STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING ______ B. WING ______	C 08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 08/18/24 through 08/21/24 . The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZTH511.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted from 08/18/24 through 08/21/24. Event ID# ZTH511. Intakes NC00212352, NC00216267, NC00220218, NC00220399, and NC00210868 were investigated. None of the complaint allegations resulted in a deficiency.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to identify the need for a significant change Minimum Data Set (MDS) for a resident with declines in weight, skin condition and activities of daily living. This was for 1 (Resident	F 637	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This	8/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/03/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 637	Continued From page 1 #37) of 20 residents reviewed for comprehensive MDS completion. The findings included: Resident #37 was admitted on 4/3/23 with Dementia, Diabetes and Congestive Heart Failure. He was diagnosed with Osteomyelitis on 7/25/24. His previous quarterly MDS dated 5/14/24 indicated Resident #37 was not coded for any weight loss, a weight of 220 pounds, no skin conditions, requiring supervision for bed mobility, lying to sit to stand , stand to sit to lying, toileting transfers, ambulation and not coded for the use of a wheelchair. Review of a wound consult note dated 6/12/24 read Resident #37 developed a diabetic ulcer to his right first and second toes. Review of another wound consult note dated 7/24/24 read Resident #37 was diagnosed with Osteomyelitis of his right first and second toes and a midline intravenous catheter was ordered and placed for intravenous antibiotics on 7/26/24. Resident #37 most recent quarterly MDS dated 7/29/24 indicated Resident #37 was coded for unprescribed weight loss, a weight of 207, an infected diabetic foot ulcer, coded for the use of antibiotics, intravenous medications, substantial to maximum assistance with bed mobility, lying to sit and sit to lying, total dependence for sit to stand, stand to sit, toilet transfers, not applicable for ambulation and requiring partial to moderate staff assistant in a wheelchair. An interview was completed on 8/21/24 at 9:40 AM with MDS Nurse #1 who reviewed the areas of change from her 5/14/24 quarterly assessment to the most recent quarterly assessment dated	F 637	Plan of Correction is submitted to meet requirements established by state and federal law. F-637 How did we correct residents affected? Resident #37 had a Significant Change in Status Assessment (SCSA) completed and transmitted on 8-21-24 by Minimum Data Set (MDS) Nurse #1. Resident #37 did not suffer any adverse effects from the alleged deficient practice. How did we ensure no other residents were affected? MDS nurse #1 and MDS nurse #2 completed a 100% audit for all residents to review current status and if those residents met the criteria for a SCSA. A Significant Change in Status MDS is required when: • A resident enrolls in a hospice program; or • A resident changes hospice providers and remains in the facility; or • A resident receiving hospice services discontinues those services; or • A resident experiences a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement, from baseline (as indicated by comparison of the resident's current status to the most recent CMS-required MDS).	

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F 637	Continued From page 2 7/29/24. She stated a significant change MDS should have been completed rather than a quarterly MDS on 7/29/24 and was definitely needed for Resident #37. An interview was completed on 8/21/24 at 10:00 AM with the Administrator. He reviewed the areas of change in Resident #37 and stated a significant change MDS should have already been completed on Resident #37 and he would see that one was started as of today.	F 637	One additional resident met the criteria to complete a SCSA. This was completed and transmitted by MDS nurse #1 on 8-29-24. No resident suffered any adverse effects from the alleged deficient practice. Systems changes The Corporate Reimbursement Manager educated MDS Nurse #1 and MDS Nurse #2 on the requirements for completing a SCSA. This was completed on 8-21-24. The Administrator educated the Interdisciplinary Team, which includes the Director of Nursing (DON), Infection Prevention nurse, Clinical Supervisors, Social Worker, Treatment nurse and MDS nurse 1 and 2 on these requirements. This was completed on 8-30-24 . The Interdisciplinary Team will review residents with criteria that meet the requirements to complete a SCSA, in morning clinical meeting to determine if the resident meets the criteria for a SCSA. Any resident meeting the criteria will have a SCSA completed within 14 days of the change. Monitoring An audit tool was developed which includes the criteria for completing a SCSA. The audit tool will be used to review residents for the following: • Does the resident meet the criteria for the completion of a SCSA? The DON will review 10 residents weekly	

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F 637	Continued From page 3	F 637	for 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will determine the need for further monitoring. QAPI The DON will bring results of the audits to the monthly Quality Assurance and Performance Improvement Committee (QAPI) meeting monthly x 3 months for review and further recommendations. Completed by 8-28-24.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 732		9/6/24

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F 732	Continued From page 4 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to display accurate Posted Nurse Staffing Information for 4 out of 30 days reviewed. The findings included: A review of the Staff Schedule/Assignment Sheet for 07/19/24 revealed 10 Nursing Assistants (NA)s worked from 7:00 AM until 7:00 PM. A review of the Posted Nurse Staffing for the 7:00 AM-7:00 PM shift on 7/19/24 revealed 11 NAs worked. On 07/21/24 during the 7:00 AM until 7:00 PM shift, the Staff Schedule/Assignment Sheet revealed 8 NAs worked and the Posted Nurse Staffing revealed 10 NAs worked. Additionally, the Staff Schedule/Assignment Sheet revealed 3 Licensed Practical Nurses (LPN)s worked and the Posted Nurse Staffing revealed 4 LPNs worked. The Staff Schedule/Assignment Sheet revealed 1 Registered Nurse (RN) worked and	F 732	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact Exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F732 Resident affected The following daily staffing hours postings were corrected by the Human Resources Coordinator (HRC) for 7-19-24, 7-21-24, 7-22-24 and 7-23-24 on 8-21-24. No resident was adversely affected by the alleged deficiency. Residents with the Potential to be affected On 8-28-24, The Administrator audited	

