the way through her brief to the sheets. Resident #50 indicated she activated her call light at 4:15 AM through 5:00 AM no staff had come to assist her yet. Resident #8 stated she watched the clock on the wall next to her. Resident #58 further revealed she had to call and wake up a family member to contact the nursing station to send someone down to change her. Resident #58 stated once the family member called the nurses station that nursing staff had	F 550	F550 Criteria 1- Resident #58 was discharged home from facility as planned on 10-19-2022. Resident was interviewed on 10-10-2022 and 10-18-2022 by the Administrator. Resident stated that she was pleased with care and had not experienced any further episodes having to wait on call light to be answered. Resident was pleased that briefs were being stored in closet and not left out for visitors to see. She stated that everything had been great since she was moved to A hall in private room. Criteria- 2 All residents residing in the facility have the potential to be affected by the alleged citation. All halls were monitored for call light and incontinent care response times by Director of Nursing and Administrator on 10-27-2022 and 10/28/2022 to assess call light response time, timely incontinent care, as well as storage of incontinent briefs as a baseline for monitoring improvement. Response time timeframe. All briefs were stored in closet and not visible in resident□s room. Criteria -3 Education will be provided to all Nursing staff by 11-7-2022 by the Administrator or Staff Development Coordinator (SDC). Education will Include Residents Rights as it pertains to answering call lights timely, timely incontinent care, and maintaining dignity	

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 10/05/2022

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 550	Continued From page 3 come to her room and she received assistance at about 5:10 AM. An interview conducted with a family member on 09/27/22 at 10:40 AM revealed Resident #58 had called her about 5:00 AM furious and mad that nursing staff had not answered her call light and she had gone through her brief and sheets. The family member further revealed she immediately called the nurses station and requested that nursing staff check on Resident #58. The family member stated the nurse refused to give her name and denied Resident #58's call light being on. An interview conducted with Nurse Aide (NA) #6 on 9/29/22 at 10:45 AM confirmed she was assigned to Resident #58 on 9/25/22 from 11:00 PM to 7:00 AM. NA #6 revealed she had assisted Resident #58 on 09/25/22 around 5:00 AM. NA #6 further revealed she was assisting another resident across the hall and does not recall Resident #58's call light being on. NA #6 stated when she returned to the nursing station a family member had contacted the front desk and NA #6 went immediately to assist Resident #58. NA #6 could not recall if Resident #58 had soaked her brief and sheets. NA #6 indicated she had changed Resident #58 earlier in the shift but could not recall what time. An interview conducted with Nurse #5 on 09/29/22 at 12:05 PM revealed she was on another hall giving medicine and Resident #58's family member called the nurses desk early in the morning. Nurse #5 stated the family member was upset and stated Resident #58 had been waiting a while to receive care. Nurse #5 indicated NA #6 was assisting another resident and Nurse #5	F 550	with briefs stored in closet prior to providing incontinent care. Any staff on leave or PRN staff will be educated prior to returning to work by SDC or Unit Manager. Newly hired staff will be educated by SDC or Unit manager prior to being allowed to work. Facility scheduler and Human Resources Coordinator (HRC) were educated that any new employees will have to be trained by SDC prior to being given their assignment. Criteria-4 Monitoring: An audit tool was developed to monitor compliance and ensure that call lights are answered timely, residents received incontinent care timely, and that briefs are stored properly prior to use. DON and or designee such as Unit managers and SDC will complete audits on 10% of Residents on all shifts to include weekends. Audits will be completed weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. Results will be reported to the Quality Assurance and Performance Improvement team (QAPI Team) by the DON. The need for further monitoring will be determined by the QAPI team reviewing the audit results. Completion date 11/7/2022	

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 10/05/2022

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 550	Continued From page 4	F 550		

could not recall how long Resident #58's call light had been on. Nurse #5 stated weekends sometimes were short staffed, and care was not given as quickly as it should. Nurse #5 indicated she recalled enough staff working this past weekend.

b. An interview and observation conducted on 09/27/22 at 10:50 AM revealed Resident #58 pointed to a chair with a clean brief laying in it. Resident #58 stated she was "embarrassed and frustrated" because therapy and her daughter had visited her room today and Resident #58 was not aware a brief was laying in the chair visitors would usually sit. Resident #58 stated she felt it was not acceptable and that she did not want her visitors knowing she had to wear a brief and felt like it was a breach of privacy.

An interview and observation conducted with Nurse #4 on 09/27/22 at 10:55 AM revealed she was not aware a brief had been left in Resident #58's bedside chair. Nurse #4 stated it was not professional and was also a breach of privacy for Resident #58. Nurse #4 indicated briefs should be kept in Resident #58's closet.

An interview conducted with NA #5 on 09/27/22 at 11:00 AM revealed she had observed the brief in the chair this morning before breakfast. NA #5 indicated Resident #58 did not complain about the brief NA #5 did not think about removing it. NA #5 stated Resident #58's gown and brief should have not been left in the chair for others to see.

An interview conducted with the Director of Nursing (DON) on 09/29/22 at 4:35 PM revealed she had not been advised Resident #58 had

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 10/05/2022

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 550	Continued From page 5 complained of waiting for her call light to be answered on 09/25/22, and a brief had been left out for other residents and visitors to see. The DON indicated she expected for staff to answer call lights in a timely manner, and to keep private items such as briefs in Resident #58's closet until use. An interview conducted with the Administrator on 09/29/22 at 6:05 PM revealed she had not been advised Resident #58 had complained of waiting for her call light to be answered on 09/25/22, and a brief had been left out for other residents and visitors to see. The Administrator stated she expected call lights to be answered in a timely manner, and 45 minutes was too long. The Administrator indicated she expected NA #5 to remove the brief when she observed it and briefs were expected to stay out of sight until use.	F 550		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and responsible person interviews, the facility failed to report to	F 607	F607 SS=D	11/8/22

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 10/05/2022

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 607	Continued From page 6 the state survey agency within the required timeframe and notify the responsible person for 1 of 1 resident reviewed for resident abuse (Resident # 21). The findings included: Review of facility policy and procedure titled "Abuse, Neglect, Misappropriation of Resident Property, and Exploitation Policy" with a revised date of November 28, 2016, read in part under the reporting section: if the events that caused the allegation involve abuse or result in serious bodily injury the notification must be made by phone or fax within 2 hours after the allegation is made. The administrator or designee would inform the resident representative within two hours of initial abuse investigation and once 5-working day report was completed notify resident representative of the results of the investigation, the corrective action taken, if any, upon completion of investigation. Resident #21 was admitted to the facility on 05/06/22. Review of facility face sheet dated 05/06/22 revealed Resident #21's mother was listed as responsible person and was to receive financial, medical, and personal information. The admission minimum data set (MDS) dated 05/11/22 revealed Resident #21 was severely cognitively impaired. Review of initial facility reported incident (FRI) report dated 06/29/22 revealed allegations of resident abuse towards Resident #21 by staff when performing incontinence care. The initial report also revealed the facility had been made	F 607	Criteria 1- Resident #21 remains in the facility and has suffered no adverse effects related to the alleged deficient practice. Criteria 2- Other Residents with potential to be affected: All residents residing in facility have the potential to be affected. All reportable 24hour and 5-day reports for the last 3 months were reviewed on 10/31/22 by Administrator. All were reported in the appropriate time frame and responsible party was notified. Criteria 3- Education was provided to the current Director of Nursing (DON) by the current Administrator on 10/31/22. Education included time frames in reporting abuse. When future reports are faxed, the Director of Nursing (DON) and or Administrator will assure that a quick fax confirmation is received and attached to the Investigation file and report was completed within 2hrs of knowledge of alleged abuse. Education was provided to all staff on abuse policy and immediate notification to supervisor with any allegation or suspected abuse. Education included immediate notification of the DON and Administrator. The DON and or Administrator will be responsible going forward to notify the responsible party of the alleged abuse. Education will be completed by 11/8/2022. Responsible party will be notified at time investigation is reported and will be notified with the conclusion of the investigation when completed. Administrator will audit all	

