JUN 27 2012

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED ÓMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345429	B. WING		C 06/08/2012
	ROVIDER OR SUPPLIER		80	EET ADDRESS, CITY, STATE, ZIP CODE 01 PINEHURSTAVENUE ARTHAGE, NC 28327	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 241 SS=D	The facility must pror manner and in an entendence each reside full recognition of his.  This REQUIREMENT by:  Based on observation record reviews the faresidents (residents with a dignified dining by staff standing over the residents in 2 of 2 and main dining room (resident #104) unatted dining room behind the end of the room reating and/or being for Findings Include:  1. Resident # 104's resident had diagnost Dementia, Parkinson Adult Failure to Thriv Care Plan dated 05/6 had Activities of Daily included, "At risk for The resident's Care "Encourage oral inta Monitor and record for physician and family The resident's annual documented the residentively impairment."	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.  T is not met as evidenced ons, staff interviews, and cility failed to provide 4 #64, #77, #114, and #50) gexperience as evidenced of four residents while feeding 2 dining areas (Restorative ons) and leaving 1 resident ended in the restorative one he meal tray transport cart at while other residents were ed.  Individuality.  Individuali	F 241	Filing the Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.  Residents 104, 64, 77, 50 and 114 were all assessed by the DON for any issues that may have been a result of findings of surveyor's observations. No resident was found to be affected as a result of the dining experience that was observed by the surveyor.	6/18  (X6) DATE

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.

If continuation sheet Page 1 of 18

Facility ID: 923405

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION	(X3) DATE SUR COMPLETI	
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		345429	B. WING		06/0	3/2012
	ROVIDER OR SUPPLIER SOURCES - PINELAKE		8	REET ADDRESS, CITY, STATE, ZIP CODE 01 PINEHURST AVENUE CARTHAGE, NC 28327		
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F 241	independently with se resident's ADL Flow Sthe resident needed a review of the resident program notes (May 2 ate on average of 25% verbal cueing during dost 13.57 pounds in the 05/14/2012.  On 06/05/2012 at 12: observation of resident she was observed seend of the restorative tray transport cart out from the table where was observed already 10 minutes.  On 06/05/2012 at 12: asked if she had eate unaware that it was luthe restorative dining.  On 06/05/2012 at 12: conducted with NA #2 resident #104 was no other residents and huncovered and getting "Resident #104 alway table." After the interibring resident #104 to began to eat her lunc after the other resident #64's mediant with the second of the resident #104 to began to eat her lunc after the other resident #64's mediant with the second of the resident with the resident with the second of the resident with the resident	st up only. A review of the Sheet for May 2012 indicated assistance with meals. A state of section of each meal and needed dining as the resident had the ninety days preceding.  15 p.m., a continuous of the dining room behind the food of view of NA #2 and away the runtouched lunch meal of uncovered for more than a uncovered for more than a uncovered for more than a the table eating with the er lunch meal being goold. NA #2 stated, as moves away from the view NA #2 was observed to the table and the resident the meal - forty-five minutes of the swhich included Dementia.	F 241	Subsequently, all residents were immediately assessed for residual effects as a result of dining techniques. The DON, Administrator and Dietary Manager were responsible for assessing each resident in the process of dining to determine that no issues were related to each resident's dining experience.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		345429	B. WING_		06/08/2012
	NOVIDER OR SUPPLIER SOURCES - PINELAKE			REET ADDRESS, CITY, STATE, ZIP CODE 801 PINEHURST AVENUE CARTHAGE, NC 28327	
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F 241	resident's Care Plan or resident had Activities deficits with, "Decreat related to - impaired of left wrist, and impaire resident's quarterly M dated 04/20/2012 dochaving severe cogniticable to eat independed On 06/05/2012 a commade of the restorative 12:05 p.m. and 12:15 doorway/hall. There assistant (NA #2) obsidining room attending was observed to rotal resident #64 and two observed to feed sev #64 while standing or rotating to the next recontinuous observationside the restorative was observed to conserved to conserved bites of food the resident before roat 12:20 p.m. an add the restorative dining #2 at which time the each of the three resfeed the residents.  On 06/05/2012 at 12 conducted with NA # while feeding resider we are not supposed we stand up but I was	dated 04/25/12 revealed the s of Daily Living (ADL) sed ability to feed self cognition, contractures of the d decision making." The linimum Data Set (MDS) cumented the resident as we impairment and being ently with food set up only.  Itinuous observation was we dining room between p.m. from the dining room's was one restorative nursing served in the restorative to ten residents. NA #2	F 24	Staff from all Departments, to include Restorative Feeding Team, nursing, administration, housekeeping, laundry and environmental services have been educated on aspects of resident dignity to include proper dining techniques. The education provided included the importance of sitting with the resident while eating, not standing over the resident, timeliness of assistance to ensure meal served at correct temperature as well as staff to report to dining room in a timely manner.	