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F 732 Continued From page 5

the Posted Nurse Staffing revealed 2 RNs worked. During the 7:00 PM until 7:00 AM shift, the Staff Schedule/Assignment Sheet revealed 5 NAs worked and the Posted Nurse Staffing revealed 7 NAs worked. The Staff Schedule/Assignment Sheet revealed 4 LPNs worked and the Posted Nurse Staffing revealed 2 LPNs worked. The Staff Schedule/Assignment Sheet revealed no RN worked and the Posted Nurse Staffing revealed 1 RN worked.

On 07/22/24 during the 7:00 AM until 7:00 PM shift, the Staff Schedule/Assignment Sheet revealed 10 NAs worked and the Posted Nurse Staffing revealed 8 NAs worked. Additionally, the Staff Schedule/Assignment Sheet revealed 2 RNs worked and the Posted Nurse Staffing revealed 1 RN worked. During the 7:00 PM until 7:00 AM shift, the Staff Schedule/Assignment Sheet revealed 7 NAs worked and Posted Nurse Staffing revealed 6 NAs worked, and the Staff Schedule/Assignment Sheet revealed 1 RN worked and Posted Nurse Staffing revealed 2 RNs worked.

On 07/23/24 during the 7:00 AM until 7:00 PM shift, the Staff Schedule/Assignment Sheet revealed 8 NAs worked and the Posted Nurse Staffing revealed 11 NAs worked. The Staff Schedule/Assignment Sheet revealed 4 LPNs worked and the Posted Nurse Staffing revealed 3 LPNs worked. The Staff Schedule/Assignment Sheet revealed 1 RN worked and the Posted Nurse.

Staffing revealed 2 RNs worked. During the 7:00 PM until 7:00 AM shift, the Staff Schedule/Assignment Sheet revealed 6 NAs worked and the Posted Nurse Staffing revealed 5

F 732

100% of the daily staffing hours postings from 07-1-24 through 8-28-24 to ensure that the postings accurately reflected actual staff working in the facility on those dates No other staffing sheets needed to be corrected. No resident was affected by the alleged deficient practice.

Systemic Changes

The HRC was educated by the Administrator on the process for completing and posting daily staffing hours. This was completed on 8-21-24.

The HRC and/or Administrator will educate all licensed nurses on the process for posting the daily staffing hours to ensure that the postings are accurate and reflect the staff working in the facility on the day of the posting. This education will be completed by 9-6-24. Any licensed nursing staff out on leave or PRN status will be educated by the HRC or designee prior to returning to duty. Any newly hired licensed nursing staff will be educated by the HRC or designee during orientation. HRC will be responsible Monday – Friday and the 100 hall nurse will be responsible for Saturday and Sunday to keep staffing hours current and posted. If the HRC is on leave then the 100 hall nurse will be responsible for updating the posted staffing hours.

Monitoring

An audit tool was developed and included the following:

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F 732	Continued From page 6 NAs worked. The assignment sheet revealed 3 LPNs worked and the Posted Nurse Staffing revealed 2 LPNs worked. The Staff Schedule/Assignment Sheet revealed no RN worked and the Posted Nurse Staffing revealed 2 RNs worked. An interview on 08/21/24 at 8:59 AM was conducted with the Human Resource Coordinator. She stated she was responsible for completing the daily staff posting sheet based on the actual working assignment sheet for the day and posting them in a viewable area. She verified that the number of licensed and unlicensed staff and the total hours worked for licensed and unlicensed staff were incorrect for 4 out of 30 days. She verified staffing sheets for 7/19/24, 7/21/24, 7/22/24 and 7/23/24 did not match the staff posting sheets. She then stated for the staffing sheet on 07/19/24 an unlicensed staff was counted twice which made the count incorrect. She explained it appeared on 07/21/24 and 07/22/24 she got the dates mixed up which resulted in the number of licensed and unlicensed staff and the total hours worked to be incorrect. She verified the staff posting sheets compared to the assignment sheets for 07/23/24 did not match and stated she was not sure what happened and why the count was incorrect. An interview was conducted on 08/21/24 at 8:39 AM with the Administrator. He stated he expected the daily nurse staff sheets, and the assignment sheets should accurately reflect the correct number of staff working.	F 732	• Are the posted daily staffing hours accurate? The Administrator will audit 25% of the daily staffing hours postings weekly x 4 weeks, then monthly x 2 months. The results of these audits will determine the need for further monitoring. This audit started on 8-28-24. All results will be brought to our monthly Quality Assurance by and Performance Improvement Committee meeting monthly x 3 months by the Administrator. Completion Date: 9-6-24	