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 10/05/2022

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 607	Continued From page 7 aware of the incident at 11:30 AM and the report was faxed to the state agency at 4:30 PM. Telephone interview with Resident #21's resident representative dated 09/26/22 at 1:08 PM revealed she was the responsible person for her son Resident #21. She stated she had no knowledge of the facility investigation for the allegation of abuse towards Resident #21 by staff during incontinence care. Resident #21's resident representative revealed no one from the facility had contacted her about an abuse investigation or of the outcome of the investigation. She revealed no one ever informed her of any concerns with abuse and she would have liked to have been notified. An interview was conducted with the previous Director of Nursing (DON) on 09/27/22 at 9:52 AM revealed she had completed an investigation of an allegation of abuse towards Resident #21 by staff during incontinence care. The previous DON revealed she was not familiar with the time frames of reporting and was not aware the initial report with allegations of resident abuse should have been faxed in within two hours or that Resident #21's responsible person should have been notified of the allegations of abuse and the outcome of the investigation. She stated she had not been trained on how to conduct a resident abuse investigation and had to rely on instructions from corporate on how to complete the initial report form and the 5-working day report. Administrator interview was conducted on 09/29/22 at 6:02 PM and revealed she had been aware of investigation of alleged abuse towards Resident #21 by staff during incontinence care,	F 607	24hr/5day reports for timely reporting on a weekly basis for 12 weeks. Any staff on leave or PRN staff will be educated prior to returning to work by Staff Development Coordinator (SDC) or Unit Manager. Newly hired staff will be educated by SDC or Unit manager prior to being allowed to work. Facility scheduler and Human Resources Coordinator (HRC) were educated that any new employees will have to be trained by SDC prior to being given their assignment. Criteria # 4 The results of the weekly audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator for 3 months. The committee will evaluate and make further recommendations as indicated based on audit results. Completion date 11/8/2022	

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 10/05/2022

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 607	Continued From page 8 but the investigation was completed by previous DON. She stated she was not aware the initial facility report alleging resident abuse had to be reported to the state agency within two hours and it had been her understanding that if the initial allegations of abuse had not alleged harm or bodily harm the initial report had to be reported within 24 hours. She also stated she had not been made aware Resident #21's responsible representative had to be notified of the investigation or of the outcome of the investigation. The Administrator reviewed the facility abuse policy and revealed she would have expected the previous DON to have faxed the initial report form to the state agency within the correct time frame and to notify Resident #21 responsible representative during the initial investigation and once the investigations had been completed.	F 607		
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	F 656		11/7/22

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 10/05/2022

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 656	Continued From page 9 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 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 care plan for activities of daily living (ADL) 1 of 7 residents reviewed showers and skin integrity (Resident #43). Findings included: 1. Resident #43 was admitted to the facility 08/15/22 with a diagnosis of Alzheimer's disease. The admission Minimum Data Set (MDS) dated 08/17/22 reveled Resident #43 was severely cognitively impaired. The MDS reflected Resident #43 required extensive assistance with	F 656	F656 SS=D Criteria 1- Resident #43 remains in the facility and suffered no adverse effects related to the alleged deficient practice. Resident #43 care plans were reviewed and revised by (IDCP) Interdisciplinary care plan team to reflect current ADL needs and for maintenance of skin integrity. Criteria- 2 All residents residing in the	

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 10/05/2022

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 656	Continued From page 10	F 656		

bed mobility, transfers, and personal hygiene; limited assistance with dressing; supervision assistance with eating and toilet use; and was totally dependent for bathing assistance.

Review of Resident #43's care plan last updated 09/07/22 revealed there was no care plan for ADL.

During an interview with the MDS Coordinator on 09/29/22 at 09:14 AM she confirmed Resident #43 did not have a care plan for ADL. The MDS Coordinator stated Resident #43 should have had a care plan for ADL in place so nursing staff would know how much assistance the resident needed with each activity of daily living. She stated the ADL care plan should have been developed within 21 days of Resident #43's admission and was not developed due to an oversight.

An interview with the Regional MDS Consultant on 09/29/22 at 04:24 PM revealed Resident #43 should have had an ADL care plan in place since she needed assistance with her activities of daily living.

An interview with the Director of Nursing (DON) on 09/29/22 at 04:35 PM revealed Resident #43 should have had an ADL care plan in place that reflected how much assistance she required with each activity of daily living, and it should have been developed within the Resident Assessment Instrument (RAI) guidelines.

An interview with the Administrator on 09/29/22 at 05:35 PM revealed Resident #43 should have had an ADL care plan in place that reflected how much assistance she required with each activity

facility have the potential to be affected by the alleged citation. All resident Care plans were audited by Regional Minimum Data Set (MDS) Consultant and current MDS nurse for ADL needs and maintenance of skin integrity. Audits completed 10/17/22. Changes were made where needed to assure care plans were appropriate for resident's current needs. No residents suffered adverse effects.

Criteria -3 Education was provided on 11-1-2022 to Interdisciplinary team by Administrator. Education included that all residents should have an ADL care plan and a care plan approach for maintenance of skin integrity regardless of Care Assessment Area (CAA'S) triggered. Care plan should be reviewed and updated at least quarterly and with any significant changes in condition.
Any newly hired MDS staff will be educated on requirement in orientation by Administrator and/or MDS Coordinator.

Criteria-4 Monitoring: An audit tool was developed to monitor that all residents have care-plans for ADL needs and skin integrity and needs are accurately reflected in plan of care.
MDS Coordinator will audit care plans for 10% of the census weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. Results will be reported to the Quality Assurance and Performance Improvement team (QAPI) by the MDS coordinator. The need for further monitoring will be determined by the QAPI

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 10/05/2022

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 656	Continued From page 11 of daily living.	F 656	team reviewing the audit results. Completion date 11/7/2022	
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 observations, record reviews, staff and resident interviews, the facility failed to provide showers for 1 of 3 dependent residents (resident #58) reviewed for Activities of Daily Living (ADL). Findings included: 1. Resident #58 was admitted to the facility on 09/02/22 with diagnoses of hypertension, hyperlipidemia, and depression. A review of the admission Minimum Data Set (MDS) dated 09/06/22 indicated Resident #58 was cognitively intact. The MDS further revealed Resident #58 was total dependent and required one staff assist for bathing. The MDS also indicated it was very important for Resident #58 to choose between a tub bath, shower, or bed bath. Review of Residents shower log documented Resident #58 was scheduled to receive showers on Monday and Friday during second shift. The shower log further documented Resident #58 had only received a shower on 09/10/22, 09/18/22, and 09/21/22.	F 677	F677 Criteria 1- Resident #58 was discharged home from facility as planned on 10-19-2022. She suffered no adverse effects related to the alleged deficient practice. Criteria- 2 All residents residing in the facility have the potential to be affected by the alleged deficient practice. All residents were interviewed for shower preferences by the Director of Nursing (DON) on 10-27-2022. Shower schedule was revised per resident preferences. Residents with cognitive impairment were monitored for trends in refusals and shower schedule was adjusted according to findings. The DON will update shower preferences upon new admission, quarterly care plan, as well as on going, as needed. The DON was educated on this by the Administrator effective 10/27/2022. Criteria -3 Education was provided on 11-4-2022 to all nursing staff by the Staff Development Coordinator (SDC) on	11/7/22

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 10/05/2022

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 677	Continued From page 12 An interview and observation with Resident #58 on 09/26/22 at 12:20 PM revealed she had not received consistent showers as scheduled since admission. Resident #58 further revealed she preferred a shower and had to ask nursing staff on weekends to receive one. Resident #58 stated nursing staff would offer bed baths, but Resident #58 preferred a shower because her hair was not washed during bed baths. Resident #58 stated her hair felt dirty and oily. Observation revealed Resident #58 to have greasy and tangled hair. An interview conducted with NA #7 on 09/27/22 at 3:25 PM revealed she had worked weekends and had given showers to Resident #58 on 09/10/22 and 09/18/22. NA #7 further revealed Resident #58 had expressed that she had not received showers on her scheduled days during the week and needed a shower. NA #7 indicated multiple residents had complained showers were not being given as scheduled and preferred. An interview conducted with NA #2 on 09/28/22 at 4:25 PM revealed she was not aware Resident #58 had not received scheduled shower days. NA #2 further revealed Resident #58 had not refused showers and was expected to receive showers every Monday and Fridays during 2nd shift but could not recall why she had not. An interview with NA #3 on 09/28/22 at 5:00 PM revealed she had assisted Resident #58 with showers, and she had never refused. NA #3 further revealed there had been days that Resident #58 had not received a shower, but a bed bath instead because NAs had run out of time to give showers. NA #3 indicated Resident #58 did not always get her hair	F 677	importance of following shower schedule. Certified Nursing Assistants (CNA) are required to notify hall nurse anytime a resident refuse or misses a shower. DON must then be notified and will investigate for root cause analysis and determine if further education or change in schedule is needed. Any staff on leave or PRN status will be educated prior to returning to work by the SDC or Unit Manager. Newly hired staff will be educated by SDC or Unit manager prior to being allowed to work. Criteria-4 Monitoring: An audit tool was developed to monitor and assure that residents are getting showers per their preference schedule. DON or designee will audit showers for 10% of the census weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. Results will be reported to the Quality Assurance and Performance Improvement (QAPI) team by the DON. The need for further monitoring will be determined by the QAPI team reviewing the audit results. Completion date 11/7/2022	