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			A. BUILDING		С	
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F 241	of Nursing (DON) was expectation of facility DON stated, "It is my next to the resident, n resident, while feeding	is off today."  5 a.m. the facility's Director interviewed concerning her staff feeding residents. The expectation that all staff sit ot stand next to the g the residents.	F 241	In addition, an audit tool was created by the DON which includes dining observations for residents. Each resident will be observed on a weekly basis for the next 90 days, and random, thereafter by either the DON, Administrative		
	resident had diagnose with left side paralysis Care Plan dated 2/10, had Activities of Daily "Self care deficit, need drinking, leaves more to - impaired cognition making ability. The integration care plan included, "P The resident's unsches 02/22/2012 document severely cognitively in extensive one person	ed the resident as being opaired and to need		nurses, Administrator or Dietary Manager. Audits will be discussed in morning administrative meetings and weekly administrative nurses meetings to ensure continued compliance. Any adverse observations will be addressed immediately with the individual staff member associated with such findings. In		tis pir pistorio in giri piete proposata del pistorio accesso.
	made of the restorative 12:05 p.m. and 12:15 doorway/hall. There wassistant (NA #2) obsidining room attending was observed to feed resident #77 while state before rotating to the interest of the continuous observinside the restorative was observed to continuous observed to c	e dining room between p.m. from the dining room's vas one restorative nursing erved in the restorative to ten residents. NA #2 several bites of food to nding over the resident next resident. At 12:15 p.m. ration was continued from dining room where NA #2 nue to feed resident #77 t a time while standing over		addition, the audits will be reviewed in our next QA meeting.		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I'''			TED
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the resident before ro At 12:20 p.m. an add the restorative dining #2 at which time the each of the three resifeed the residents.  On 06/05/2012 at 12: conducted with NA #: while feeding resident we are not supposed we stand up but I was done as I am the only that is usually in here.  On 06/08/2012 at 7:4 of Nursing (DON) was expectation of facility DON stated, "It is my next to the resident, it resident, while feeding the resident, while feeding the resident had diagnoss Lack of Coordination the resident's Care Prevealed the resident (ADL) deficits indicat for imbalanced nutritirequirements." The incare plan included, "It is an into small bite size pinguarterly MDS dated	stating to the next resident. itional staff member entered room and spoke to the NA NA #2 started sitting next to dents while continuing to  45 p.m. an interview was 2 regarding her standing t #77. NA #2 stated, "I know to feed the residents while s trying to get everything one in here, the other girles off today."  5 a.m. the facility's Director interviewed concerning her staff feeding residents. The expectation that all staff site not stand next to the girles the residents.  medical record indicated the es which included Syncope, and Dementia. A review of lan dated 03/20/2012 thad Activities of Daily Living ing the resident was, "At risk on - less than body interventions listed on the Staff to encourage resident mall portions, and cut food eces." The resident's 03/30/12 indicated the	F 24			
	Continued From page the resident before ro At 12:20 p.m. an add the restorative dining #2 at which time the leach of the three resifeed the residents.  On 06/05/2012 at 12: conducted with NA #3 while feeding resident we are not supposed we stand up but I was done as I am the only that is usually in here.  On 06/08/2012 at 7:4 of Nursing (DON) was expectation of facility DON stated, "It is my next to the resident, in resident, while feeding.  4. Resident #114's m resident, while feeding that diagnoss Lack of Coordination the resident's Care Prevealed the resident (ADL) deficits indicat for imbalanced nutriti requirements." The if care plan included, "It is my to eat, offer food in sinto small bite size pid quarterly MDS dated resident as being, "Sand needing, Total as a sinto small page in the size pid quarterly MDS dated resident as being, "Sand needing, Total as a size pid to the size pid quarterly MDS dated resident as being, "Sand needing, Total as a size pid to the size pid quarterly MDS dated resident as being, "Sand needing, Total as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid quarterly MDS dated resident as pid to the size pid to the siz	CONTINUED ROUNDER OF SUPPLIER  SOURCES - PINELAKE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 the resident before rotating to the next resident. At 12:20 p.m. an additional staff member entered the restorative dining room and spoke to the NA #2 at which time the NA #2 started sitting next to each of the three residents while continuing to feed the residents.  On 06/05/2012 at 12:45 p.m. an interview was conducted with NA #2 regarding her standing while feeding resident #77. NA #2 stated, "I know we are not supposed to feed the residents while we stand up but I was trying to get everything done as I am the only one in here, the other girl that is usually in here is off today."  