(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		NH0403	B. WING		05/15/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PEAK RES	SOURCES-CHERRYVILLI		AS CHERRYV LLE, NC 2802	ILLE HIGHWAY 1		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 226	10A NCAC 13F .0702 (b) The discharge of a one of the following re (1) the discharge is not welfare and the reside the facility as docume physician, physician a practitioner; (2) the resident no lon provided by the facility resident's physician, practitioner; (3) the safety of other endangered; (4) the health of other endangered as documphysician assistant or (5) failure to pay the caccommodations by the according to the reside written notice of warning to pay; or (6) the discharge is mediangle is not met a Based on record revisitinterviews, the facility	ecessary for the resident's ent's needs cannot be met in nted by the resident's assistant or nurse.  Ith has improved sufficiently ger needs the services y as documented by the physician assistant or nurse individuals in the facility is individuals in the facility is nented by a physician, nurse practitioner; sosts of services and the payment due date ent contract after receiving ing of discharge for failure andated under G.S.  The service of the residents and staff failed to utilize a justified of 1 of 4 residents reviewed	D 226	Filing the plan of correction does not constitute admission that the deficient alleged did in fact exist. The plan of correction is filed as evidence of the facility s desire to comply with the requirements and to continue to provide	cies	6/17/14
	revised May 2007, ref Administrative Code 1 lists the reasons for d	sident discharge policy, ferred to North Carolina IOA NCAC 13F .0702 and ischarge of a resident he Administrative Code.		high quality of care. D226 Resident # 1 was discharged on 3/19/ For all residents, 100% of all facility-initiated discharges will be base on one of the following reasons: (1) th	14. ed	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/09/14 **Electronically Signed** 