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 10/05/2022

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 677	Continued From page 13 washed during a bed bath if nursing staff did not have time. NA #3 stated Resident #58 did prefer showers. An interview with the Director of Nursing (DON) 09/29/22 at 4:35 PM revealed she did not recall Resident #58 had not refused showers but was aware recently Resident #58 did not receive a shower on her scheduled day and it was pushed to the next day. The DON stated it was expected for residents to receive their scheduled days and preference. An interview with the Administrator 09/29/22 at 6:05 PM revealed she was aware Resident #58 had sometimes not received a shower on scheduled days but could not recall why. The Administrator stated Resident #58 should receive showers as preferred and on scheduled days.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, Physician Assistant, and physician interviews, the facility failed to ensure skin assessments were completed as ordered and new skin breakdown was reported for 1 of 1 resident reviewed for	F 684	F684 Criteria 1- Resident #21 remains in facility. Residents care plan was revised to reflect weekly skin assessment to correct the error of twice a week skin assessment per	11/7/22

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 10/05/2022

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 684	Continued From page 14 wound care (Resident #21). Findings included: Resident #21 was admitted to the facility on 05/06/22. Diagnoses included rash and other nonspecific skin eruption, adult failure to thrive, and pain. Review of the admission Minimum Data Set (MDS) dated 05/11/22 revealed Resident #21 was coded as having skin issues upon admission and required ointment or medications to feet. Review of Resident #21's revised care plan dated 08/09/22 revealed Resident #21 was at risk for skin breakdown related to incontinence, assistance needed with daily living, and poor distribution of adipose tissue. Care plan goal stated Resident #21 would remain intact and free from any signs or symptoms of additional skin breakdown. Interventions included conducting skin inspection twice a week and paying particular attention to the bony prominences. Review of Resident #21's skin assessments revealed assessments had been completed only once a week from 05/09/22-08/03/22, and on 09/21/22, and 09/28/22. No skin assessments had been completed from 08/03/22 through 09/21/22. Skin assessments included checking yes or no for preexisting skin impairments and any new skin impairments observed and documenting the type of skin impairment and where it was located. Review of admission skin assessment dated 05/09/22 revealed Resident #21 was admitted with preexisting skin impairments of sacrum and	F 684	facilities general orders. Resident was seen by wound doctor on 10-3-2022. Area resolved on 10-10-22. Criteria- 2 All residents residing in the facility have the potential to be affected by the alleged deficient practice. 100% audit of skin assessments was completed on 10-27-2022 by Peak Regional Nurse Consultant. No residents suffered adverse effects from alleged deficient practice. Criteria -3 Education was provided on 11-4-2022 to all licensed nurses by the Staff Development Coordinator (SDC). Education included importance of accurately and timely completing skin assessments per weekly schedule and notification of Medical Doctor/Physician Assistant (MD/PA) with any changes to skin. Education also included obtaining wound care consults when indicated and notification of resident's responsible party. Any staff on leave or PRN staff will be educated prior to returning to work by SDC or Unit Manager. Newly hired staff will be educated by SDC or Unit manager prior to being allowed to work. Facility scheduler and Human Resources Coordinator (HRC) were educated that any new employees will have to be trained by SDC prior to being given their assignment. Criteria-4 Monitoring: An audit tool was developed to monitor and assure that residents are getting weekly skin assessments completed with accuracy. Director of Nursing (DON), treatment	

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 10/05/2022

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 684	Continued From page 15 groin area to include scabbed areas on the sacrum and rash like bumps on groin area. Review of weekly skin assessment dated 05/16/22 revealed yes for preexisting skin impairments with no description of skin impairments and checked no for any new skin impairments. Review of weekly skin assessment dated 05/25/22 revealed no was checked for preexisting skin impairments and any new skin impairments. Review of weekly skin assessment dated 06/01/22 revealed no was checked for preexisting skin impairments and any new skin impairments. Review of weekly skin assessment dated 06/08/22 revealed no was checked for preexisting skin impairments and any new skin impairments. Review of weekly skin assessment dated 06/15/22 revealed yes was checked for preexisting skin impairments with no description of skin impairment and checked no for any new skin impairments. Review of nursing note dated 06/20/22 revealed Resident #21 had raw/ pink area underneath left scrotum. Nursing staff had cleansed area with soap and water and notified Nurse Practitioner in-person. Review of skin tear assessment form dated 06/20/22 revealed Resident #21 was observed having skin tear underneath left scrotum. Nursing staff cleansed area with soap and water. Treatment was somewhat effective, and Nurse Practitioner was notified in-person with no further	F 684	nurse and unit manager will audit skin assessments daily M-F from previous day. Audits will be completed on 50% of the census weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. Results will be reported to the Quality Assurance and Performance Improvement (QAPI) team by the DON. The need for further monitoring will be determined by the QAPI team reviewing the audit results. Completion date 11/7/2022	

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 10/05/2022

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 684	Continued From page 16	F 684		

orders or recommendations for treatment.

Review of skin assessment dated 06/28/22 revealed no was checked for preexisting skin impairments and any new skin impairments.

Review of nursing note written by the Unit Manager dated 07/01/22 revealed she was informed by nursing staff of Resident #21 worsening rash to buttocks and groin. Order was received for Nystatin cream twice daily for 14 days.

Review of physician order dated 07/01/22 revealed Nystatin Cream one application to sacrum and groin twice daily for 14 days due to rash and other non-specific skin eruptions.

Review of skin assessment dated 07/07/22 revealed no was checked for preexisting skin impairments and any new skin impairments.

Review of nursing note written by Nurse #4 dated 08/01/22 revealed Resident #21 verbalized complaints of pain and redness to his penile tip. Resident #21 was in no acute distress. Resident #21 placed on doctor's board for evaluation as requested.

Review of nursing note written by Nurse #6 dated 08/02/22 revealed Resident #21 called 911 twice. Resident #21 stated his rectum was burning and "on fire" internally. No abnormality was noted to rectal area upon examination. Nursing Assistant to clean area with soap and water and apply clean brief. No note of physician or nurse practitioner being notified.

An interview conducted with Nurse #6 on

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 10/05/2022

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 684	Continued From page 17	F 684		

09/29/22 at 2:44 PM revealed she worked second shift at the facility and was familiar with Resident #21 and his on-going skin issues. She stated Resident #21 was admitted with skin issues and had continued to have skin issues on his bottom, groin, and genital area. She revealed she had been working with Resident #21 in August 2022 when he called 911 twice complaining of burning and pain inside and around his rectum. Nurse #6 stated she had completed an evaluation on Resident #21 and was not able to observe any issues. She revealed she had asked the nursing assistant to clean Resident #21 with soap and water and apply a new brief. Nurse #6 stated she did not recall notifying the physician of the 911 call or the concerns from Resident #21 but should have and did not recall if she had informed the on-coming nurse of the incident.

Review of physician progress note dated 08/03/22 revealed Resident #21 was seen by physician for routine check. No notes were made during routine visit addressing incidents from 08/01/22 or 08/02/22 where Resident #21 had complaints of pain, redness, and burning of genital area.

Review of skin assessment dated 08/03/22 revealed no was checked for preexisting skin impairments and no for any new skin impairments.

Review of nurses note written by the Unit Manager dated 09/06/22 revealed nursing staff was called to Resident #21's room. Resident #21 had blood in his brief and no blood was noted coming from his penis. Resident #21 had a pinkish red excoriation under the head of penis.

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 10/05/2022

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 684	Continued From page 18	F 684		

Telephone order received from Physician Assistant (PA) for Nystatin cream to be applied twice daily for 14 days.

Review of the physician order dated 09/06/22 revealed Nystatin Cream one application to sacrum and groin twice daily for 14 days due to other non-specific skin eruptions.