On 06/08/2012 at 7:45 a.m. the facility's Director of Nursing (DON) was interviewed concerning her expectation of facility staff feeding residents. The DON stated, "It is my expectation that all staff sit next to the resident, not stand next to the resident, while feeding the residents.  4. Resident #114's medical record indicated the resident had diagnoses which included Syncope, Lack of Coordination, and Dementia. A review of the resident's Care Plan dated 03/20/2012 revealed the resident had Activities of Daily Living (ADL) deficits indicating the resident was, "At risk for imbalanced nutrition - less than body requirements." The interventions listed on the care plan included, "Staff to encourage resident to eat, offer food in small portions, and cut food into small bite size pieces." The resident's quarterly MDS dated 03/30/12 indicated the resident as being, "Severely cognitively impaired, and needing, Total assistance via one person	CORRECTION  A BUILDI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 the resident before rotating to the next resident. At 12:20 p.m. an additional staff member entered the restorative dining room and spoke to the NA #2 at which time the NA #2 started sitting next to each of the three residents while continuing to feed the residents.  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	Continued From page On 06/05/2012 a con made of the restoratir 12:05 p.m. and 12:15 doorway/hall. There assistant (NA #2) obs dining room attending was observed to feed resident #114 while is before rotating to the p.m. the continuous of from inside the restor #2 was observed to of #114 several bites of standing over the resident. At 12: member entered the spoke to the NA #2 a started sitting next to one at a time while of residents.  On 06/05/2012 at 12 conducted with NA # while feeding resident know we are not sup while we stand up be everything done as 1	tinuous observation was ve dining room between of p.m. from the dining room's was one restorative nursing served in the restorative g to ten residents. NA #2 of several bites of food to standing over the resident next resident. At 12:15 observation was continued rative dining room where NA continue to feed resident food at a time while sident before rotating to the 20 p.m. an additional staff restorative dining room and at which time the NA #2 of each of the three residents, ontinuing to feed the		CROSS-REFERENCED TO		
	of Nursing (DON) we expectation of facility DON stated, "It is my	45 a.m. the facility's Director as interviewed concerning her a staff feeding residents. The sy expectation that all staff sit not stand next to the ang the residents.				

STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		CONSTRUCTION	COMPLE	TED
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F 241	diagnoses which incomplete Alzheimer's, Dementhrive, Muscle weak Coordination. A revelor plan initially dated 0 resident had Activitic deficits with eating, nutrition - less than Care Plan Interventional intake of foods food intake, Monitor malnutrition." The mod/30/12 documente "Severely cognitivel "Limited assistance  On 06/05/2012 at 12 continuous observation was observed stand the resident. At 12: observation was codining room to continuous observed the resident. At 12: observation was codining room to continuous plant the mode of the Microsoft of the Microsoft of the Microsoft observation.  On 06/05/2012 at 12:57 Nursing (DON) was room and tell the Microsoft observation.  On 06/05/2012 at 1 conducted with the coordinator stated, here, I am an old his would stand all the	s admitted to the facility with luded Parkinson's, tia, Syncope, Failure to ness, and Lack of iew of resident # 50's Care 3/01/2012 revealed the es of Daily Living (ADL) "At risk for imbalanced body requirements." The ons included, "Encourage fluids, Monitor and record for signs and symptoms of esident's quarterly MDS dated ed the resident as being, y impaired," and needing, via one person for eating."	F	241			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		HITTO	E CONSTRUCTION	(X3) DATE SURV	EY
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E POMOTION	COMPLETE	
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		345429	B. Wil	IG		06/08/	2012
NAME OF PR	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RES	SOURCES - PINELAKE				1 PINEHURSTAVENUE ARTHAGE, NC 28327		
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F 241	Continued From pag		F	241			
	residents, I didn't kno	ow that."		ĺ			
F 312 SS=D	was interviewed con- staff feeding resident expectation that all s not stand next to the residents. I had to to down when she was main dining room who lunch meal."	A5 a.m. the facility's DON cerning her expectation of ts. The DON stated, "It is my taff sit next to the resident, resident, while feeding the ell the MDS coordinator to sit feeding the resident in the nen you were observing the ARE PROVIDED FOR DENTS	F	312	Resident #36 nails were cleaned and trimmed on		6/18
	daily living receives	able to carry out activities of the necessary services to ion, grooming, and personal			6-8-12. The resident was assessed at that time for any residual effects of nails not being trimmed.		
	by: Based on observation interview and record	IT is not met as evidenced on, resident and staff I review, the facility failed to of 3 residents (Resident ncluded:			An Audit/ Resident observation was done on 100% of resident by administrative nurses and the DON and nails were trimmed and cleaned if indicated.		