TITLE

Division of Health Service Regulation

DIVISION OF FICAULT SCIVICE REgulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		NH0403	B. WING		05/15/2014	
		14110403			03/13/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DE 417 DE 4		_ 7615 DALL	AS CHERRYV	ILLE HIGHWAY		
PEAK RES	SOURCES-CHERRYVILL	E CHERRYVI	LLE, NC 2802	21		
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	J (VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	( - /	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
				DEFICIENCY)		
D 226	Continued From page 1		D 226			
				dia da a a a a a a a a a a a a a a a a a	.4	
		adult care home resident		discharge is necessary for the resider	l l	
		included schizophrenic		welfare and the resident □s needs can		
	· · · · · · · · · · · · · · · · · · ·	opathy, and chronic pain		be met in the facility as documented b	ру	
	_	f Resident #1's most recent		the physician, physician assistant, or		
		0/13 included the problem of		nurse practitioner; (2) the resident □s		
		ng with a target goal dated		health has improved sufficiently so the		
	01/24/14 to verbalize			resident no longer needs the services	l l	
	demonstrate coping behaviors.			provided by the facility as documented	а бу	
	Review of Resident #1's medical record revealed a psychiatric mental health nurse practitioner			the resident s physician, physician		
				assistant, or nurse practitioner; (3) the		
				safety of other individuals in the facility	y is	
		n dated 01/25/14. The resident was relatively		endangered; (4) the health of other individuals in the facility is endangered	4.00	
	stable with nursing st	•		documented by a physician, physician		
	_	NP assessment noted		assistant, or nurse practitioner; (5) fail		
		e better off in a group home		to pay the costs of services and	uic	
		ould make this difficult and		accommodations by the payment due	date	
		w up consultation in 4 to 8		according to the resident contract after		
		chiatrist consultation dated		receiving written notice of warning of		
		e resident was smoking		discharge for failure to pay; or (6) the		
		arettes from other residents		discharge is mandated under G.S.		
		e butts. The psychiatrist		131D-2(a1).		
		inselling the resident on this		6-6-14		
		dent as stopping it but		Education was provided to the		
		ns were documented as		Interdisciplinary Care Plan Team by th	ne	
	reviewed during this			Administrator regarding the reasons for		
				the transfer/ discharge of a resident.		
	Review of a controlled	d drug		staff member on leave of absence will		
		ition form revealed the		educated prior to beginning work.		
		the narcotic analgesic		6-6-14		
	oxycodone/acetamino	<del>-</del>		An audit tool was developed to include	e if	
		with instructions to take 1		the proper reason was met for the		
		4 hours as needed (PRN)		initiation of the resident □s discharge.		
		d on this form was a date of		100% of all residents being discharge	d will	
		ement "33 with pt [patient]		be audited for compliance with proper		
		e]" and with an illegible		transfer/ discharge reasons. Audits w	l l	
		progress notes dated		completed by the Administrator weekly		
	_	e resident leaving on a LOA		8 weeks. Audits will continue quarterl		
		cations sent with him after		and the results will determine the nee		
	narcotic verification b	y 2 nurses and a medication		more frequent monitoring.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NH0403	B. WING		05/15/2014
					1 00/10/2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST		
PEAK RE	SOURCES-CHERRYVILL	E		VILLE HIGHWAY	
	CHER			21	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 226	Continued From page	2	D 226		
	dosages and how to t	a copy of a medication list, ake them.  of Responsibility for Leave		6-13-14 All audit information will be analyzed discussed by the Administrator at the Committee meetings.	
	of Absence form reve of the facility on 03/02	aled Resident #1 signed out 2/14 at 9:40 PM and signed on 03/06/14 at 6:00 PM.		6-17-14	
	of another progress in the resident refused to was slurred, he was larespond to conversate the resident as finally Another progress note "new orders" were red note dated 03/19/14 in "discharge- discharge	was in no distress. Review ote dated 03/10/14 revealed o take a shower, speech			
	no acute distress note resident." Review of form completed by the revealed Resident #1 wheelchair, no referra health, the medication	left by van, using a als were made to home a administration record and at with him and he was to			
	dated 03/19/14 revea the pre-printed staten care completed". Boy pre-printed statement "discharge plan discu and "other." Admittin hand-written in the de	ssed with member/family" g diagnoses were esignated block on the form re noted in the block labeled			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:	(X3) DATE SURVEY COMPLETED			
		NH0403	B. WING		05/15/2014	4
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	·	
TVAINE OF T	NOVIDEN ON OUT FEEL		LLAS CHERRYVILI			
PEAK RE	SOURCES-CHERRYVILL	E	VILLE, NC 28021	LE MIGHWAI		
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE COMP THE APPROPRIATE DA	X5) PLETE ATE
D 226	Continued From page	3	D 226			
	to [name of facility]" v	of the "Resident transferred vith disposition noted as egible signature was noted ature line and dated				
	03/19/14 as he was "himself." This documn his LOA on 03/07/14 medication than orde NHA [nursing home at Resident #1 on 03/10 and discuss discharg where he would like the had no preference a new facility. This discare Coordinator ass	hed 03/19/14 revealed harged from the ALF on an endangerment to hent hoted he returned from				
	PM revealed her rout skilled nursing unit, b certain number of ALI separate unit to addreas reviewing vital sign to care, nausea and conditions. She state was "by exception" at the ALF resident's cofacility had a good me with a psychiatrist availed the facility interviewed residents psychiatrist if needed #1 had resided in the	ed charting on ALF residents and done only with changes in ndition. She stated the ental health system in place allable by pager if needed.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			D W//NO			
		NH0403	B. WING		05	/15/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
DE AK DE	OOUDOEO OUEDDWALL	7615 DAI	LAS CHERRYVIL	LE HIGHWAY		
PEAK RE	SOURCES-CHERRYVILL	E CHERRY	VILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 226	Continued From page		D 226			
	wanted his PRN oxyc 4 hours. She stated with family and return oxycodone/acetaming evening of his return did not ask for any of oxycodone/acetaming checked on him and him as responsive an stated there was noth him for the missing paresident did not share was going to another psychiatrist was checked medications and the	ophen. She stated on the from his LOA, Resident #1 the ophen. She added she he was fine and described d not over-sedated. She hing punitive done toward ain medication and the with her a reason why he facility. Nurse #1 stated the king on him, adjusting resident received adequate so she stated the resident seen by the nurse				
	AM revealed ALF disc performed on a case the family or the resic staff would be notified with an interdisciplina of returning home threassessment. She sta move to another facil with the new facility. preferred a 5 day not but they would work of for an expedited disc stated the discharge completed with inform information and nursi would sign the form. there was no place to discharge and the mo	by case basis, meaning, if lent requested, discharge If and a care plan meeting ry team to determine safety bugh a home health lited if the resident wanted to ty this would be coordinated She stated the facility lice to perform these tasks with residents and families marge. The Social Worker blan of care form was nation such as ombudsman ng staff and the resident She stated on this form				

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PRINTED: 12/01/2014

Division of	of Health Service Regu	lation			FURIV	APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NH0403	B. WING		05/1	5/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
PEAK RESOURCES-CHERRYVILLE 7615 DA		LLAS CHERRYV	ILLE HIGHWAY			
PEARICE	300KCE3-CHERRI VILL	CHERRY	VILLE, NC 2802	1		
(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) COMPLETE DATE
D 226	Continued From page	e 5	D 226			
	would leave the facilit him, be gone for under and upon his return was more medications that She stated there was nurse investigated what take a shower, having he finally agreed to take that incident was the done that. She stated smoking and would "I residents. She stated coming back from a Ladanger to himself" and they were not themse stumbling and falling stated her progress monly documentation is the incident. The SW notified the following return to the facility for pending discharge dusafety. She stated the and Administrator we same day or the next recalled everything has thought her progress on Monday morning,	as a danger to himself as he ty, take his medications with etermined lengths of time was noted to have taken an what he should have. If an incident which she and a men the resident refused to go an odor and lethargy, and ake a shower. She stated second or third time he had do he broke rules about bum" cigarettes off other do the "last straw" was also an another than the possibility of the on someone. The SW tote on 03/10/14 was the she was aware of regarding of continued that she was day, after Resident #1's belowing his LOA, of his use to his and other resident's the Director of Nursing (DON) are notified, possibly the morning. She stated she appened on a Friday, so she note was written first thing 03/10/14. She stated the DON) and Administrator must				