An interview conducted with the Unit Manager on 09/28/22 at 11:35 AM revealed she was familiar with Resident #21 and his on-going skin issues. She stated Resident #21 was admitted to the facility with skin issues on his bottom and groin area, and those had continued along with new skin issues on his genital area. The Unit Manager revealed early in September 2022 she had to notify the PA of a new skin issue on Resident #21's genital area and Nystatin cream was prescribed. She stated nursing staff was responsible for completing weekly skin audits on every resident as a standing order and nursing assistant staff was responsible for notifying nursing staff of any changes or new skin issues and the treatment nurse was responsible for reviewing weekly skin audits. The Unit Manager revealed she was not aware Resident #21's care plan interventions included skin audits twice weekly nor was she aware he had not received any skin audits from 08/03/22 through 09/21/22. She stated nursing staff should have followed Resident #21's care plan and completed twice weekly skin audits since admission.

An interview was conducted with Nurse Aide (NA) # 4 on 09/28/22 at 9:41 AM revealed she was familiar with Resident #21 and was responsible for providing his personal care. She stated

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 10/05/2022

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 684	Continued From page 19	F 684		

Resident #21 was admitted to the facility with skin issues on his bottom and groin area. She also stated Resident #21 continued to have on-going skin issues on his bottom, groin, and genital area and described them to be scabbed over sores on some areas of bottom, rash like bumps in his groin area, and raw red areas in his genital area. NA #4 revealed she had not been in-serviced on providing personal care to residents with skin issues but attempted to be gentler when providing personal care to Resident #21 and when he was showing signs of pain during personal care would ask what was causing pain and notified nurse. She also revealed Resident #21 did not vocalize being in pain when she was performing personal care but would grimace or wince when being cleaned. She stated nursing staff had been responsible for completing weekly skin checks for Resident #21, but she would notify nurse if any new skin issues had been observed during personal care.

An interview conducted with NA #9 on 09/28/22 at 10:19 AM revealed she was familiar with Resident #21 and had been responsible for providing his personal care. She stated Resident #21 was admitted to the facility with skin issues on his bottom and genital area and continued to have skin issues on his bottom and genital area. NA #9 described Resident #21's skin issues as being scabbed, open, and raw areas from his bottom to his genital area. She revealed on occasions when she had assisted Resident #21 with personal care, he had made comments of it hurting or being tender and would show signs of it hurting by making a face and she notified the nurse. She stated she believed the Treatment Nurse had been visiting Resident #21 daily for his skin issues but was not aware of any new

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 10/05/2022

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 684	Continued From page 20	F 684		

treatments or referrals made to the physician or the wound doctor. NA #9 revealed she notified nursing staff of any changes with Resident #21's skin issues observed during personal care and nursing staff was responsible for completing weekly skin checks.

An interview was conducted with the Physician Assistant (PA) on 09/28/22 at 10:42 AM revealed she was familiar with Resident #21 and his on-going skin issues. She stated to her knowledge Resident #21 was admitted to the facility with skin issues that had continued and on a couple of occasions required an order for Nystatin cream. The PA revealed she had not been made aware of continued red and raw areas on the genital area since ordering Nystatin cream on 09/06/22. She stated nursing staff should have been completing weekly skin checks and following up with any treatments needed or notifying physician of any changes. The PA revealed she believed Resident #21 was being followed by the wound doctor that comes every Monday but when checked the electronic record she found Resident #21 had not been referred to the wound doctor and she would discuss with the team if a referral needed to be made.

An interview conducted with the Treatment Nurse on 09/29/22 at 2:33 PM revealed she had been the Treatment Nurse since 09/06/22 and prior to that had been the interim Director of Nursing and Staff Development Coordinator. She stated she was familiar with Resident #21 and his on-going skin issues. The Treatment Nurse revealed Resident #21 was admitted to the facility with skin issues on his bottom and groin area and those have continued along with skin issues on genital area. She stated since becoming the Treatment

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 10/05/2022

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 684	Continued From page 21	F 684		

Nurse, she had been assessing Resident #21's skin weekly not due to receiving a referral but because of Resident #21's on-going skin issues. The Treatment Nurse revealed Resident #21 had not been referred or evaluated by the facility wound doctor and to her knowledge had only received Nystatin treatment on a couple of occasions. She stated nursing staff had completed at least weekly skin audits on Resident #21 as a standing order, but if the care plan required twice weekly skin audits nursing staff should have completed skin audits according to care plan. The Treatment Nurse had no knowledge as to why twice weekly skin audits were not completed or why no one completed skin audits from 08/03/22 through 09/21/22. She stated the facility physician should have been contacted anytime there had been skin changes with Resident #21 to evaluate for a change in treatment or when 911 was called.

An interview conducted with the facility Attending Physician on 09/29/22 at 2:49 PM revealed he had begun working at facility as the Attending Physician the end of July 2022 and was at the facility every Thursday. He stated he was not as familiar with Resident #21 and was only notified around two weeks ago that Resident #21 had on-going skin issues being treated with barrier cream. The Attending Physician revealed he was not made aware Resident #21 had been admitted with skin issues that had continued and traveled to new areas or that he had been ordered Nystatin cream on different occasions with continued skin issues. He stated the facility physician should be notified when there had been skin changes with a resident or when skin issues were not improving so the resident could be assessed for a different treatment or if a referral

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 10/05/2022

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 684	Continued From page 22 needed to be completed to the wound doctor or another specialty. The Attending Physician revealed no knowledge of Resident #21 complaining of pain and redness in his genital area or calling 911 with concerns of pain and burning around his rectum which should have been reported to physician immediately and followed up to make sure was he evaluated properly. He stated nursing staff should have been completing at least weekly skin audits on Resident #21 to document and notify physician of any changes so treatment could be assessed. An interview was conducted with the Director of Nursing (DON) on 09/29/22 at 4:50 PM revealed no knowledge of the physician not being notified of Resident #21's skin changes or calling 911 with care concerns and that nursing staff should have notified facility physician immediately of any skin changes or Resident #21 calling 911 with care concerns. An interview with the Administrator on 09/29/22 at 6:02 PM revealed nursing staff should have also notified the PA or the physician of pain and changes in skin issues with Resident #21.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		11/8/22

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 10/05/2022

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 689	Continued From page 23 by: Based on observations, record reviews and resident, staff, Physician Assistant (PA), and Medical Doctor (MD) interviews, while under their care, the facility failed to implement an effective plan to protect the residents from accidents and injuries when smoking. Resident #34 and Resident #48 both utilized wheelchairs for mobility and had to navigate uneven pavement, with holes and cracks, to get to the side of the two-lane road which had a posted speed limit of 35 miles per hour and heavy local traffic. There were frequently cars parked across the street and during one observation a car had to go around Resident #48 as they smoked at the side of the road. The facility failed to ensure Resident #34 had a means to call for help. Both residents smoked during the day and night. Staff were not always aware of when the residents were at this location smoking. Sometimes when the residents returned to the building, the entrance door would be locked. There was no protection from the elements or interventions in place to warn drivers of the residents by the side of the road. There was no receptacle provided for the residents to extinguish their cigarettes or to leave their cigarette butts. This deficient practice occurred for 2 of 2 sampled residents (Resident # 34 and Resident #38). Immediate Jeopardy began on 08/15/22 when Resident #48 was provided an unsafe area to smoke. The Immediate Jeopardy was removed on 10/01/22 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to	F 689	F689 IJ Criteria 1- Resident #34 discharged home from facility against medical advice on 10-13-2022 Resident #38 was provided additional safety attire and devices for off property smoking to include: orange toboggan, wheelchair (WC) reflective flag, hand held flash light, water resistant poncho, and hand walkie talkie. Facility smoking policy reviewed with resident on 10/5/22 and again on 11/2/2022. Resident also has a cell phone to call facility staff for assistance if needed. Reflective flag was placed on resident's wheelchair 11/2/2022. Facility purchased "Wheelchair Traffic" signs to alert car drivers of potential residents off property. Signs installed 11/2/2022 in front of facility. Smoking assessment will be completed on resident at least quarterly and with any significant change in condition. Criteria- 2 There are currently no other residents in building that are going off property to smoke. If future residents insist on smoking and decline smoking cessation, then Criteria #2 from IJ removal plan will be followed which includes safety attire, reflective gear as well as 30-day discharge notice from facility. Criteria -3 Education was provided for all staff on 9/30/22 as already confirmed prior to the IJ removal and validation on 10-5-2022.	