	Resident #36 was la 6/22/09. Cumulative hemiplegia.	ast readmitted to the facility on ediagnoses included					
	(MDS), a quarterly of the had moderate correlect care and was	trecent Minimum Data Set dated 5/10/12, indicated that ognitive impairment, did not totally dependent on staff for dis care plan, dated 5/20/12, self care deficit and					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	S FOR MEDICARE & N	MEDICAID SERVICES				T T	. 0930-0391
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	ULTIPE LDING	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
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PEAK RES	OURCES - PINELAKE				M PINEHURSTAVENUE ARTHAGE, NC 28327		
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F 312	Continued From page approaches included daily living.  On 6/6/12 at 10:15 Al observed with long fir On 6/8/12 at 3:28 PM observed with long fir 3/16 of an inch beyon this time the resident fingernails and he stabeing so long; they no #2 stated that nail trin of the nursing assistaresident had diabetes NA's did weekly skin days and nails should Nurse #2 indicated the NA's to inform her of observed Resident # they should be trimm A "Skin Audit" form, 6/6/12, indicated that	total care for all activities of  M, Resident #36 was agernails.  Resident #36 was again agernails, extending 1/8 to ad the tips of his fingers. At was asked about his ated he did not like them eeded to be cut.  In 6/8/12 at 3:30 PM, Nurse mming was the responsibility ants (NA's) unless the audits on residents' shower d be trimmed then if needed. at she depended on the any problems. Nurse #2 36's fingernails and indicated ed.  completed by NA #1, dated a Resident #36 refused his aluded a section entitled	F	312	Staff education was provided by the SDC and DON to include importance of proper nail hygiene and trimming. Staff were educated on their roles in providing nail care. Further education was provided on importance of accuracy on skin audit sheets.  The DON developed an audit tool to track nail care and grooming in the facility. An audit will be done weekly for 90 days and then randomly thereafter by either the DON, Administrative Nurses and Administrator to ensure compliance. The audits will be discussed daily in		
i	"Toenails/Fingernails	need attention?Yes			morning administrative meetings and weekly in		
	No ". The line for was also signed by N	'No" was checked. The form lurse #3.			Administrative Nurses		
		ble to be interviewed.			meetings		
	#3 indicated she sign	on 6/8/12 at 3:45 PM, Nurse ned the form to acknowledge ade aware that Resident #36 ver.					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	MEDIOADE 0 1	MEDICAID SERVICES					). 0938-039
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A, BUIL			C	
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PEAK RES	OURCES - PINELAKE				ARTHAGE, NC 28327		
LATER			T 15	1	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD 8E	COMPLETION DATE
					Adverse findings will be		
F 312	Continued From page	e 9	F	312	discussed with the		
				1	employee assigned and		
	On 6/8/12 at 3:57 PM	1, Nurse #2 indicated that	1		corrected immediately.		
	she trimmed Resider	nt #36's naiis.			In addition the audits will		
	During an interview o	on 6/8/12 at 4:05 PM, the			be reviewed in our next		
	Director of Nursing (	DON) indicated she expected			QA meeting.		
	the NA's to trim nails	on shower days if needed.			con meeting.		- 10
F 328	483.25(k) TREATME	NT/CARE FOR SPECIAL	ļ Ē	328			7/3
SS≃D	1				Resident #159 was		
		that racidants receive			assessed by DON and		
	The facility must ens	ure that residents receive d care for the following			MDS nurse for any		
	special services:	y dato to talle tollers.			residual effects of		
	Injections;				improper technique, and		
	Parenteral and enter	ral fluids;			it was determined that		
		tomy, or ileostomy care;			there was no adverse		
	Tracheostomy care;				effect to the resident.		