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have had a conversation with him, possibly on Monday 03/10/14, and they normally had conversations regarding his behavior. The SW stated she recalled the Administrator telling her to have a talk with Resident #1 and she gave him a "heads up" that he may need another place to live, at which point he became very angry. She stated it was after this conversation that the DON and Administrator told her to find a new facility for the resident and when an opening was found, the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 \ /			DATE SURVEY COMPLETED	
		NH0403	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	, ZIP CODE	, ,	5/15/2014
		7615 DAL	LAS CHERRYVILI			
PEAK RE	SOURCES-CHERRYVILL	E CHERRY\	/ILLE, NC 28021			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE	
D 226	Resident #1 was recescheduled visits as we She stated the psych issues regarding addiff the resident receive to the incident upon head of the incident upon head solurred speech a later. She stated he was at that time, he agreed did not take 2 people she told the NAs he as the returned to her of have let the SW documents and answer corresponding the facility with an emmedications. She stated to the facility with an emmedication after his returned to her of the facility with an emmedication technician anything they replied the facility with an emmedication after his returned to PM and 6:00 PM. See history of drinking and she was a she was a history of drinking and she was a she was a history of drinking and she was a she was a history of drinking and she was a she w	in discharge. The SW stated siving psychiatric care for ell as for acute concerns. Intrist would address any oction and she was not sure do a medical referral related his return from his LOA.  In the second shift and he had a stated he appeared dazed, and he would take a shower was asked to take a shower was asked to take a shower was asked to take a shower and fire. She stated she may ment this interaction with the heappeared as if he pretty was able to extly. She stated when as were asked if he took no, but that he returned to apply medication card of pain the she was told of his curn on the second shift and to see him between 4:00 he stated she knew he had	D 226			
	A phone interview wit at 11:05 AM revealed cognitively intact and He stated he was told DON while in the smo and must leave the fa	h Resident #1 on 05/15/14 him to be alert, oriented, appropriate for an interview. I by the Administrator and oking area he had no choice icility. He stated he was not tifying him of the right to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		NH0403	B. WING	·	05	/15/2014
NAME ∩E P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	,	
NAIVIE OF F	ROVIDER OR SUFFLIER		LLAS CHERRYVIL			
PEAK RE	SOURCES-CHERRYVILL	.E	VILLE, NC 28021	LE NIGRWAT		
0/0.15	QUIMMADV QT	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	CORRECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 226	Continued From page	e 7	D 226			
	to stay as it was a bravery comfortable and everybody. He state amount of morphine short 5 or 6 of the ox	o discharge and he wanted and new building, he was I he got along with d he returned with right sulfate but was told he was ycodone/acetaminophen no reason to be kicked out of				
	PM revealed her assinurse to the ALF unit was real pleasant wit bond. She stated he certain staff to do cer way with him. She sine left the facility as i shift as she was com	rse #3 on 05/15/14 at 1:04 ignment as a "back up"  . She stated Resident #1 the her and that they had a was a smoker, he liked tain things and she had a tated she did not know why toccurred on the seconding in. She stated Resident r even though he might not				
	DON on 05/15/14 at residents were more discharge was indica their preferences or trappropriate setting, a Resident #1. In case DON and Administratibe asked for their prestate one, they found and accepted his administration was aware of before he left and the offer due to the natur "unsafe." They state occurrence, they had prior occasions and he	ted, it was usually due to o place them in a more				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
		NH0403	B. WING		05/15/	/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
DEAK DE	SOUDCES CHEDDAVIII I	7615 DALL	AS CHERRYV	ILLE HIGHWAY		
PEAN RE	SOURCES-CHERRYVILL	CHERRYV	ILLE, NC 2802	<b>1</b>		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 226	Continued From page	2.8	D 226			
D 226	DON stated she cour medication and figure needed for the time he the facility. She state medications and the missing doses was the oxycodone/acetaming Resident #1 was his chad no impaired cogrunderstanding instructional incident occurred in require hospital treatmental any documental discussion they had were needed for the time of the time	overdose situation. The steed out the narcotic sed out how many doses here was expected to be out of sed the resident took all his conly narcotic medication see to be seen to b	D 226			
	Resident #1 returned of 03/06/14 and it was morning 03/07/14 that the resident had not be him up and the SW with Nurse #2. They the SW had a discussion, he undershappy he showed no there were more convibred waiting for the atteir assessment. The was "a danger to him "subjective verses obsure if the resident pomedication from the proom. They stated the feel comfortable manimedications as they conversed to the state of	stood and although not resistance. They stated versations with Resident #1 accepting facility to complete the DON stated the resident self" and their decision was jective" as they were not opped the narcotic backaging to stash in his e physician assistant did not aging Resident #1's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	NH0403		B. WING		05/15/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
PEAK RES	PEAK RESOURCES-CHERRYVILLE 7615 DA CHERRY			ILLE HIGHWAY 1		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 226	covering for them ass DON and Administrate provider should have	sure if the PA or the staff dessed the resident. The or stated they did think a been called and notified. on for discharge of a resident	D 226			
D 227	10A NCAC 13F .0702 (c) Discharge Of Residents  10A NCAC 13F .0702 Discharge Of Residents  (c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:  (1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or  (2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.  This Rule is not met as evidenced by: Based on record review, resident interview and staff interview, the facility failed to provide		D 227	D227 Resident # 1 was discharged on 3/19/	/14.	6/17/14
	discharge and appeal care home resident w 1 of 4 residents review procedures. (Resident Review of a facility re revised May 2007, ref Administrative Code 2 included providing a control of the care o	rights notices to an adult rithin a 30 day timeframe for wed for discharge t #1). Findings included:  sident discharge policy, ferred to North Carolina 10A NCAC 13F .0702 which discharged resident state in 30 days of notifying a		For all residents, for 100% of all facility-initiated discharges, all residen will be provided the discharge and appright notices within a 30 day timeframe except when the notice needs to be mas soon as practicable based on healt and safety reasons. 6-6-14 Education was provided to the Interdisciplinary Care Plan Team by the Administrator regarding the 30 day no of discharge and appeal rights. Any smember on leave of absence will be	nts peal e nade th	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		NH0403	B. WING		05/15/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PEAK RES	SOURCES-CHERRYVILL	E		ILLE HIGHWAY		
		CHERRYVI	LLE, NC 2802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 227	Continued From page	e 10	D 227			
D 227	Resident #1 was an a with diagnoses which state, idiopathic neuro syndrome. Review of care plan dated 12/20 psychosocial well-bei 01/24/14 to verbalize demonstrate coping but Review of progress not revealed the following from ALF [assisted live another facility], medischarge instructions distress noted, belong Review of a discharge completed by the soci Resident #1 left by vareferrals were made to medication administration were sent with him arthis primary care physical Review of a facility did dated 03/19/14 reveat the pre-printed statement "discharge plan discutant "other." Admitting hand-written in the debut no comments were "Discharge Diagnosis handwritten notation of to [name of facility]" were sent with pre-printed statements were "Discharge Diagnosis handwritten notation of the comments were "Discharge Diagnosis handwritten notati	included schizophrenic pathy, and chronic pain f Resident #1's most recent poly 13 included the problem of any with a target goal dated positive feelings and pehaviors.  Totes dated 03/19/14 gr. "discharge- discharge ring facility] to [name of a sent with resident, a provided and no acute gings sent with resident." are plan of care form ital worker (SW) revealed and, using a wheelchair, no no home health, the pation record and medications and he was to follow up with dician.  Total check in the box for the serion order, seed with member/family greated with member/family greated block on the form the noted in the block labeled of the "Resident transferred with disposition noted as egible signature was noted"	D 227	educated prior to beginning work. 6-6-14 An audit tool was developed to include the resident being discharged receiver. 30 day notice of discharge and appearights. 100% of all residents being discharged will be audited for complia with proper transfer/ discharge notice. Audits will be completed by the Administrator weekly for 8 weeks. Au will continue quarterly and the results determine the need for more frequent monitoring. 6-13-14 All audit information will be analyzed a discussed by the Administrator at the Committee meetings. 6-17-14	d a I nce dits will	
	An internal document	provided by the				