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 10/05/2022

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 689	Continued From page 24 ensure safety measures, education, and monitoring systems put into place are effective. The findings included: 1. Review of the facility policy "Smoking/Tobacco Use/ Electronic Cigarette Policy" revised 07/07/2022 revealed for residents and families a.) Smoking/tobacco products are strictly prohibited, except in designated smoking areas and only for residents who are "grandfathered" tobacco product users. b) The use of tobacco products in any form is allowed off campus. Resident #48 was admitted to the facility on 08/09/22 with diagnoses which included hypertension, heart failure, renal failure, and age-related physical debility. Review of Resident #48 ' s admission Minimum Data Set (MDS) dated 08/22/22 revealed he was cognitively intact and required limited assistance for majority of activities of daily living (ADL). The MDS further revealed Resident #48 was coded for using a wheelchair and not coded for behaviors. The MDS also indicated Resident #48 was coded for tobacco use. Review of Resident #48 ' s care plan dated 08/15/22 revealed he currently used tobacco. The care plan ' s goal was Resident #48 would safely smoke cigarettes. Interventions included educate resident on potential risks of continuing tobacco use and offer tobacco cessation interventions, explain facility's smoking policy to resident and remind as needed, and explain to resident where the designated smoking areas are located.	F 689	Any staff on leave or PRN staff will be educated prior to returning to work by the Staff Development Coordinator (SDC) or Unit Manager. Newly hired staff will be educated by SDC or Unit manager prior to being allowed to work. Facility scheduler and Human Resources Coordinator (HRC) were educated that any new employees will have to be educated on smoking policy by SDC prior to being given their assignment. Criteria-4 Monitoring: An audit tool was developed to monitor compliance with resident signing out and in of facility to smoke as well as residents' compliance with individualized safety measures such as appropriate weather attire, flag on WC, Reflective strips on WC and orange toboggan and flashlight to be carried and used after dark. Monitoring tool was added to the resident sign out sheet and will be checked by the nurse signing resident in and out. QAPI tool will be monitored daily by the Director of Nursing (DON), Administrator or designee x 4 weeks then weekly x 8 weeks. Results will be reported to the Quality Assurance and Performance Improvement (QAPI) team by the DON. The need for further monitoring will be determined by the QAPI team reviewing the audit results. Completion date 11/08/2022	

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 10/05/2022

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 689	Continued From page 25	F 689		

Review of the smoking assessment dated 08/15/22 revealed Resident #48 was a safe smoker. The assessment further revealed Resident #48 frequency use was hourly and was moderately mobile. The assessment stated Resident #48 had some difficulty maneuvering through the gate due to the latch and must take frequent rest breaks when self-propelling to the street.

Review of Resident #48 ' s sign-out sheet revealed Resident #48 signed out to smoke on 08/15/22. The sign-out sheet further revealed Resident #48 had not signed out to smoke since 09/01/22. The sign out sheet indicated from 08/15/22 to 09/01/22 Resident #48 was not signed back in by facility representative.

An observation conducted on 09/26/22 at 2:50 PM revealed Resident #48 was an estimated of 3 ft from the curb in the road smoking in a wheelchair with no staff present. It was observed to be no sidewalk out to the road where Resident #48 was sitting to smoke and no receptable for extinguished cigarette butts. The only way to the road was the driveway that visitors and transportation use. The observations further revealed cars parked on the other side of the road and traffic coming both ways. Observation revealed vehicles had go around Resident #48 due to where he was in the road. Observations of the smoking area revealed no cover area for different elements of weather, no fire extinguisher, or safety interventions in case of an emergency. Observations revealed an outside streetlight near the curb where Resident #48 had stationed to smoke. Resident #48 had a cell phone in his lap listening to music.

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 10/05/2022

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 689	Continued From page 26	F 689		

An interview and observation conducted with Resident #48 on 09/26/22 at 3:15 PM revealed he had to go out to the road to smoke because the facility was a nonsmoking facility. Resident #48 further revealed he went out several times a day to smoke and sometimes at night and was not supervised because he was considered a safe smoker. Resident #48 had a cell phone in his hoodie pocket listening to music. Resident #48 was observed in his wheelchair and had to roll over multiple holes and cracks in the road. Resident #48 appeared to be tired and had to stop three times to catch his breath and strength to continue towards the facility door. Resident #48 was observed to also take two times to get up the small ramp to the facility door. Resident #48 was breathing hard and requested water from the Administrator once to the facility door.

An interview conducted with the facility Physician Assistant (PA) on 09/28/22 at 10:45 AM revealed she was aware Resident #48 consistently smoked throughout the day. The PA further revealed she did not feel like it was safe for residents to be in the road smoking. The PA indicated Resident #48 was not able to move quick enough in his wheelchair due to being weak sometimes from dialysis treatments.

An interview with the Administrator 09/28/22 at 3:35 PM revealed Resident #48 had not had an incident while smoking and felt that he was safe because he had completed a smoking assessment and was alert and oriented. The Administrator further revealed the facility was a nonsmoking facility before Resident #48 was admitted but felt like it was the residents right if he wanted to smoke. The Administrator stated

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 10/05/2022

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 689	Continued From page 27	F 689		

there was no area other than the road for residents to smoke, but Resident #48 had been educated verbally on smoking rules and signing out. The Administrator revealed there was not a set time that doors were locked in the evening, but usually did when it started to get dark outside. The Administrator indicated she did not recall smoking residents had gone out in harsh weather elements, but indicated she had no plans or provisions for upcoming weather elements.

An observation conducted on 09/28/22 at 4:30 PM revealed from the facility door to the road was an estimation of 132 feet. From the road to the road that intersected was 69 feet. It was further observed cars to be lined up parked on the right side of the road and made it impossible for two vehicles to pass one another other where Resident #48 had sat to smoke during observations. The road observed to have broken and uneven.

An interview and observation was conducted on 09/29/22 revealed Resident #48 had exited the facility at 8:32 AM and was positioned to smoke at 8:37 PM. It was further observed Resident #48 was able to light his own cigarette and extinguished it by throwing it down on the road. Resident #48 had flickered the ashes in front of him and ashes were observed on his clothing and the seat of his wheelchair. Resident #48 revealed he sometimes got weak from dialysis, and it was harder for him to get back to the facility when he felt weak and tired. Resident #48 indicated he smoked during the day and night and would have to ring the bell to get back in. Resident #48 stated he usually didn ' t tell staff he as smoking and just went because he felt he didn ' t have too.

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 10/05/2022

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 689	Continued From page 28	F 689		

An interview conducted with a Nurse Aide (NA) #3 on 09/29/22 at 10:55 AM revealed Resident #48 went out to smoke several times a day and sometimes at night. NA #3 further revealed Resident #48 would rarely sign out and staff would not know when he was outside smoking. NA #3 stated nursing staff had not been educated on assisting or knowing when residents went out to smoke. NA #3 indicated at night there was an outside light that was on at some hours of the night. The NA revealed when the light was not on it was pitch dark and residents did not have a flashlight. NA #3 indicated residents that smoked would have to ring the bell to get back in because doors locked every evening around dark. The NA stated she did not feel that it was safe for residents to be in the road smoking and staff not being aware when they were outside.

An interview conducted with the Medical Director (MD) on 09/29/22 at 2:55 PM revealed Resident #48 was a fall risk and was weak sometimes due to renal failure. The MD further revealed he believed Resident #48 was not completely safe in the road smoking and could be potential for an incident to occur.

An interview conducted with the Director of Nursing (DON) on 09/29/22 at 4:50 PM revealed she was not aware Resident #48 was not consistently signing out. The DON further revealed Resident #48 should have been encouraged and educated on the importance of signing out each time he had smoked. The DON stated she did not know the smoking rules, interventions, or if residents were smoking at night.

2. Resident #34 was admitted to the facility on 05/02/22 with diagnoses which included fracture

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 10/05/2022

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 689	Continued From page 29	F 689		

of lumbar vertebrae with routine healing, peripheral vascular disease, and peripheral neuropathy.

Review of Resident #34's quarterly Minimum Data Set dated 08/11/22 revealed she was cognitively intact, required extensive assistance of 2 staff with transfers and utilized a wheelchair for mobility. The MDS assessment indicated Resident #34 required supervision with locomotion on and off the unit with set up help only.

Review of a Smoke Risk Assessment performed on 08/20/22 revealed Resident #34 was assessed as a safe smoker by Nurse #1. The Smoking Risk Assessment revealed the resident was assessed with a score of 0 with 0-9 being documented as a safe smoker according to the scale on the assessment form.

A telephone interview was attempted with Nurse #1 on several occasions without success.

Resident #34 was documented starting on 08/21/22 as going out to smoke as indicated by her sign out/sign in sheet located in the resident's smoking notebook at the nurse's station.