	Tracheal suctioning; Respiratory care;	•			An audit tool was		
	Foot care; and				i ·		
	Prostheses.		į.		developed and		
			1		completed on all		
		IT is and mot on ovidenced			residents with IV medications to check for		
	1	IT is not met as evidenced			1		
	by:	ion, staff interview and			proper technique.		
	manufacturer specif	fications, the facility failed to			One to one education		-
	remove a foil seal for	om the set port on an			was completed with the		1
1	intravenous (IV) me	dication bag prior to inserting			nurse involved to include		
	the IV administratio	n set for 1 of 2 residents	ļ		following manufacturer's		
	(Resident #159). Th	ne findings included:	1		guidelines for		
	Manufacturer speci	fications for "cefazolin for			adminstation of IV		
	injection" (an antibi	otic for IV administration) read			medications. In addition		
	in part "Using asec	otic technique, peel foil cover			the nursing staff has		
	from the set port ar	nd attach sterile administration			been educated on the		
	set."				been engineed on the		
1							

STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPL	E CONSTRUCTION	(X3) DATE SUR	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		c	,
		345429	B. WIN	G		06/08	3/2012
	OVIDER OR SUPPLIER			80	EET ADDRESS, CITY, STATE, ZIP CODE 1 PINEHURST AVENUE ARTHAGE, NC 28327		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 328	preparing to administ #159. The cefazolin wo fillutent in an IV be 30 minutes. The nurse spike of the IV administed covering the set IV tubing with the cell bag.  During an interview of Staff Development Of the foil seal on the IV prior to inserting the During an interview of Director of Nursing (I expected the nurse the inserting the IV set.  During an interview of #1 stated that the type came in was new to explained that the spenetrated the foil senecessary to remove that she now knew the 483.25(n) INFLUEN. IMMUNIZATIONS  The facility must devite the tensure that	M, Nurse #1 was observed the cefazolin IV to Resident was mixed with 50 milliliters and to be administered over see was observed to insert the distration set through the foil port of the IV bag, prime the fazolin solution, and hang the second form of the IV bag, prime the fazolin solution, and hang the second form of the IV bag should be peeled off IV set.  In 6/8/12 at 4:05 PM, the poor of IV bag the cefazolin the facility. The nurse poe of IV bag the cefazolin the facility. The nurse peel and she did not believe it the foil. Nurse #1 added to remove the foil seal.  IZA AND PNEUMOCOCCAL relop policies and procedures the influenza immunization, a resident's legal ves education regarding the all side effects of the		328	manufactuer's recommendation for the duplex drug delivery system. The facility has scheduled an educational in-service on July 1 <sup>st</sup> and 2 <sup>nd</sup> , 2012 with the Pharmacy consulting RN on infusion equipment update.  An audit tool was developed by the DON to monitor for usage of appropriate technique with IV medication administration. The audit will be done by the administrative nurses weekly for 90 days then randomly thereafter. The findings will be discussed in daily administration meetings and weekly in administrative nurses meeting. Any inconsistencies will be addressed immediately with the Nurses involved. In addition the audits sheets will be reviewed at our next QA meeting.		6/25
	(ii) Each resident is	offered an influenza					

STATEMENT O	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MOLTIPLE CONSTRUCTION COM		(X3) DATE SU COMPLE						
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			) c			
		345429	B. WIN	G	06/08/2012				
	OVIDER OR SUPPLIER			80	ET ADDRESS, CITY, STATE, ZIP CODE 1 PINEHURSTAVENUE ARTHAGE, NC 28327				
FLARTIC	_			L	PROVIDER'S PLAN OF CORRECT	спои	(X5)		
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	)ULD BE	COMPLETION DATE		
				334	F 334				
F 334	Continued From pag		F	334					
	immunization Octobe	er 1 through March 31	1						
	annually, unless the	immunization is medically e resident has already been			D. d.l. at #7-and real-deast				
1	immunized during th	is time period;			Resident #7and resident #14 has been educated				
	(iii) The resident or t	he resident's legal							
	representative has t	he opportunity to refuse			regarding the potential side effects of the				
	immunization; and				side effects of the influenza vaccine on				
	(iv) The resident's m	nedical record includes							
		indicates, at a minimum, the			6/25/2011. This is documented in resident				
	following: (A) That the resident or resident's legal			'					
	representative was t	provided education regarding			#7 and #14 medical		ļ		
	the benefits and pot	ential side effects of influenza			record.				
	immunization; and				An audit tool was		1		
	(B) That the reside	nt either received the			developed and				
	influenza immunizat	tion or did not receive the			completed for all current				
	contraindications or				residents who received				
	COHERINGICATIONS OF	Tordoui			the influenza vaccine for				
	The facility must de	velop policies and procedures			the 2011-2012 flu season				
i	that ensure that				addressing influenza				
	(i) Before offering the	ne pneumococcal			education.				