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NH0403  STREET ADDRESS, CITY, STATE, ZIP CODE  7615 DALLAS CHERRYVILLE HIGHWAY  CHERRYVILLE, NC 28021  (A4) ID PREFIX IZAG CHORPICIENCY BALLAS CHERRYVILLE, NC 28021  D 227  Continued From page 11  Administrator and dated 03/19/14 revealed Resident #1 was discharged from the ALF on 03/19/14 after a discussion with the resident about where he would like to like. This document noted he had no preferences and referral was made to a new facility. This document stated the Resident Care Coordinator assessed the resident was discharge from the ALF on 03/19/14.  An interview with the SW on 05/15/15 at 10:00  AM revealed ALF discharge planning was performed on a case by case basis, meaning, if the family or the resident experience and referral was made to a new facility. This document safety of returning home through a home health assessment. She stated if the resident wanted to move to another facility this would be coordinated with the new facility. She stated the facility preferred a 5 day notice to perform these tasks but they would work with residents and families for an expedited discharge. The SW stated her progress note on 03/10/14 was the only documentations he was aware of regarding the	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  PEAK RESOURCES-CHERYVILLE  (X4) ID  (X5)  (X6)  (X6)  (X7)  (X7)  (X8)  (X8)  (X9)  (X4)  (X4) ID  (X6)  (X9)  (X9)	AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWIFE	EIED
PEAK RESOURCES-CHERRYVILLE  (X4] ID (X4] ID (REACH OFFICIENCE) TAG    SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE    D 227			NH0403	B. WING		05/15/2014	
(24) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECIDED BY FULL PREFIX TAG (EACH DEFICIENCY MIST BE PRECIDED BY FULL PREFIX TAG (EACH DEFICIENCY MIST BE PRECIDED BY FULL PREFIX TAG (EACH DEFICIENCY MIST BE PRECIDED BY FULL PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  D 227  Continued From page 11  Administrator and dated 03/19/14 revealed Resident #1 was discharged from the ALF on 03/19/14 after a discussion with the resident about where he would like to live. This document noted he had no preferences and referral was made to a new facility. This document stated the Resident Care Coordinator assessed the resident, made a bed offer and the resident was discharged on 03/19/14.  An interview with the SW on 05/15/15 at 10:00  AM revealed ALF discharge planning was performed on a case by case basis, meaning, if the family or the resident requested, discharge staff would be notified and a care plan meeting with an interdisciplinary team to determine safety of returning home through a home health assessment. She stated if the resident wanted to move to another facility this would be coordinated with the new facility. She stated the facility preferred a 5 day notice to perform these tasks but they would work with residents and families for an expedited discharge. The SW stated her progress note on 03/10/14 was the only documentation she was aware of regarding the	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHERRYVILLE, NC 28021  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 227  Continued From page 11  Administrator and dated 03/19/14 revealed Resident #1 was discharged from the ALF on 03/19/14 after a discussion with the resident about where he would like to live. This document noted he had no preferences and referral was made to a new facility. This document stated the Resident Care Coordinator assessed the resident, made a bed offer and the resident was discharged on 03/19/14.  An interview with the SW on 05/15/15 at 10:00 AM revealed ALF discharge planning was performed on a case by case basis, meaning, if the family or the resident requested, discharge staff would be notified and a care plan meetling with an interdisciplinary team to determine safety of returning home through a home health assessment. She stated if the resident wanted to move to another facility this would be coordinated with the new facility. She stated the facility preferred a 5 day notice to perform these tasks but they would work with residents and families for an expedited discharge. The SW stated her progress note on 03/10/14 was the only documentation she was aware of regarding the	DEAK DE	POLIDOES CHEDDWILL	7615 DALL	AS CHERRYV	ILLE HIGHWAY		
PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DATE	PEAN RE	SOURCES-CHERRY VILL	CHERRYV	LLE, NC 2802	21		
Administrator and dated 03/19/14 revealed Resident #1 was discharged from the ALF on 03/19/14 after a discussion with the resident about where he would like to live. This document noted he had no preferences and referral was made to a new facility. This document stated the Resident Care Coordinator assessed the resident, made a bed offer and the resident was discharged on 03/19/14.  An interview with the SW on 05/15/15 at 10:00 AM revealed ALF discharge planning was performed on a case by case basis, meaning, if the family or the resident requested, discharge staff would be notified and a care plan meeting with an interdisciplinary team to determine safety of returning home through a home health assessment. She stated if the resident wanted to move to another facility this would be coordinated with the new facility. She stated the facility preferred a 5 day notice to perform these tasks but they would work with residents and families for an expedited discharge. The SW stated her progress note on 03/10/14 was the only documentation she was aware of regarding the	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
incident precipitating the resident's discharge.  The SW stated that she was notified on 03/07/14, after Resident #1's return to the facility on 03/06/14 following his LOA, of his pending discharge. She stated she recalled the Administrator telling her to have a talk with Resident #1 and she gave him a "heads up" that he may need another place to live, at which point he became very angry. She stated it was after this conversation that the DON and Administrator told her to find a new facility for the resident and when an opening was found, the facility proceeded with discharge.  A phone interview with Resident #1 on 05/15/14	D 227	Administrator and dat Resident #1 was discussion of the had no preferred to a new facility. Resident Care Coord resident, made a bed discharged on 03/19/  An interview with the AM revealed ALF discussion of returning the hading of returning home threat assessment. She start move to another facility preferred a 5 day not but they would work of an expedited disciprogress note on 03/documentation she wincident precipitating. The SW stated that after Resident #1's reconstitution of the start and she he may need another he became very angrithis conversation that told her to find a new when an opening was proceeded with discharge.	ted 03/19/14 revealed charged from the ALF on ussion with the resident dike to live. This document erences and referral was y. This document stated the inator assessed the offer and the resident was 14.  SW on 05/15/15 at 10:00 charge planning was by case basis, meaning, if tent requested, discharge d and a care plan meeting any team to determine safety ough a home health ated if the resident wanted to ity this would be coordinated She stated the facility ince to perform these tasks with residents and families harge. The SW stated her 10/14 was the only reas aware of regarding the the resident's discharge. The was notified on 03/07/14, eturn to the facility on a LOA, of his pending ed she recalled the her to have a talk with gave him a "heads up" that or place to live, at which point by She stated it was after at the DON and Administrator facility for the resident and as found, the facility arge.	D 227			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:						
		NH0403	B. WING		05/15/2014				
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STAT	E. ZIP CODE					
PEAK RE	PEAK RESOURCES-CHERRYVILLE CHERRYVILLE CHERRYVILLE, NC 28021								
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE				
D 227	Continued From page	: 12	D 227						
D 227	at 11:05 AM revealed cognitively intact and He stated he was told Director of Nursing (Darea he had no choice He stated he was not him of the right to app discharge and he war brand new building, hhe got along with eve Combined interviews DON on 05/15/14 at 4 residents were more I discharge was indicat their preferences or to appropriate setting, as Resident #1. In cases DON and Administrate be asked for their prestate one, they found and accepted his admiresident was aware or before he left and the offer due to the nature transfer was not going stated Resident #1 was person and had no im him from understandinand Administrator furt Monday, 03/10/14 the Resident #1 about whit was a discussion, hoot happy he showed there were more convivile waiting for the at their assessment. The	him to be alert, oriented, appropriate for an interview. I by the Administrator and io(N) while in the smoking and must leave the facility. I given a document notifying weal the decision to need to stay as it was a e was very comfortable and rybody.  With the Administrator and it. 15 PM revealed ALF ong term and when ed, it was usually due to oplace them in a more is it was the case for so like Resident #1's, the for stated the resident would ference and when he did not a facility who assessed him hission. They stated the fir approach with him was an experience of the discharge, but his go to be an option. They as his own responsible apaired cognition preventing and instructions. The DON	D 227						
	When shown a copy of	of the NC Administrative							

