DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-WILMINGTON, INC	**2305 SILVER STREAM LANE WILMINGTON, NC 28401**

(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 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted from 9/17/24 through 9/19/24. Event ID# 1WQU11. The following intakes were investigated: NC00216118, NC00216160, NC00216905, NC00216917, NC00216999, NC00220175, NC0021936, NC00222060. 2 of 9 complaint allegations resulted in a deficiency.	F 000		
F 684 SS=D	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 record review, and staff and Nurse Practitioner interviews the facility failed to assess Resident #4 before transferring her back to bed after she was found on the floor for 1 of 2 residents reviewed for falls. The findings included: Resident #4 was admitted to the facility on 08/20/21. Resident #4's diagnoses included Alzheimer's disease, anxiety, failure to thrive, and cerebrovascular disease.	F 684	483.25 Quality of Care This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. Affected Resident	10/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/02/2024

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 684

Continued From page 1

The quarterly Minimum Data Set (MDS) dated 08/21/24 revealed that Resident #4 had severe cognitive impairment and required one-person supervision with transfers. There were behaviors and rejection of care noted during the assessment reference period. There was also a history of falls since admission to the facility. The MDS also revealed that Resident #4 had a prognosis of less than 6-months to live and received Hospice care.

Resident #4's Medication Administration Record dated 04/2024 revealed the resident was only receiving one medication, Tylenol 500-milligrams three times a day.

Review of an initial allegation report dated 04/17/24 at 1:20 PM read, staff reported Resident #4 was observed in bed with a hematoma over right eye, an injury of unknown origin. The resident was not interviewable. The facility staff-initiated skin checks and interviews for residents on the same wing. Staff interviews were initiated. The resident appeared at baseline currently and will be monitored for any negative outcomes. The initial allegation report was completed by Former Administrator #1.

A handwritten statement from NA #2 read in part, "On 04/17/2024 at 6:30 AM., I found resident #4 on the floor on her mat. She didn't seem hurt, but I placed her up and placed her back on the bed. I changed her and put the bed at the lowest position." The statement was signed by NA #2.

A phone interview was conducted on 09/17/24 at 9:57 AM with Nurse Aide (NA) #2. NA #2 confirmed that she was working the night 11:00

F 684

Certified Nursing Assistant (CNA) #2 was terminated from employment on 05/01/2024 after the facility conducted an investigation into Resident #4 fall on 04/17/2024. CNA #2 failed to notify the nurse that the resident had fallen, therefore, the resident was not immediately assessed by the nurse. The resident remains in the facility and has not suffered any continued adverse effects related to the alleged deficient practice.

Other Residents with potential to be affected

The Director of Nursing (DON)/designee will review all falls that have occurred in the last 30 days to ensure that the residents were evaluated by a licensed nurse prior to being moved after the fall. This will be completed by 10/4/2024. Any staff who have not complied with this process will be educated and/or disciplined.

Systemic Changes

The Director of Nursing/designee will educate all CNA�s on the requirement that any a nurse will be notified of any resident fall prior to the CNA moving the resident so that the resident can be assessed. This will be completed by 10/4/2024. Any CNA out on leave or PRN status will be educated on this prior to returning to duty by the DON/designee. This education is part of the education provided during orientation to all CNA�s

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F 684	Continued From page 2 PM to 7:00 AM shift on 04/16/24. She stated she was walking past Resident #4's room and found her lying flat on the floor on her fall mat. NA #2 stated she was exhausted that night, and normally would have requested assistance from the nurse but instead she lowered resident's bed and put the resident back in bed. NA #2 stated the resident did not appear to be injured or in any pain. NA #2 stated she should have gone to get the nurse to assess the resident before putting her back to bed and was fired for it. An interview was conducted on 09/17/24 at 1:30 PM with Nurse #1. He confirmed that he was working the day shift on 04/17/24. He stated NA #3 approached him about something. It was reported to him that Resident #4 had a hematoma above her eye, and that NA #2 got her back into the bed without being assessed. Nurse #1 stated that it was not reported to him that Resident #4 had fallen until after NA #2 had transferred her back to bed. He stated when he found out he did go and fully assess Resident #4 for injuries, completed neuro-check, and range of motion but could not identify any other injuries sustained from the fall, except for the hematoma above the resident's eye. After the assessment, Nurse #1 stated he notified the Medical Director (MD)/Physician Assistant (PA), Administrator, Director of Nursing (DON), and resident's Responsible Party (RP). A handwritten statement from NA #3 read in part, "I entered Resident #4's room to perform patient care, and noticed a knot on patient's forehead. I notified my nurse and nurse manager." The statement was signed by NA #3. An interview was conducted on 09/18/24 at 9:53	F 684	by the Staff Development Coordinator/designee. Monitoring An audit tool was developed that includes the following: ¿ Was the resident assessed by a licensed nurse prior to staff moving the resident or transferring the resident to bed or chair? The Director of Nursing/designee will audit 10% of all resident falls weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will be brought to the monthly Quality Assurance and Performance Improvement Committee meeting by the DON for review and further recommendations. Date of Completion: October 4, 2024	

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F 684	Continued From page 3 AM with NA #3. NA #3 confirmed that she was working the 7:00 to 3:00 PM day shift on 04/17/24. NA #3 stated she recalled that while making her morning rounds of her residents on the 200-hall, she observed Resident #4 lying in bed with a goose-egg hematoma over her left eye. She said she reported it to Nurse #1 who came, assessed the resident, and notified the Physician Assistant (PA) to also assess, which she did. NA #3 stated the resident did not appear in pain and ate well that morning. NA #3 stated the resident was a one-person assist with transfers, and could pivot and transfer with one NA. NA #3 stated during morning report, before making her rounds NA #2 never mentioned Resident #4 had a fall or injury. An interview was conducted on 09/18/24 at 9:50 AM with the Director of Nursing (DON) and the Corporate Consultant. The DON stated when a resident had a fall they have to be assessed by a nurse before being moved. The NAs should never get anyone up including Resident #4 without an assessment from the nurse. Once the nurse assessed the resident and deemed it safe to move the resident then the resident can be assisted back to bed or chair. They both stated that any resident that had a fall should be assessed by a nurse for injury before being moved. An interview was conducted on 09/18/24 at 12:45 PM with the Physician Assistant (PA). She stated that any resident that had a fall should be assessed by a nurse for injury before being moved. An interview was conducted on 09/19/24 at 1:15 PM with the Administrator. She stated that any	F 684		

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F 684	Continued From page 4 resident that had a fall should be assessed by a nurse for injury before being moved.	F 684		