	immunization, each	resident, or the resident's							
	legal representative	receives education regarding tential side effects of the			Staff have been in-				
	immunization;	territar side sineste et int			, serviced on importance				
	(iii) Each resident is	offered a pneumococcal			of educating				
İ	immunization, unles	ss the immunization is			resident/families on flu				
	medically contraind	icated or the resident has			vaccine. The vaccine log				
ĺ	already been immu	inized;			has been revised for the				
	(iii) The resident or	the opportunity to refuse	l		2012 and for additional				
	immunization; and	the opportunity to release			seasons to include an				
[	(iv) The resident's	medical record includes			area to indicate that				
	documentation that	t indicated, at a minimum, the			education was provided				
	following:				to resident/family. The				
	(A) That the resid	ent or resident's legal			DON and administrative				
	representative was	provided education regarding			nurses will audit for				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>		С	
		345429	B. WNG		06	/08/2012	
	OVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 101 PINEHURSTAVENUE CARTHAGE, NC 28327			
(X4) ID PREFIX TAG	(FACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 334	pneumococcal immuthe pneumococcal in contraindication or re (v) As an alternative, and practitioner reconneumococcal immuyears following the firmunization, unless	ential side effects of inization; and int either received the inization or did not receive inmunization due to medical efusal. in based on an assessment immendation, a second inization may be given after 5 irst pneumococcal is medically contraindicated or esident's legal representative	F 334	compliance during the flu season. Any issues will be addressed immediately. We will discuss findings of audits in weekly administrative nurses meeting during the flu season. The audits will be reviewed in our scheduled QA meeting during that time period as well.			
	by: Based on staff inter the facility failed to o vaccination education residents (Resident Findings included: Review of the facility Vaccine revised Nov part, "8. Family an on admission regard 1. Review of the im Resident #7 reveale vaccine on 12/22 (n 10/15/11. Review of the Influe Consent for Reside	view and document review document provision influenza on annually for 2 of 5 #7 and Resident #14).  If policy titled Influenza vember 2008 revealed, in defend will be educated ding influenza vaccine. "  munization record for and she received the influenza o year noted) and on the province of the province of the province of the influenza o year noted and on the province of the pro					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ALM OF THE CARE	MEDICAID SERVICES					O. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIF		IDENTIFICATION NUMBER:		LDING			С
		345429	B. WIN	.G		06	08/2012
	OVIDER OR SUPPLIER	340429		8	EET ADDRESS, CITY, STATE, ZIP CODE 01 PINEHURST AVENUE CARTHAGE, NC 28327		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 334	arm; slight fever (occ aches (occasionally) the Responsible Par the section that read representative), the of resident), who is not this facility, hereby facility to administer annually in the fall (0.31st). "Documentate ducation prior to revaccine dose was not record.  Interview with the Si (SDC) on 6/8/12 at a mails the most curres Statement (VIS) on Responsible party a information in the VI However, she state provision of this edu or anywhere else. Or not the vaccine with documented in the Immunization Recoresident of RP refusitheir mind and wan year, the Informed otherwise the Information at admission. The think the regulation documentation of immedical record.	of the arm; redness of the casionally); and muscle ." The form was signed by ty and dated 10/6/10 under, in part, "I (name of responsible party for (name my (relationship) and resident y give my permission for the an influenza vaccination of the an influenza vaccination of provision of influenza ceipt of the 2011 influenza of present on the medical caff Development Coordinator 4:30 PM revealed that she cant Vaccine Information influenza vaccine to the mol/or discusses the ISD with the resident annually. It that she did not document the SDC added that whether was given annually was medical record on the rd. She also stated that if a sed previously but changed the the vaccine the following Consent form was redone but med consent was only signed SDC indicated that she did not	F	334			
	Interview with the A revealed that it was	Administrator on 6/8/12 at 5 PM s his understanding the facility			Facility ID: 923405	If continuation	sheet Page 14 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345429					; 3/2012
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - PINELAKE				801 PI	ADDRESS, CITY, STATE, ZIP CODE INEHURST AVENUE I'HAGE, NC 28327		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>(</b>	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 334	requirements for influ according to the regular according to the immediate waccine on 10/5/09 and Review of the Influent Consent for Resident side effects of influent discomfort; soreness arm; slight fever (occaches (occasionally)), the resident and date that read, in part, "I permission for the facinfluenza vaccination 1st through March 31 provision of influenza vacon the medical recording the 2011 influenza vacon the medical recording the most current Statement (VIS) on in Responsible party an information in the VIS However, she stated provision of this education of the vaccine was documented in the milmunization Recording in the MRP refuse their mind and wanted the regular according to the regular according to the refuse their mind and wanted the regular according to the regular acc	incation and documentation enza vaccine correctly lations.  Inunization record for dishe received the influenza and on 10/30/11.  Iza Immunization Informed #14 revealed it listed some za vaccination as: "slight of the arm; redness of the asionally); and muscle "The form was signed by dished 3/24/10 under the section (name of resident) give my cility to administer an annually in the fall (October st). Documentation of education prior to receipt of eccine dose was not present dished.  Iff Development Coordinator and PM revealed that she int Vaccine Information influenza vaccine to the dor discusses the SD with the resident annually. It is that she did not document as given annually was	F3	334			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