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Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NH0403	B. WING		05/15/2014	
	ROVIDER OR SUPPLIER	7615 DA	ADDRESS, CITY, STA	ILLE HIGHWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	l l	
D 227	Continued From page for discharge notice, not receive 30 day no	they stated Resident #1 did	D 227			
D 228	(d) The reason for didocumented in the reDocumentation shall following as applicable Paragraph (b) of this (1) documentation be assistant or nurse preParagraph (b) of this (2) the condition or of the health or safety of discharged or endangindividuals in the facilitaken to address the discharge of the resident accommodations; or (4) the specific health resident that the facility pursuand as disclosed in the upon the resident's accommodations. This Rule is not met Based on record revies staff interview, the fact the record of an adult reason for discharge	E Discharge Of Residents scharge shall be sident's record. include one or more of the e to the reasons under Rule: y physician, physician actitioner as required in Rule; sircumstance that endangers if the resident being gers the health or safety of ity, and the facility's action problem prior to pursuing lent; warning of discharge for as of services and h need or condition of the ty determined could not be suant to G.S. 131D-2(a1)(4) he resident contract signed dmission to the facility.	D 228	D228 Resident # 1 was discharged on 3/19/1 For all residents, for 100% of all facility-initiated discharges, the reason discharge will be documented in the record of the adult care home resident. Documentation will be completed by the	for	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		NH0403	B. WING		05/15/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	NTE, ZIP CODE		
DEAK DE	SOURCES-CHERRYVILL	7615 DALL	AS CHERRYV	ILLE HIGHWAY		
PEAR RES	SOURCES-CHERRY VILL	CHERRYV	ILLE, NC 2802	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 228	Continued From page	e 14	D 228			
D 228	Review of a facility rerevised May 2007, readdinistrative Code included documentation the medical record.  Resident #1 was an awith diagnoses which state, idiopathic neurosyndrome.  Review of a facility didated 03/19/14 reveathe pre-printed statem care completed. Bospre-printed statement discharge plan discurand "other." Admittin hand-written in the debut no comments were "Discharge Diagnosis handwritten notation to [name of facility]" wassisted living. An ille on the physician sign 04/22/14.  Combined interviews Administrator and Dirat 4:15 PM. They stated of a resident was made	sident discharge policy, ferred to North Carolina 10A NCAC 13F .0702 which on of a reason for discharge adult care home resident included schizophrenic opathy, and chronic pain scharge summary form led a check in the box for nent "post discharge plan of kes were not checked for the s "physician order", ssed with member/family" g diagnoses were esignated block on the form the noted in the block labeled of the "Resident transferred with disposition noted as egible signature was noted ature line and dated was conducted with the ector of Nursing on 05/15/14 ted the reason for discharge de in the SW notes and they eason for discharge missing	D 228	physician, physician assistant, or nurs practitioner. Documentation will include the condition or circumstance that endangers the health of safety of the resident being discharged or endange the health or safety of individuals in the facility, and the facility saction taken address the problem prior to pursuing discharge of the resident. It will include written notices of warning of discharge the failure to pay the costs of services accommodations and will include the specific health need or condition of the resident that the facility determined conot be met in the facility.  6-6-14  Education was provided to the Interdisciplinary Care Plan Team by the Administrator regarding the required documentation of the reasons for the discharge. Any staff member on leave absence will be educated prior to beginning work.  6-6-14  An audit tool was developed to include the resident second included the required documentation for the reason discharge. 100% of all residents being discharged will be audited for complia with proper transfer/ discharge documentation. Audits will be comple by the Administrator weekly for 8 weekly will determine the need for monotine frequent monitoring.  6-13-14  All audit information will be analyzed a discussed by the Administrator at the Committee meetings.  6-17-14	de  ars e to  de e for and e build  de e of e if n of g nnce ted ks.	

