STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345494	A. BUILDING ______ B. WING ______	C 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - GASTONIA	**2780 X-RAY DRIVE GASTONIA, NC 28054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide the necessary care required to safely care for a resident that was rolled out of bed while being dressed for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 06/09/03 with diagnoses that included Alzheimer's disease and others. Resident #1's care plan specified an approach dated 03/18/13 that staff were to turn and reposition the resident during rounds and that staff were to assist the resident with activities of daily living. A document titled "Resident Care Information Sheet" (not dated) for Resident #1 specified that Resident #1 required total care for dressing and required 2 persons to assist with bed mobility and was transferred with a mechanical lift. The most recent Minimum Data Set (MDS) dated 06/09/15 specified the resident had short and long term memory problems and severely impaired cognitive skills for daily decision making. The MDS also specified the resident did not resist care but required extensive 2 person assistance with bed mobility and dressing. At the time of the	F 323	Filing of this 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. Affected Resident: Resident # 1 was assessed with no apparent injuries noted. Resident #1¿s bed was changed to a bariatric bed. Potentially Affected Residents: All residents have the potential to be affected. Director of Nursing completed 100% Audit to identify the appropriate number of staff required to safely care for a resident regarding bed mobility. Systemic Changes: Bed mobility will be updated on the Standards of Care sheet. Standards of	7/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 07/19/2015

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

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F 323	Continued From page 1 MDS assessment, Resident #1 had not fallen in the facility. On 07/08/15 at 10:15 AM observations were made of nurse aide (NA) #1 and nurse aide #2 providing care for Resident #1. The nurse aides were interviewed and reported that Resident #1 was unable to assist with activities of daily living and that it took 2 staff to provide care for the resident due to her dependent state. During the observation, Resident #1 made repeated gestures with her hands and arms and the nurse aides had to reassure her. The nurse aides rolled Resident #1 on her side and the Resident stated, "Don't throw me out, and don't kill me." NA #1 and NA#2 reported that it was difficult to provide care for Resident #1 because she moved her arms around during care and needed reassurance. Review of Resident #1's medical record revealed a nurse's entry dated 06/25/15 that read in part, resident rolled out of bed while a nurse aide was assisting the resident in bed but no injuries were noted. An incident report dated 06/25/15 for Resident #1's fall from the bed revealed that NA #3 rolled Resident #1 over on her left side and the resident used her arms to reach and grab onto the bedside table causing the resident to roll off the bed landing in the floor. On 07/08/15 at 12:52 PM NA #3 was interviewed and reported that she had only provided care for Resident #1 during her orientation process and that it took 2 people to care for Resident #1. NA #3 stated that she wasn't familiar with all the residents' care needs and level of assistance. The NA was not aware of the "Resident Care Information Sheet" that indicated a resident's required level of assistance. NA #3 reported that on 06/25/15 she was in the room alone with	F 323	care updated daily and reviewed weekly by interdisciplinary team. Administrative Nurses conducted education to all nursing staff to include: transition from resident care sheets to standards of care, expectation of C.N.A.s to communicate changes in bed mobility as they occur, and review of appropriate ADL documentation. Monitoring: A monitoring tool was developed to monitor providing the necessary care required to safely care for a resident to include (but not limited to): the resident is positioned close to the staff member prior to being turned on his/her side? ; resident extremities are in alignment in order to be turned without incident? ; Staff member turned the resident properly as evidenced by the resident lying in the bed in the proper position post being turned? ; Appropriate number of staff members providing care? DON (or Administrative Nurse) to conduct audits of 10% of residents weekly for 4 weeks, then 10% of residents every other week for 4 weeks, then 10% of residents monthly for 2 months. The need for additional monitoring will be determined based on the results of the previous audits. All audits will be discussed/reviewed during monthly QAPI meeting.	

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F 323	Continued From page 2 Resident #1 assisting the resident with care in bed. The nurse aide explained that she rolled Resident #1 over on her left side with her right leg over the left leg hanging off the bed. NA #3 added that Resident #1 had a concave mattress but due to the resident's size had little room in the bed for movement which cause her to be near the edge of the mattress when she was turned. NA #3 stated that while she had the resident rolled over, Resident #1 reached for the bedside table causing the resident to roll out of bed onto the floor. On 07/08/15 at 2:00PM the Assistant Director of Nursing (ADON) was interviewed and reported that she investigated falls for the facility. The ADON reported that Resident #1 had consistent behaviors such as using her arms to reach during care and scratched herself repeatedly. The ADON reported that this made it difficult for staff to provide care and was why there were to be 2 staff in the room to provide care. The ADON stated that in her investigation of the fall on 06/25/15 she discovered that NA #3 and a treatment nurse had been in the room with Resident #1. The ADON added that the treatment nurse left the room, leaving NA #3 in the room alone to complete the care. The ADON explained that NA #3 rolled the resident over in bed to assist the resident with dressing and the resident rolled out of bed. On 07/08/15 at 3:20 PM the Director of Nursing (DON) was interviewed and reported that it was her understanding of the fall on 06/25/15 that NA #3 was in the room alone providing care for Resident #1. The DON stated that at the time Resident #1 rolled out of bed she required 1 person assistance with care. The DON explained that NAs were trained to refer to the "Resident Care Information Sheet" to know what level of	F 323		

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F 323	Continued From page 3 assistance a resident required and added that she did not expect nurse aides to decide how much level of assistance a resident required. The DON stated that she expected nurse aides to always use more care rather than less for safety. The DON reviewed medical record documentation that specified Resident #1 required 2 person assistance with dressing and bed mobility and reported that NA#3 should not have attempted to provide care for Resident #1 alone. The DON stated that NA #3 should have asked for help to assist Resident #1 with care on 06/25/15.	F 323		