PARTE PART OF SOME OF STREET			A BUILDING			С	
		345429	B. WIN	IG		06/0	8/2012
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - PINELAKE				80	EET ADDRESS, CITY, STATE, ZIP CODE 01 PINEHURSTAVENUE ARTHAGE, NC 28327		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 356 SS=C	otherwise the Informer at admission. The SI think the regulations is documentation of influsional medical record.  Interview with the Admirevealed that it was home was following the education of influsional medical recording to the regulation of	ed consent was only signed DC indicated that she did not required annual plants and additional plants. The following information on		334	The daily nursing staffing sheets identified by the surveyors were corrected at that time. The facility reviewed the staffing sheets for the past 6 months and corrected the forms if indicated.  One to one education was provided to the staffing coordinator to ensure understanding of staff that are supposed to be listed on the form. Education was provided on importance of having census on form daily as well. Education was provided to the third		6/18
	make nurse staffing d	n oral or written request, ata available to the public of to exceed the community			shift nurses to write the census on the form when it is changed out daily.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) N A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345429	B. WIN			C 8/2012	
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - PINELAKE				8	REET ADDRESS, CITY, STATE, ZIP CODE 101 PINEHURST AVENUE CARTHAGE, NC 28327		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 356	staffing data for a min required by State law, This REQUIREMENT by: Based on observation facility failed to post a and include the censular findings included: Observations on 6/5/1 "Daily Nursing Depart across from the 100/2 On both aforemention that 4 RN's (registered (licensed practical nur resident care on the 7 census field was bland During an interview of Director of Nursing (Diverted to All nurses treatment nurse, the complete the hall nurses the MDS nurses and the helped the hall nurses tasks, such as inserting device, but did provide majority of their duty to form of 6/8/12 to reflenurse) for the 7-3 shift that no census was rethat the form did not helped the fo	tain the posted daily nurse imum of 18 months, or as whichever is greater.  is not met as evidenced and staff interview, the courate staffing information is on the staff posting. The 2 and 6/8/12 revealed a ment Staffing Form" posted 00/300 hall nurses' station. ed days the form indicated dinurses) and 3 LPN's ress) were providing direct as shift. The resident k on both days.  In 6/8/12 at 5:15 PM, the ON) said that the 3 LPN's The RN's included the unit manager and 2 MDS rurses. The DON added that unit manager sometimes when needed for specificing an intravenous access and intravenous acces an		356	The nursing coordinator will follow up at the beginning of her shift to ensure census is on form and make correction for staffing if indicated. The DON and weekend supervisor will check sheet daily to ensure compliance with standards. Any issues will be addressed immediately. Compliance will be reviewed daily in administrative meetings. In addition we will review compliance at our next QA meeting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		CONSTRUCTION	(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED	
345429			G		06/	C 08/2012	
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - PINELAKE			801 F	TADDRESS, CITY, STATE, ZIP CODE PINEHURST AVENUE ITHAGE, NC 28327	•		
PREFIX (EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES ( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	EACTION SHOULD BE TO THE APPROPRIATE		
member responsib	she would educate the staff	F	356				

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- I	iultipi Ilding	E CONSTRUCTION 01 - BUILDING 0101	(X3) DATE SI COMPLE	
		345429	8. WII	νe		07/0	3/2012
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - PINELAKE				891	ET ADDRESS, CITY, STATE, ZIP CODE PINEHURST AVENUE RTHAGE, NG 28327		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	This Life Safety Co conducted as per T at 42 CFR 483.70(a Health Care section publications, This b construction, and is	ode (LSC) survey was The Code of Federal Register a); using the 2000 Existing n of the LSC and its referenced building is Type V protected s utilizing Delayed Egress The facility is equipped with an	K	000			·
K 062 SS=E	Required automatic continuously maint condition and are in	3.70 (a) AFETY CODE STANDARD C sprinkler systems are ained in reliable operating aspected and tested 7.6, 4.6.12, NFPA 13, NFPA	K	062	Filing the plan of correction does not constitute and omission that the deficiencie alleged did in fact exist. This plan of correction is filled as ouldence of the facilities desi		8/10/2012
	This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/3/2012 The sprinkler heads installed in room 108 were a mix of a quick response head and a standard fused head, Actual NFPA Standard: NFPA 13,6-3,1.5.2  CFR#: 42 CFR 483.70 (a)				evidence of the facilities desire to comply with the requirements and to continue to provide high quality of care.  Environmental Services Director immediately contacted the sprinkler company and ordered appropriate sprinkler head. The sprinkler head will be replaced in the identified location.		