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		NH0403	B. WING	<del></del>	0	5/15/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
PEAK RE	SOURCES-CHERRYVILL	E	ALLAS CHERRYVIL YVILLE, NC 28021	LE HIGHWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 229	(e) The facility shall a requirements for writt discharging a resident (1) The Adult Care H with the Adult Care H shall be hand delivered the resident on the sall be obtained at n Medical Assistance, 2 Raleigh, NC 27699-2 (2) A copy of the Adult Discharge with a copy Hearing Request Forwith receipt requested the resident's responsive representative on the Home Notice of Discharge. (3) Failure to use an specific forms accord and (e)(2) of this Rule discharge. Failure to these forms shall not unless the facility has a change in the forms of the latest forms by and Human Services (4) A copy of the corn Notice of Discharge, Hearing Request Forfacility prior to giving the receipt of hand defined the states of the sall of	E Discharge Of Residents  assure the following en notice are met before it: Home Notice of Discharge ome Hearing Request Form ed, with receipt requested, to ame day the Adult Care harge is dated. These forms to cost from the Division of 2505 Mail Service Center, 505. Lilt Care Home Notice of ty of the Adult Care Home m shall be hand delivered, d, or sent by certified mail to sible person or legal same day the Adult Care harge is dated. d simultaneously provide the ing to Subparagraphs (e)(1) e shall invalidate the use the latest version of invalidate the discharge to been previously notified of and been provided a copy the Department of Health mpleted Adult Care Home	D 229			6/17/14