On 08/22/22 Resident #34 was assessed again as a safe smoker by Nurse #2. The Smoking Risk Assessment revealed the resident was assessed with a score of 3 with 0-9 being documented as a safe smoker according to the scale on the assessment form. The assessment indicated Resident #34 had a moderate problem with being careless with smoking materials (2) and a minimal problem with mobility (1) but was still documented as being a safe smoker. Under

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 10/05/2022

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 689	Continued From page 30	F 689		

the smoking risk it was documented a smoking apron was needed.

An interview on 09/28/22 at 3:03 PM with Nurse #2 revealed she had completed Resident #34's Smoking Risk Assessment on 08/22/22. She stated the resident had seen another resident smoking and had requested to be assessed for smoking safely on her own. Nurse #2 further stated it had been explained to the resident she would have to be able to sign out, accept responsibility for herself while out smoking as though she had signed out as leaving the facility. She indicated the resident was willing to sign in and out of the facility to accept responsibility for herself and wished to move forward with the assessment to be able to smoke off the facility premises. Nurse #2 further indicated during the assessment Resident #34 had minimal trouble maneuvering her wheelchair out to the road due to uneven pavement and had issues with lighting her cigarette and slight difficulty with not getting ashes on her pants when flicking them from her cigarettes. According to the assessment, Nurse #2 recommended a smoking apron due to her hand tremors but said she was not sure if one had been provided for the resident or where it was located. Nurse #2 stated she had not provided the apron nor evaluated whether the resident was able to put the apron on by herself and said she had not seen the resident wearing an apron when leaving the unit to go out to smoke.

A review of Resident #34's care plan dated 08/24/22 revealed a focus area for resident currently using tobacco. The interventions included educate resident on potential risks of continuing tobacco use and offer tobacco

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 10/05/2022

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 689	Continued From page 31	F 689		

cessation interventions, evaluate continued safety with smoking/tobacco product use quarterly, explain facility's smoking policy to resident and remind as needed, explain to resident where designated smoking areas are located and remind as needed, observe clothing/skin for any burns, holes, etc., and report to physician as appropriate and provide supervision when smoking as needed.

An observation on 09/27/22 at 2:11 PM revealed Resident #34 sitting in her wheelchair up against the curb on the side of the road in front of the facility smoking. The resident was not wearing a smoking apron.

An observation on 09/28/22 at 2:13 PM revealed Resident #34 sitting in her wheelchair up against the curb on the side of the road in front of the facility smoking. The resident was not wearing a smoking apron.

An interview on 09/28/22 at 10:36 AM with the Physician Assistant (PA) for the facility revealed she didn't think it was a good idea for residents to be on the road smoking; however, she stated she understood they had to be off the property to smoke. The PA stated she didn't think it was safe for the residents to be on the road smoking.

An interview on 09/28/22 at 11:18 AM with the Unit Manager (UM) revealed she was aware Resident #34 went out to smoke off the property. The UM stated Resident #34 signed herself out to smoke and while off the property smoking, she was responsible for herself just like residents who left the building on a leave of absence. The UM further stated she was not aware the resident had been assessed as needing a smoking apron and

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 10/05/2022

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 689	Continued From page 32	F 689		

said she had not seen the resident wearing an apron and was not sure if an apron had been provided to Resident #34. She indicated staff including herself were out during their breaks smoking off the premises as well and saw the residents out on the road smoking. The UM further indicated she was not aware if Resident #34 had a smoking apron in her room but said if she had been assessed to wear one it should be kept in her room.

An interview on 09/28/22 at 3:03 PM with Nurse #2 revealed Resident #34 went out to smoke a lot during the day but said she had to sign out and sign back in when she returned. Nurse #2 stated the resident usually didn't tell them when she went out or came back in but was supposed to sign out and back in. She further stated any staff member could sign her back in. After seeing the sign in and out book, Nurse #2 indicated she was not sure why Resident #34 was not being signed back in by the staff.

An interview on 09/28/22 at 3:35 PM with the Administrator revealed Resident #34 was allowed to smoke but had to do so off the property since their facility was non-smoking. She indicated during inclement weather she assumed Resident #34 would not go out to smoke and when it was hot, they could come to the front porch and the staff would get them some water or give them some water before they went out to smoke. The Administrator further indicated Resident #34 had been assessed as a safe smoker and was able to sign out as though she was leaving the building on a leave of absence and go out by herself to smoke. She stated Resident #34 was intact and able to get off the property to smoke so they had decided to let her smoke. The Administrator

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 10/05/2022

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 689	Continued From page 33	F 689		

further stated Resident #34 was able to hold her cigarette, light it and extinguish it so she was able to smoke without assistance. The Administrator said she was not aware it had been recommended for the resident to wear a smoking apron and said to her knowledge she was not wearing one. She indicated the facility did have a smoking policy although they were a non-smoking facility and provided a copy of the policy.

An interview on 09/28/22 at 4:00 PM with the Admissions Director revealed she was not aware Resident #34 wanted to smoke prior to her admission. She stated Resident #34 was admitted from home and in the admissions process she was informed the facility was smoke free and signed the admission paperwork. The Admissions Director further stated she was not aware why the resident was allowed to smoke after being non-smoking at the facility for 3 months but said she was aware when she admitted to the facility smoking was not allowed on the premises.

An interview on 09/28/22 at 4:29 PM with NA #2 revealed Resident #34 was in and out of the facility pretty much all-day smoking. She stated she was out before daylight at 6:00 AM some mornings and had been out late at night when it was dark. NA #2 further stated when the door was locked the resident rang the bell for staff to let her back in at night. She indicated when Resident #34 had been out to smoke she had not noticed the resident wearing a smoking apron and was not aware she had been assessed as needing to wear an apron.

An interview on 09/28/22 at 4:55 PM with NA #3

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 10/05/2022

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 689	Continued From page 34	F 689		

revealed Resident #34 smoked a lot and was out smoking late at night. She stated the staff was not always aware that she was out smoking until they looked for her and couldn't find her. NA #3 indicated the resident did not have a cell phone to call if she had a problem while out smoking but said employees were out smoking and would probably see and assist her if she had any problems. She further indicated Resident #34 was able to maneuver her wheelchair pretty well out to the road where she smoked and back into the facility. NA #3 said she was able to hold her cigarette, light it, flick her ashes and extinguish it without any problems. NA #3 indicated she was aware the resident had to be off the property to smoke but stated it was not safe because she was not fast enough in her wheelchair to get out of the way of a car and there was a lot of traffic on the road where the residents and the staff smoked.

A continuous observation and interview on 09/29/22 from 8:23 AM to 8:53 AM revealed Resident #34 out in the road smoking. The resident was in her wheelchair dressed in sweatpants, sweatshirt, tee shirt under the sweatshirt, socks, and tennis shoes. The weather was 54 degrees, and the wind was moving at 13 miles per hour making it feel like 51 degrees according to the Weather.com app. The resident was actively smoking and there were ashes noted on her pants and wheelchair. There were no burn holes noted in her pants or shirt. The resident was able to hold her cigarette, get it to her mouth and with both hands light it due to her tremors. She was able to hold the cigarette with one hand and flick the ashes off her wheelchair, but some blew back on her clothing with the wind. Resident #34 extinguished her

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 10/05/2022

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 689	Continued From page 35	F 689		

cigarette by throwing it on the road and putting it out with her shoe. An interview with the resident revealed she had been educated to sign out when going out to smoke, so she accepted responsibility for herself as though she had signed out and left the building. She further revealed she had not been told to wear a smoking apron and had not been provided a smoking apron by the facility. Resident #34 stated her sweatshirt was the only warm clothing she had and said she didn't have a coat for the colder weather. Resident #34 further stated she didn't have a cell phone or any means to communicate with the staff while out smoking. Resident #34 explained she was out one day when it was raining and by the time, she got back into the building from outside she was soaked from head to toe and had to have a complete clothing change. She stated no one had offered her an umbrella or raincoat on days she was out smoking when it was raining. Resident #34 further stated on days it was cooler she crossed the road in her wheelchair so she could sit in the sun where it was warmer. There were cigarette butts noted all along the side of the road and Resident #34 stated it was from the residents and staff smoking because there was no where to extinguish their cigarettes except on the pavement of the road.

An observation on 09/29/22 at 10:00 AM revealed Resident #34 across the road in her wheelchair sitting in the sun. The back of her wheelchair was facing the road and she was sitting in her wheelchair in front of a parked car.

An interview on 09/29/22 at 2:47 PM with the attending physician revealed from a professional opinion he would recommend all patients go on a

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 10/05/2022

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 689	Continued From page 36	F 689		

patch and not smoke; however, if they are alert and oriented you really can't tell them they can't go off the property to smoke. The physician stated he would prefer for them to be able to smoke in a safer place that was not on the road but said they had to be off the property. The physician indicated it was not ideal for them to smoke in the road but said it was off the property as the facility required. He further indicated it might be advantageous to check into the city easement of the property to see if they could smoke within the easement that was not actually the property but not the road.