ABORATOR	ODECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		7ITLE		(X8) DATÉ

Any deficiency statement ending with an exterisk (6 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.

If continuation sheet Page 1 of 1

A :PROVIDER OR SUPPLIER  EAK RESOURCES - PINELAKE  STREET ADDRESS, CITY, STAYE, 2IP CODE BY FINEHURST AVENUE  CARTHAGE, NC 28327  TAG  PROVIDER OR 2804 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTION AUGUS BE PRECEDED BY FULL TAG  NOTICE (EACH CORRECTION ON THE DEFICIENCIES (EACH CORRECTION AUGUS BE PRECEDED BY FULL TAG  PROVIDERS PLAN OF CORRECTION GRACH CORRECTION AUGUS BE PRECEDED BY FULL TAG  PRECIDENCY TAG  PRECIDENC	TEMENT OF DEFICIENCIES ) PLAN OF CORRECTION (X1) PROVIDENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
A PROVIDER OR SUPPLIER  EAK RESOURCES - PINELAKE    STREET ADDRESS, CITY, STATE, ZIP CODE BOT FINEHURST AVENUE CARTHAGE, NC. 28327   GACH DEFICIENCY NUST BE PRECEDED BY FULL TAG   GEACH CORRECTIVE ACTION SHOULD BE CACHS-REFERENCED TO THE APPROPRIATE COATE   TAG   CACHS-REFERENCED TO THE APPROPRIATE COATE				A. BUILDING		400 1400 1400 1400 1400 1400 1400 1400		
EAK RESOURCES - PINELAKE    SOF FINEHURST AVENUE   CARTHAGE, NC 28327     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOULATORY OR LISC IDENTIFYING INFORMATION)   PREFIX TABLE			345429	B. VVII			07/0	3/2012
REGULATORY OR ISC IDENTIFYING INFORMATION   PREFIX TAG   CROSS-REFERENCE TO THE APPROPRIATE   COMMENTS			KE		80	1 FINEHURST AVENUE		
This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This portion of the facility is the new rehabilitation building and it is Type V protected construction. The facility is equipped with an automatic sprinkler system.  There were no Life Safety Code Deficiencies noted during the survey.  CFR#: 42 CFR 483.70 (a)  CFR#: 42 CFR 483.70 (a)  Environmental Services Director will conduct monthly inspections to determine continued compliance, regarding the ongoing use of similar sprinkler heads throughout the facility. Also a contracted sprinkler company will conduct annual inspections as well.  Any discrepancies will be discussed with the Administrator and any issues found, based on inspections, will be brought to the facility safety committee meeting each	REFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	
SORATORY DIRECTOR'S OR PROVIDERSUPPLIER PRPRESENTATIVES SIGNATURE TITLE (X6) DATE		This Life Safety Coconducted as per Tat 42 CFR 483.70(s Care section of the publications. This prehabilitation buildiconstruction. The frautomatic sprinkler.  There were no Life noted during the sufficient of t	the Code of Federal Register (a); using the 2000 New Health LSC and its referenced (ortion of the facility is the new (ng and it is Type V protected (acility is equipped with an system.  Safety Code Deficiencies (1709).			entire building was conducted by the Environmental Service Director to determine that mother areas in the facility we compromised. No further issues were noted from inspection.  Environmental Services Dire will conduct monthly inspections to determine continued compliance, regarding the ongoing use of similar sprinkler heads throughout the facility. Also contracted sprinkler company will conduct annual inspections well.  Any discrepancies will be discussed with the Administrator and any issue found, based on inspections will be brought to the facility safety committee meeting emonth.	ed es io ere ctor  f a ny ons	(¾0) DATE
Benef Byyl Odninis duction 7/12/12	/	Deut t	Engl	1	1	* <i>i</i>	7/1/2	11>.

lency statement ending with the states (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that her regulards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 tys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogrem participation.