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		NH0403	B. WING		05/15/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
PEAK RES	SOURCES-CHERRYVILL	E	AS CHERRYV	ILLE HIGHWAY 21		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 229	Continued From page	e 16	D 229			
	This Rule is not met Based on record revies staff interview, the fact discharged adult care forms for 1 of 4 reside procedures. (Resider Review of a facility rerevised May 2007, readdinistrative Code included providing a discharge forms.  Resident #1 was an awith diagnoses which state, idiopathic neurosyndrome. Review of care plan dated 12/20 psychosocial well-bei 01/24/14 to verbalize demonstrate coping to Review of progress not revealed the following from ALF [assisted live another facility], medical discharge instructions distress noted, belong Review of a discharge completed by the soci Resident #1 left by vareferrals were made to medication administrative were sent with him ar his primary care physical review of a facility discharge of a facility discourse work as a facility discours	as evidenced by: ew, resident interview and cility failed to provide a chome resident discharge ents reviewed for discharge ent #1). Findings included: sident discharge policy, fers to North Carolina 10A NCAC 13F .0702 which discharged resident state  adult care home resident included schizophrenic copathy, and chronic pain f Resident #1's most recent 0/13 included the problem of ng with a target goal dated positive feelings and behaviors.  otes dated 03/19/14 g: "discharge- discharge ring facility] to [name of seent with resident, seprovided and no acute gings sent with resident. " e plan of care form ital worker (SW) revealed an, using a wheelchair, no no home health, the ation record and medications and he was to follow up with diction.		D229 Resident # 1 was discharged on 3/19/For all residents, for 100% of all facility-initiated discharges, all resider will be provided the required discharg forms to include the Adult Care Home Notice of Discharge and the Adult Care Home Hearing Request Form and a comaintained in the resident second. 6-6-14 Education was provided to the Interdisciplinary Care Plan Team by the Administrator regarding issuing the prodischarge and appeal rights forms. A staff member on leave of absence will educated prior to beginning work. 6-6-14 An audit tool was developed to include the resident being discharged receive Notice of Discharge and Hearing Requestion forms. 100% of all residents being discharged will be audited for complia with proper transfer/ discharge and apprights forms. Audits will be completed the Administrator weekly for 8 weeks. Audits will continue quarterly and the results will determine the need for monofrequent monitoring. 6-13-14 All audit information will be analyzed a discussed by the Administrator at the Committee meetings. 6-17-14	e e e e e e e e e e e e e e e e e e e	
	Review of a facility di dated 03/19/14 revea the pre-printed staten					