An interview on 09/29/22 at 4:48 PM with the Director of Nursing (DON) revealed they were a non-smoking facility and if the residents were alert and oriented and signed themselves out what they did while signed out was their right. The DON reviewed the sign out books and said the residents should have consistently signed out and the staff should have consistently signed them back in to the facility.

A follow up interview on 09/29/22 at 5:48 PM revealed the Administrator was not aware the residents were not consistently signing themselves out to smoke and staff was not consistently signing them back into the facility after smoking. She stated she expected them to sign out accepting responsibility for themselves while out smoking and expected the staff to sign them back in consistently to account for their whereabouts.

The Administrator was notified of Immediate Jeopardy on 09/29/22 at 12:45 PM.

The facility provided the following IJ Removal

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 10/05/2022

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 689	Continued From page 37	F 689		

Plan with the correction date of 10/01/22.

#1 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
Peak Resources Shelby failed to ensure the safety of Resident #48 and Resident #34 while they were smoking off facility property. The Administrator and Director of Nursing determined that there were no additional residents who were smoking off facility property.

#2 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
Peak Resources Shelby is a smoke-free facility. All residents/representatives are advised of this prior to or during the admission process by facility staff. Residents of Peak Resources Shelby are not allowed to smoke on facility property and must exit facility property to do so. If a resident notifies facility staff that they wish to smoke after being admitted to the facility, facility staff offer resident smoking cessation options, including patches, gum, or medication, if approved by resident's physician. If they still choose to smoke off facility property, licensed nursing staff will complete a Peak Smoking Risk Observation to determine if the resident is safe to smoke independently off property. Residents who are able to smoke off property independently, will be educated by licensed nursing staff where to smoke, required safety equipment, including reflective vest, reflective strips if using a wheelchair, flashlights if smoking after dark, appropriate attire for inclement weather and the procedure to notify facility staff upon exiting and returning to the facility after smoking and the

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 10/05/2022

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 689	Continued From page 38	F 689		

requirement to sign in and out at the nurse's station. Any resident who is unable to smoke off property independently will be offered smoking cessation options and will be issued a Nursing Home Notice of Transfer/Discharge. If resident chooses to smoke supervised, staff supervision will be provided at designated times.
The Administrator purchased reflective vests, reflective strips, and flashlights on 9/29/2022 and provided them to Resident #48 and Resident #34. The reflective strips were put on Resident #48 and Resident #34 wheelchair on 9/29/2022 by the Maintenance Department. Resident #34 was provided a smoking apron on 08/22/2022 to prevent ashes from dropping on her clothes. The smoking apron is kept in the resident's room. Resident #34 was educated on the use of the smoking apron on 09/29/2022 by the Director of Nursing. The Administrator purchased a pair of Walkie-Talkie's on 09/30/2022 for Resident #34. One was provided to Resident #34 on 09/30/2022 and one was provided to the nurse assigned to Resident #34 by the Administrator on 09/30/2022. One walkie-talkie will be kept in Resident #34 room, and one will be kept with the nurse who is assigned to provide care to the resident.
Resident #48 and Resident #34 were educated by the Director of Nursing on 9/29/2022 on the following:
" Smoking must occur off property in front of the curb in front of the facility and Resident #48 and Resident #34 were shown the location.
" Must wear a reflective vest when outside smoking. Resident #48 was able to don the reflective vest independently. Facility staff will assist Resident #34 with donning her reflective vest upon request if needed. Resident has been educated to ask for assistance if having difficulty with donning or doffing reflective vest. The

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 10/05/2022

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 689	Continued From page 39	F 689		

reflective vests will be kept in the resident's rooms.
" Must have reflective strips on wheelchair while outside smoking
" Must use a flashlight after dark while outside smoking. The flashlights will be kept in the resident's rooms.
" Must notify facility staff when exiting the facility to smoke and upon returning to the facility after smoking.
" Smoking materials must be locked in a locked box in the resident room.
" Must sign in/out at the nurse's station upon exiting the facility to smoke and upon returning to the facility after smoking.
" To wear appropriate weather attire if choosing to smoke off property during inclement weather.
" To wear appropriate weather attire if choosing to smoke off property during extreme heat or cold weather.
" Risk of smoking during inclement and/or extreme weather conditions (potential for injury, dehydration, frost bite, heat exhaustion, sunburn)

Resident number #34 was also educated to use the smoking apron and Walkie Talkie when outside smoking. Resident was informed that the apron is used to prevent ashes from being dropped onto her clothing and the Walkie Talkie is to be used to call for assistance. Resident was educated on the use of the Walkie-Talkie by the Administrator on 09/30/2022 and was able to use the Walkie-Talkie independently. The Walkie-Talkie was tested from the area where Resident #34 smokes off property to ensure that it worked properly, and communication was successful with the nurse inside the facility.
All licensed nurses, medication aides, CNAs, and

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 10/05/2022

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 689	Continued From page 40	F 689		

agency staff who may provide care to Resident #48 and Resident #34 will be in-serviced on the following:

" Smoking must occur off property in front of the curb in front of the facility and any resident who chooses to smoke off property must be shown the location.

" Residents who smoke off property must be provided a reflective vest when outside smoking. Facility staff must observe the resident donning the vest independently. If the resident cannot don the vest independently, facility staff will assist the resident to don the vest. The resident's reflective vests will be kept in the resident's room.

" Residents smoking off property in wheelchair must have reflective strips on the wheelchair.

" Residents must be provided a flashlight and be instructed to use the flashlight after dark. The flashlights will be kept in the resident's rooms.

" Residents will be instructed that they must notify facility staff when exiting the facility to smoke and upon returning to the facility after smoking. Resident rounds are completed at a minimum of every two hours.

" Residents must be provided a locked box and smoking materials must be locked in a locked box in the resident room.

" Residents must sign in/out at the nurse's station upon exiting the facility to smoke and upon returning to the facility after smoking. Resident rounds are complete at a minimum of every two hours.

" Residents must be instructed to wear appropriate weather attire if choosing to smoke off property during inclement weather.

" Residents must be instructed to wear appropriate weather attire if choosing to smoke off property during extreme heat or cold weather.

" Resident must be instructed about the risk of

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 10/05/2022

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 689	Continued From page 41 smoking during inclement and/or extreme weather conditions (potential for injury, dehydration, frost bite, heat exhaustion, sunburn) " If the resident does not have a cellphone to notify facility of assistance, a Walkie Talkie is provided by facility staff. " The nurse that is assigned to any resident who requires a Walkie Talkie for communication will keep one Walkie Talkie on during their shift. " Staff supervision will be provided to any resident identified as unsafe to smoke independently at times designated by facility. This education will be completed by the Administrator, Corporate Management Nurse, DON, or SDC and will be completed by 09/30/2022. Any facility staff out on leave or on PRN status will be educated prior to returning to duty by the Administrator, Director of Nursing, or Staff Development Coordinator. Any newly hired licensed nurse, medication aide, CNA or agency nurse will be educated during orientation by the Director of Nursing, Staff Development Coordinator, or designee. The Director of Nursing will be responsible for tracking staff that have not received the education. The Director of Nursing, Corporate Management Nurse and Staff Development Coordinator were advised of their responsibilities on 09/29/2022 by the Administrator. TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION FOR IMMEDIATE JEOPARDY REMOVAL.	F 689		

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 10/05/2022

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 689	Continued From page 42	F 689		

The Administrator and the Director of Nursing will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy.

Immediate Jeopardy Removal Date: 10-1-2022

The credible allegation for the immediate jeopardy removal was validated on 10/5/22 with a removal date of 10/1/22.

On 10/5/22, the facility's credible allegation was validated through observations, staff interviews, and record reviews.

The facility provided education documentation for all staff on safe smoking practices for the smokers at the facility which included use of reflective vest, reflective strips on the wheelchairs, use of flashlight after dark, signing in and out when going outside for smoking, resident rounds at a minimum of every two hours, use of cellphone or walkie-talkie, provision of a locked box for the smoking materials and encouragement to dress appropriately for the weather.

Interviews with licensed nurses, medications aides, nurse aides and agency staff revealed they received education on safe smoking practices for the smokers at the facility.