Division of Health Service Regulation

STATE FORM 6899 I70V11 If continuation sheet 17 of 20

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA				DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		LETED	
			B. WING			4-10-44	
		NH0403	B. WING	······································	05/	15/2014	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,			
PEAK RE	SOURCES-CHERRYVILL	E		ILLE HIGHWAY			
			ILLE, NC 2802			_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
D 229	Continued From page	e 17	D 229				
D 229	pre-printed statement "discharge plan disculand "other." Admittin hand-written in the debut no comments were "Discharge Diagnosis handwritten notation to [name of facility]" wassisted living. An illed on the physician sign 04/22/14.  An interview with the AM revealed the discompleted with information and nursi would sign the form. there was no place to discharge and the most this would be in the pathere were no others discharged residents discharge plan of carry progress note on 03/documentation she wincident precipitating. The SW stated that s day, after Resident # following his Leave of discharge. She state Administrator telling he Resident #1 and she he may need another he became very angrithis conversation that	is "physician order", ssed with member/family" g diagnoses were esignated block on the form re noted in the block labeled it." This form had of the "Resident transferred with disposition noted as egible signature was noted ature line and dated.  SW on 05/15/15 at 10:00 harge plan of care form was nation such as ombudsmaning staff and the resident. She stated on this form on note the reason for pre likely place to document rogress notes. She stated documents she provided to other than a copy of the reason of the earn of the stated her 10/14 was the only as aware of regarding the the resident's discharge, the was notified the following the recalled the per to have a talk with gave him a "heads up" that replace to live, at which point ty. She stated it was after the Director of Nursing	D 229				
	, ,	ator told her to find a new t and when an opening was					
	_	ceeded with discharge.					
	A phone interview wit	h Resident #1 on 05/15/14					

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		NH0403	B. WING		05/	15/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DE AK DE	COURCES OUEDDWAILL	_ 7615 DALI	AS CHERRYV	ILLE HIGHWAY		
PEAK RE	SOURCES-CHERRYVILL	CHERRYV	ILLE, NC 2802	21		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T		COMPLETE DATE
TAG	REGULATORTORT	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC		DATE
			+			
D 229	Continued From page	e 18	D 229			
	at 11:05 AM revealed	him to be alert, oriented,				
		appropriate for an interview.				
	He stated he was told	by the Administrator and				
	DON while in the smo	oking area he had no choice				
	and must leave the fa	acility. He stated he was not				
		tifying him of the right to				
		o discharge and he wanted				
	_	and new building, he was				
	very comfortable and	he got along with				
	everybody.					
	Combined interviews with the Administrator and					
		4:15 PM revealed ALF				
	residents were more					
		ted, it was usually due to				
	_	o place them in a more				
	appropriate setting, a					
	Resident #1. In case	s like Resident #1's, the				
	DON and Administrat	or stated the resident would				
	be asked for their pre	ference and when he did not				
		a facility who assessed him				
		nission. They stated the				
		of the transfer the whole time				
		ir approach with him was an				
		e of the discharge, but his				
		g to be an option. They as his own responsible				
		npaired cognition preventing				
		ing instructions. The DON				
	and Administrator fur					
		e SW had a discussion with				
	_	nere he would like to go, that				
		ie understood and although				
		I no resistance. They stated				
		versations with Resident #1				
	while waiting for the a	accepting facility to complete				
	their assessment. Th	ney stated the reason for				
		nt was made in the SW				
		copies of required forms				
	referenced in the NC	Administrative Code to be				

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Division of Health Service Regulation

NH0403  B. WING  PEAK RESOURCES-CHERRYVILLE  SITREET ADDRESS. CITY. STATE, ZP CODE  7615 DALLAS CHERRYVILLE HIGHWAY  CHERRYVILLE, NC. 28021  (PA)  DAIL DEPTINE THAN OF CORRECTION  (PA)  (PA)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED				
PEAK RESOURCES-CHERRYVILLE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)  D 229 Continued From page 19 presented to a discharged resident, they stated they did not complete these forms for Resident	NH0403			B. WING	B. WING					
CHERRYVILLE, NC 28021  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 229 Continued From page 19 presented to a discharged resident, they stated they did not complete these forms for Resident	NAME OF P									
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  D 229  Continued From page 19  presented to a discharged resident, they stated they did not complete these forms for Resident	I PEAK RESOURCES.CHERRYVII I E									
presented to a discharged resident, they stated they did not complete these forms for Resident	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE			
	D 229	presented to a discha they did not complete	rged resident, they stated	D 229						

Division of Health Service Regulation

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