Observations were made of both Resident #48 and Resident #34. Both wheelchairs were lined with reflective strips at the back and on the wheels. An observation of Resident #48 while smoking outside the facility revealed him wearing a bright orange toboggan to help with increased visibility.

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 10/05/2022

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 689	Continued From page 43 Interviews with Resident #48 and Resident #34 revealed they received education on use of reflective vest, flashlight after dark, use of cellphone or walkie-talkie as needed and to notify facility staff by signing in and out when going outside to smoke. In addition, they were provided instruction to wear appropriate weather attire and were told about the risks of smoking during inclement and/or extreme weather conditions. A review of the Sign-Out/Sign-In Book revealed both residents had signed the book to sign in and out whenever they went outside to smoke.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		11/8/22

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 10/05/2022

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 880	Continued From page 44 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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 10/05/2022

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 880	Continued From page 45 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement infection control for hand hygiene when 1 of 1 facility staff (Nurse Aide #1) did not remove his gloves and perform hand hygiene after providing incontinence care for 2 of 3 residents observed for incontinence care (Resident #55 and Resident #38). Findings included: Review of the facility's policy titled "Handwashing/Hand Hygiene" revised June 2019 read in part as follows: "The facility considers hand hygiene to be the primary means to prevent the spread of infections. All personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based-hand rub containing 60-95% ethanol or isopropanol and rub for the following situations: after contact with bodily fluids or excretions, before moving from a contaminated body site to a clean body site during resident care, and after removing gloves". 1. A continuous observation of Nurse Aide (NA) #1 on 09/27/22 from 03:15 PM to 03:20 PM revealed NA #1 provided incontinence care for Resident #55. With gloved hands, NA #1 cleaned stool with a washcloth and placed it in a trash	F 880	F880 Criteria 1- Resident #55 and Resident #38 continue to reside at facility. Neither resident suffered adverse effects related to the alleged deficient practice. Criteria- 2 All residents residing in the facility have the potential to be affected by the alleged citation. An observation audit of incontinent care was conducted by Director of Nursing on 10/17/22 to ensure that proper hand hygiene was followed. No abnormal findings noted at time of audit. Criteria -3 Education will be provided to all Certified Nursing Assistants and licensed nursing staff by 11-7-2022. Education will be provided by the Director of Nursing (DON) and/or Staff Development Coordinator (SDC). Education will Include hand hygiene before, during, and after resident care including the 7 steps of hand hygiene. CNA # 1 will have 1:1 education regarding the 7 steps of hand hygiene, hygiene before, during, and after resident care and will include bedside competency/return demonstration evaluation during incontinent episodes. 1:1 education provided by 11/8/2022 by Staff Development Coordinator.	

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 10/05/2022

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 880	Continued From page 46 bag, removed the soiled brief and placed it in a trash bag, applied a clean brief, applied barrier cream to Resident #55's inner thighs, fastened the brief, pulled Resident #55's gown down, and removed his gloves. NA #1 adjusted Resident #55's overbed table, applied a clean pair of gloves, adjusted Resident #55's bed cover, picked up the trash bags containing the dirty washcloth and soiled brief, pulled both gloves down over the top of the trash bags, opened Resident #55's door, walked down the hall, opened the soiled utility door and placed the trash bags in the soiled utility room, walked back down the hall, and used hand sanitizer. NA #1 did not remove his gloves and perform hand hygiene after removing stool and before applying barrier cream to Resident #55's inner thighs or before fastening Resident #55's brief and pulling down her gown. NA #1 did not perform hand hygiene after removing gloves and before touching Resident #55's overbed table, the doorknob of Resident #55's door, or the doorknob to the soiled utility room. During an interview with NA #1 on 09/27/22 at 03:45 PM he confirmed he did not remove his gloves and perform hand hygiene after removing stool and before applying barrier cream to Resident #55's inner thighs. NA #1 stated he usually cleaned stool first because he often contaminated the washcloth with stool if he cleaned urine away first, and he was not trained to wipe from front to back for female residents. He stated he had not been trained to remove gloves and perform hand hygiene when moving from a dirty task to a clean task, such as removing stool and then applying barrier cream to a resident's inner thighs. NA #1 stated not performing hand hygiene after removing his	F 880	Any staff on leave or PRN staff will be educated prior to returning to work by SDC or Unit Manager. Newly hired staff will be educated by SDC or Unit manager prior to being allowed to work. Facility scheduler and Human Resources Coordinator (HRC) were educated that any new employees will have to be trained by SDC prior to being given their assignment. Criteria-4 Monitoring: An audit tool was developed to monitor compliance and ensure that hand hygiene with donning and doffing of gloves and washing hands with soap and water or use of alcohol-based sanitizer. DON, SDC, or designee will complete audits on 10 nursing staff weekly on all shifts to include weekends. Audits will be completed weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. Results will be reported to the Quality Assurance and Performance Improvement team (QAPI Team) by the DON. The need for further monitoring will be determined by the QAPI team reviewing the audit results. Completion date 11/8/2022	

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 10/05/2022

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 880	Continued From page 47	F 880		

gloves and before touching other items was an oversight.

An interview with the Infection Preventionist on 09/29/2022 at 02:12 PM revealed staff were trained to wipe from front to back during incontinence care for female residents. The Infection Preventionist stated NA #1 should have removed his soiled gloves after cleaning stool, performed hand hygiene, donned a clean pair of gloves, applied barrier cream to Resident #55's inner thighs, removed those gloves, and performed hand hygiene. She also stated staff were trained to perform hand hygiene after removing gloves and before touching other items.

An interview with the Director of Nursing (DON) on 09/29/22 at 04:35 PM revealed NA #1 should have removed his gloves and performed hand hygiene after cleaning stool. She stated NA #1 should have donned a clean pair of gloves to apply barrier cream to Resident #55's inner thighs, removed those gloves, and performed hand hygiene before touching other items in the resident's environment.
An interview with the Administrator on 09/29/22 at 05:35 PM revealed staff should wipe from front to back during incontinence care for female residents. She stated gloves should be removed and hand hygiene should be performed after providing incontinence care and before touching other items in the resident's environment.

2. A continuous observation of Nurse Aide (NA) #1 on 09/27/22 from 03:32 PM to 03:42 PM revealed NA #1 provided incontinence care to Resident #38. With gloved hands NA #1 cleaned stool with a washcloth and placed the washcloth in a trash bag, removed the soiled brief and

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 10/05/2022

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 880	Continued From page 48	F 880		

placed it in a trash bag, applied a clean brief, applied barrier cream to Resident #38's bottom, asked Resident #38 to roll onto her back, cleaned urine with a wash cloth, applied barrier cream, fastened the brief, pulled Resident #38's gown down, removed his gloves, picked up the trash bags containing the dirty wash cloths and soiled brief, pulled back the privacy curtain, and used hand sanitizer.

During an interview with NA #1 on 09/27/22 at 03:45 PM he confirmed he cleaned stool first for Resident #38, applied barrier cream, removed urine, and applied barrier cream while using the same pair of gloves. NA #1 stated he usually cleaned stool first and then urine because he usually contaminated the washcloth with stool if he cleaned urine away first, and he was not trained to wipe from front to back for female residents. He stated he had not been trained to remove gloves and perform hand hygiene after removing stool and before cleaning away urine. NA #1 stated not performing hand hygiene after removing his gloves and before touching other items was an oversight.

An interview with the Infection Preventionist on 09/29/2022 at 02:12 PM revealed staff were trained to wipe from front to back during incontinence care for females. The Infection Preventionist stated NA #1 should have cleaned urine first and then cleaned stool for Resident #38, removed his soiled gloves, performed hand hygiene, donned a clean pair of gloves, applied barrier cream to the front of Resident #38's bottom, applied barrier cream to the rear of Resident #38's bottom, removed those gloves, and performed hand hygiene. She also stated staff were trained to perform hand hygiene after

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 10/05/2022

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 880	Continued From page 49	F 880		

removing gloves and before touching other items.

An interview with the Director of Nursing (DON) on 09/29/22 at 04:35 PM revealed NA #1 should have cleaned urine first and then cleaned stool during incontinence care for Resident #38. She stated after the incontinence care was provided NA #1 should have removed his soiled gloves, performed hand hygiene, donned a clean pair of gloves, applied barrier cream to the front and then rear of Resident #38's bottom, removed his dirty gloves, and performed hand hygiene before touching other items in the resident's environment.

An interview with the Administrator on 09/29/22 at 05:35 PM revealed staff should wipe from front to back during incontinence care for female residents. She stated gloves should be removed and hand hygiene should be performed after providing incontinence care and before touching other items in the resident's environment.